Commerce and Care: The Irreconcilable Tension Between Selling and Caring

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I. INTRODUCTION

American doctors have one foot in each of two conflicting worlds. They practice health care, which implies that they are guided by an ethic of care. They also compete in a capitalist market economy in order to survive and thrive.[1] This article describes the tension that results from pressures emanating from those two worlds, and it examines the problems created by conflicting demands and differing ethical and economic motivations. It points out that dentists and patients alike frequently do not understand the implications of this conflict and concludes that increasing commercialization of dental practice is likely to leave patients in a vulnerable position in the future.

Table 1 shows the essential elements of the conflict faced by doctors and patients. The components of Table 1 are described below.

TABLE 1.

Commerce	**Care**
Profit is goal (proprietary)	Care is goal (fiduciary)
Money is primary	Money is derivative
Customer as "means"	Patient as "end"
Competitive:	Cooperative:
between companies	between doctors
between buyer and seller	between doctor and patient
Endorsements, anecdotes	Science, empiricism
Caveat Emptor	Buyer cannot fairly compete (trust)
Widgets, things	Life or death, health

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1. This idea was first presented by David Nash in 1994. *See* David A. Nash, *A Tension Between Two Cultures . . . Dentistry as a Profession and Dentistry as Proprietary*, 58 J. DENTAL EDUC. 301, 301-06 (1994) (discussing the conflicting interests of professionals to both serve others and earn a living).

II. OF COMMERCE AND CARE

A. The World of Commerce

Buyers and sellers in the commercial marketplace are driven by competitive forces. What follows is an analysis that compares and contrasts each of the elements in Table 1, starting with the left side of the chart.

The profit motive. In the commercial marketplace, sellers have a proprietary interest in their product or service. Profit is the goal, and if sellers are not able to make a profit, they flounder and are eventually eliminated from the game. Corporate officers in publicly held companies view the requirement to make a profit as an essential *ethical* demand. Ever since Alfred Rappaport persuasively argued in the 1980s that shareholder value is the best way to evaluate a publicly held company,[2] business students have memorized this obligation. Corporate officers now uniformly feel that their primary goal is to "enhance shareholder value."[3] Decisions at odds with this point of view are thought to be, at best, suspect and, at worst, unethical. Shareholders invest in a company with an expectation that their investment will yield dividends. Shareholder value, of course, is typically produced by profit-making activity. Companies need to make money to thrive.

Money. Money is the primary way that corporations are evaluated in the American marketplace. In this model and arena, money is a summative proxy for all the other value variables. If a business does not make money it is, by definition, a failure.

Customers. In the commercial arena, customers are only of interest because they are the means through which profit is made.[4] Without customers there can not be sales; without sales there will be no profit. Customers are a means to an end. Customers serve companies as a way to make money. That is generally the only reason that companies have an interest in customers, especially in the long view. Companies sometimes make much of a "relationship" with customers, but this kind of relationship is only of instrumental interest, meaning that the relationship is only valuable as a vehicle for long-term profitability.

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2. *See generally* ALFRED RAPPAPORT, CREATING SHAREHOLDER VALUE: THE NEW STANDARD FOR BUSINESS PERFORMANCE (1986).

3. Alfred Rappaport, *Let's Let Business Be Business*, N.Y. TIMES, Feb. 4, 1990, at A13 [hereinafter, Rappaport, *Business*]; *see also* JOEL. E. ROSS, TOTAL QUALITY MANAGEMENT 93 (2d ed. 1994) (discussing the mission statements of various companies, one of which states, "Create Value for Our Stakeholders"); George Day & Liam Fahey, *Valuing Marketing Strategies*, J. MARKETING, July 1988, at 45, 45 ("Managers of diversified companies are rapidly replacing their usual yardsticks of performance . . . with approaches that judge market strategies by their ability to enhance shareholders' value.").

4. ROSS, *supra* note 3, at 35; *see also* ARCHIE B. CARROLL, BUSINESS & SOCIETY: ETHICS AND STAKEHOLDER MANAGEMENT 293 (3d ed. 1996).

Competition. The commercial marketplace is competitive. Competitiveness is a concept widely cherished in American lore and in the business community.[5] The power of competition is clearly responsible for many of the good things that derive from the American economy. Competition can be healthy, and, in American lore, the best people compete hard and win. Competition creates efficiencies, and that same competition weeds out weak and poorly run companies. Products, ideas, processes, and people who are not optimally productive are eliminated, making room for better. Competition sets the proper price for goods and services. Competition brings us cheap products, and we all appreciate affordable food, clothing, gadgets, and accessories. Competition breeds innovation. Competition yields improved drugs that cure terrible diseases and prevent early deaths. In this model, competition benefits nearly everyone.

Competition is at the base of a market economy, and it functions at two levels.[6] First of all, companies compete with each other. If they don't compete, they disappear. Companies work hard to gain market share, and often that increased share must come from the share of other companies. Organizations hold employee rallies and establish incentives to motivate employees to try harder to do what it takes to gain market share.[7] Strategic planning is done to create ways to increase market share. Jobs, reputations, and the well-being of families depend on gaining and maintaining market share. Companies strive to improve customer service in order to compete and survive. They treat customers well in order to keep the customers they have and to attract additional ones, often taking customers from other companies.

In this competitive atmosphere, companies do not typically help each other. When one stumbles upon an improvement or exciting new product, it does not share the innovation with competitors. The lucky company keeps it a secret and establishes legal protections. When the world braced for an epidemic of avian flu in 2005, Roche went on record to refuse to share patented information about its

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5. *See* MICHAEL E. PORTER, COMPETITIVE ADVANTAGE: CREATING AND SUSTAINING SUPERIOR PERFORMANCE 1 (1985); Paul J. McNulty, *Economic Theory and the Meaning of Competition*, 82 Q.J. ECON. 639, 639 (1968) ("There is probably no concept in all of economics that is at once more fundamental and pervasive, yet less satisfactorily developed, than the concept of competition."); *see also* KATHRYN M. BARTOL & DAVID C. MARTIN, MANAGEMENT 88, 667-69 (1991) (defining competitors and explaining the role competition plays in strategic management decisions); Rappaport, *Business*, *supra* note 3 (describing the importance of competitiveness in sustaining a corporation's existence).

6. *See* PORTER, *supra* note 5, at 1. *See generally* ROSS, *supra* note 3; McNulty, *supra* note 5.

7. *See, e.g.*, Professional-Resumes.com, Developing Team Spirit, http://www.professional-resumes.com/developing-team-spirit.html (last visited Feb. 25, 2008) (on file with the *McGeorge Law Review*); gNeil.com, Employee Motivation—The Key to Boosting Morale and Increasing Productivity, http://www.gneil.com/info/motivation/?sessoinid=d9qvo44075-324.149 (last visited Jan. 27, 2008) (on file with the *McGeorge Law Review*); *see also* William N. Cooke, *Employee Participation Programs, Group-Based Incentives, and Company Performance: A Union-Nonunion Comparison*, 47 INDUS. & LAB. REL. REV. 594, 594 (1994) ("[M]any American companies have sought to improve company performance . . . . Central to many of these recent efforts are employee participation programs . . . and group-based pay incentives tied to performance . . . .").

effective vaccine, even though its medicine had the potential to save many lives.[8] Few were surprised by this behavior.[9] It is how the competitive American game is played. When a pharmaceutical company creates a new drug, it patents the drug so that other companies do not share in the benefit. They set a price as high as the market will bear, with no regard for what patients might need or how difficult it might be to pay for an important new drug.[10] The company has costs to recover.

Companies also spy on each other.[11] They reverse-engineer the successful products of competitors and find ways to improve on a working design in order to succeed in the same market. They try to lure successful executives from other companies to their own. The American business world is deeply and fundamentally competitive.

The buyer-seller relationship. The second level of competition is in micro-relationships between buyers and sellers. The primary competitive relationship in a market economy is found there. While we do not think much about this dynamic, it is essential; it allows the market to behave efficiently.[12] When buyers purchase a product or service, their goal is to get as much of that product or service as they can while paying as little as they must. Buyers are trying to get the most and give the least, and this motivation and behavior mirrors that of the seller. If buyers discover that an item of desire is scheduled to go on sale over the weekend, they wait and come back. If buyers find identical items with differing price tags, they choose the one with the lower price. If buyers know a place that sells an item for less, they buy it there. This is not rocket science, and everyone knows the game.

On the other side of the equation, sellers strive to make the best deal by doing the opposite. Sellers try to give up as little of a product or service as

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8. Sabin Russell, *Flu Drug Maker Won't Share Patent*, S.F. CHRON., Oct. 13, 2005, at A1.

9. *Cf.* Marwaan Macan-Markar, *A Dose of Double Standards over Bird Flu*, ASIA TIMES ONLINE, Oct. 25. 2005, http://www.atimes.com/atimes/Southeast_Asia/GJ25Ae01.html (on file with the *McGeorge Law Review*) ("[People] in the developing world[] are well aware of the fierce defense mounted by the US and the EU to protect the patents of drugs produced by their pharmaceutical giants, despite such medicines being desperately needed to save the lives of millions in the Third World.").

10. *See, e.g.*, Press Release, Fed. Trade Comm'n, FTC Reaches Record Financial Settlement to Settle Charge of Price-Fixing in Generic Drug Market (Nov. 29, 2000), http://www.ftc.gov/opa/2000/11/mylanfin.shtm (on file with the *McGeorge Law Review*) (summarizing the lawsuit against drug maker Mylan, which eliminated competition in the generic drug market, resulting in high costs for medication).

11. Bruce Schneier, Corporate Spying, Jan. 16, 2008, http://www.schneier.com/blog/archives/2008/01/corporate_spyin.html (on file with the *McGeorge Law Review*) (providing summaries of various articles written about corporate spying); Peter Schweizer, *The Growth of Economic Espionage*, 75 FOREIGN AFF. 9, 10 (1996) ("Indeed, economic espionage, the outright theft of private information, has become a popular tool as states try to supplement their companies' competitive advantage.").

12. *See* ROSS, *supra* note 3, at 217-18 (describing the buyer-seller relationship). *See generally* F. Robert Dwyer et al., *Developing Buyer-Seller Relationships*, J. MARKETING, Apr. 1987, at 11 (discussing the buyer-seller relationship and "outlin[ing] a framework for developing buyer-seller relationships"); Stephen W. Clopton, *Seller and Buying Firm Factors Affecting Industrial Buyers' Negotiation Behavior and Outcomes*, J. MARKETING RES., Feb. 1984, at 39 (describing the goals of buyers and sellers in negotiations).

possible and get as much for it as they can. This relationship is a competition, and all parties are well aware of that fact. The competition may be friendly, but it is nonetheless competitive at its base. Sellers may take a loss from time to time, but the goal of the short-term loss is to enhance profit over a longer period of time, perhaps by investing in a relationship or in goodwill or in making space for newer, more profitable items. If either buyers or sellers fail to compete, they lose, and they are unlikely to survive over the long haul.

Type of evidence. In the commercial world, buyers learn about products and services in a variety of ways. For example, anecdotes and celebrity endorsements serve to inform or convince buyers about the relative value of competing products.[13] They even urge buyers to try new products that buyers don't yet know they need. Anecdotes qualify as evidence in this world. Buyers are expected to believe the recommendation of a satisfied customer. Stories of impressive cures or pounds lost are used to convince buyers of the attractiveness and value of a product.

Caveat emptor.[14] In the case of the buyer-seller relationship, parties must look after their own interest. Caveat emptor applies. The parties are driven by self-interest. Buyers must do their homework. If they fail to do so, tough luck. They should have known better, and they will pay a premium for their sloth or inadequacy. Consumers must do their research, and sources of information grow all the time. If consumers are going to purchase automobiles, they certainly cannot rely on salespeople to look after their interests, but surely they can find ample information on the Internet, in consumer magazines, in the newspaper, and through friends who like cars and own them. Sellers are, generally, not obligated to help or inform buyers, and buyers know this—or should. Enlightened or modern sellers tend to treat customers well, but, in the end, it is the buyers' responsibility to be diligent. This duty is contingent upon the premise that buyers are capable of due diligence and that information is available and comprehensible.

Buyers and sellers in the commercial marketplace play the roles of "customers" and "salespeople," and those roles encourage competitive behavior. Customers ask questions. They are skeptical. They shop around. They try things

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13. *See* Ruth La Feria, *The Celebrity Endorsement Game*, N.Y. TIMES, May 19, 2005, at G1; *see also* Jack Trout, *Celebs Who Un-Sell Products*, FORBES.COM, Sept. 13, 2007, http://www.forbes.com/opinions/2007/09/12/jack-trout-marketing-celebs-oped-cx_jt_0913trout.html (on file with the *McGeorge Law Review*) (describing the best and worst of celebrity endorsements); About.com, Celebrity Endorsements: In-Depth Coverage on the Advertising Side of Your Favorite Celebrities, http://advertising.about.com/od/celebrity endorsements/Celebrity_Endorsements.htm (last visited Feb. 15, 2008) (on file with the *McGeorge Law Review*) (providing a list of articles describing the latest celebrity endorsements, including Terri Hatcher, Paris Hilton, and Gwyneth Paltrow).

14. *See generally* Trideep Raj Bhandari, Caveat Emptor or Caveat Venditor: Where Are We Headed?, http://www.legalserviceindia.com/articles/caveat1.htm (last visited Mar. 19, 2008) (on file with the *McGeorge Law Review*); *see also* BLACK'S LAW DICTIONARY 236 (8th ed. 2004) (defining "caveat emptor" as "[a] doctrine holding that purchasers buy at their own risk" and stating that the term is Latin for "let the buyer beware").

on and compare. Occasionally they even return items if they subsequently find them cheaper elsewhere.

Commodities. Products and services in the commercial arena (when contrasted against the doctor's office) tend to be "widgets" or commodities.[15] They are interchangeable with other objects that can be bought or sold. They do not typically make a difference between life and death. It is no crisis when a newly purchased vacuum cleaner does not work out. Even if it is a significant inconvenience, a buyer can still recover. This is, of course, not always so true, as in the case of brakes on a car or flood insurance in New Orleans, but those examples are atypical.

B. The Arena of Care

Doctors care for patients, and they are guided by what might be called "the ethics of care." Now to the variables listed on the right side of Table 1. Variables related to the dimensions of "care" (found in the world of healthcare and doctoring) are listed in the right column.

The doctor-patient relationship. The doctor-patient relationship is different from the buyer-seller relationship, and differences begin with the premise and goal of health care. The purpose of the doctor-patient relationship is *care of the patient*.[16] That is where everything starts and ends. That is why doctors exist and why they occupy a privileged position in society.

Money is derivative. Profit in the care arena is thought to be derivative; that is, it is *derived* from good practice.[17] It is not a goal, and it is not a primary interest, but it comes about when doctors take good care of patients. While serious challenges to this premise have recently arisen in medicine,[18] the

15. *See generally* Peter Hill, *Tangibles, Intangibles and Services: A New Taxonomy for the Classification of Output*, 32 CANADIAN J. ECON. 426 (1999). In this article, Hill discusses the distinctions between goods (commodities) and services, arguing that the conventional breakdown "between goods and services should be replaced by a breakdown between tangible goods, intangible goods, and services." *Id.* at 427.

16. *See, e.g.*, Mayo Clinic, The Needs of the Patient Come First, http://www.mayoclinic.org/needs-of-patient/ (last visited Feb. 25, 2008) (on file with the *McGeorge Law Review*) (explaining that "the needs of the patient come first" is "the bedrock commitment Mayo Clinic makes to every patient every day").

17. *See* CHERYL MATSCHEK, THE PRINCIPLED PRACTICE 61 (1995).

> Make sure you practice dentistry and live your life so you don't compromise your values. Satisfaction will follow, and with it success, *your style*, following right on its heels. Quality in dentistry is related to the fulfillment of your purpose, to the lives that you touch . . . and one of the most important is yours!

Id. See generally Claire Andre & Manuel Velasquez, *A Healthy Bottom Line: Profits or People?*, ISSUES IN ETHICS, Summer 1988, http://www.scu.edu/ethics/publications/iie/v1n4/healthy.html (on file with the *McGeorge Law Review*). In his article "Profession or Business," David Nash argues that the business dimensions to dentistry are secondary to caring for patients. *See* David A. Nash, *Profession or Business*, 135 J. AM. DENTAL ASS'N 21, 21-22 (2002). This article further develops those arguments in Part III.

18. *See, e.g.*, Andre & Velasquez, *supra* note 17 (providing examples of how the desire to make money has compromised the ethics of health care); Joanna Garritano, *US Health Care Puts Profit over People*, SEATTLE POST-INTELLIGENCER, Jan. 10, 2007, at B7 ("Modern medicine has morphed from a healing

derivative view of money in dentistry holds true.[19] Dentists in the United States can still make a very good living by focusing primarily on the needs and care of patients. Money will follow.

Patient as an "end." On the care side, patients are not a "means" to anything (except, perhaps, feelings of occupational satisfaction for doctors). Patients and their care are ends in and of themselves.[20] Health care professionals do not use patients for selfish purposes, including using them as a means to get money.

Cooperation. When care rather than profit is the overarching goal, relationships necessarily become cooperative.[21] Doctors do not compete with each other. They cooperate on behalf of the needs of patients and the public. When one dentist runs into a problem in her office, the culture of dentistry encourages her to call a colleague for help.[22] Dentists routinely teach each other new techniques, and they will complete treatments for colleagues who are stymied or who find themselves in over their heads with a particular patient. They do not charge each other a fee for such professional assistance or service.

Relationships between doctor and patient are also cooperative rather than competitive.[23] This is the only way it can be, under the circumstances. Unlike the situation faced by the buyer in a commercial relationship, patients cannot possibly evaluate the work of the dentist. Caveat emptor is null and void in the arena of care. It would not be a fair fight or an even playing field. Doctors simply know too much and patients know too little. Doctors have had sufficient training and experience to put them completely out of the patient's league, and no matter how hard patients try, they cannot adequately evaluate a doctor's advice. They could go to the medical library, but they will not know exactly where to look, or

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profession into a business where the primacy of profit takes precedence over greater human needs."); Nash, *supra* note 17, at 21 ("The professional dentist's primary motivation and responsibility is, or should be, 'caring' for patients.").

19. *See* Marcia A. Boyd et al., *Beginning the Discussion of Commercialism in Dentistry*, 36 CAL. DENTAL ASS'N J. 57, 65 (2008) ("The core theme in the recommendations from Ethics Summit on Commercialism is that competent, comprehensive, and continuous oral health care is appropriate and should be promoted to the American public."). *But see* Roger Levin, *The Purpose of a Business*, 134 J. AM. DENTAL ASS'N 1118, 1118 (2003) (noting that one of the philosophies that a dental practice may follow is that "[t]he purpose of a business is to provide income to the dentist").

20. Nash, *supra* note 17, at 21.

21. *See generally* Carole Ward, *Time Is Of the Essence*, 16 J. GEN. INTERNAL MED. 712 (2001) (discussing the importance of spending time with the patient to improve physician job satisfaction).

22. Dean Tjosvold, *Networking by Professionals to Manage Change: Dentists' Cooperation and Competition to Develop Their Business*, 18 J. ORG. BEHAV. 745 (1997). In this study, the author examined cooperative and competitive interactions, finding that other dentists provided "important sources of assistance in solving technical professional problems." *Id.* at 751.

23. *See, e.g.*, Edward Friedler, *The Evolving Doctor-Patient to Provider-Consumer Relationship*, 45 J. FAM. PRACTICE 485 (1997) ("My patients and I cooperate, which is key to creating and nurturing the long-term relationships we value in family practice."); Kent Bottles, Is the Doctor/Patient Relationship in the ICU?, Sept. 19, 2005, http://www.soundpractice.net/article.cfm?id=205 (on file with the *McGeorge Law Review*) ("The physician/patient relationship is at the center of the health care enterprise. Hospitals, insurance plans, third-party payers, government entities, and others are important, but they are really adjuncts that support, finance, and facilitate the key relationship between those who are sick and those who care for them.").

what texts mean. Patients do not understand the esoteric vocabulary of dentistry, for example, terms like "patency" or "periradicular." Patients can go onto the Internet, which certainly might help, but they will quickly find contradictory information [24] and will not know which advice to accept.

Consider the following situations that can arise in the dentist's office. If a dentist informs a patient that she needs a root canal ("endo"), and she is experiencing no symptoms, she has only two choices: trust the dentist (the one who will benefit financially from the treatment) or seek advice from another dentist, another member of the same profession. She could try to read the x-ray ("radiograph") herself, but it is unlikely that the light and dark shades on the film or screen will make any sense to her at all, even after someone explains it. A dentist has to show a patient how radiographs work and what they mean, which means patients have to trust dentists to tell them the truth.

Further, when faced with emergency surgery such as an appendectomy, both patients and doctors must make quick decisions. Patients typically do not choose their surgeon. Imagine patients in an emergency room after a serious automobile accident. They do not choose their doctor. They must rely on choices made for them, on their behalf, by strangers who stand to gain financially from the treatments they propose. Because patients cannot fairly evaluate the situation, they cannot compete. A competitive relationship between doctor and patient simply does not work.

Type of evidence. On the care side, anecdotes and endorsements are insufficient to inform doctors about the care of patients. Doctors do not rely on them for proof of the value or validity of a product or treatment. While patients are not typically capable of evaluating scientific claims and literature, they expect their doctor to do so on their behalf. Science is the gold standard in a doctor's world.[25] Empirical evidence is demanded. A one-time, dramatic cure or a famous doctor's endorsement has no value in the arena of care. Claims of a medical or dental supply company are obviously suspect.

Trust. A patient does not enter a doctor's office anticipating that the doctor will try to take advantage of the situation by withholding information to increase profit; however, an individual may expect that in a commercial buyer-seller interaction. The doctor does not recommend a treatment because it is associated with the most significant profit margin for himself and his office.[26] The patient

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24. *See, e.g.*, Joseph Shapiro, *Patients Turn to the Internet for Health Information*, NPR.ORG, Oct. 11, 2007, http://www.npr.org/templates/story/story.php?storyId=15166387 (on file with the *McGeorge Law Review*).

25. *See, e.g.*, Am. Dental Ass'n, ADA Positions & Statements, ADA Policy on Evidence-Based Dentistry, http://www.ada.org/prof/resources/positions/statements/evidencebased.asp (last visited Mar. 19, 2008) (on file with the *McGeorge Law Review*). The ADA's policy encourages dentists to use the best available research when making patient-care decisions. *Id.* The evidence-based medicine process "help[s] practitioners provide the best care for their patients." *Id.*

26. *See Dental Managed Care in the Context of Ethics*, 63 J. AM. COLLEGE DENTISTS 19 (1996) (requiring American College of Dentists fellows to "[a]ct in the best interests of patients and society even when

does not expect the doctor to shade information to take advantage. Instead, the patient expects the truth. If this is not the case, that is, if the patient is not secure in this assumption, the system has broken down. This is a very serious matter, and all bets are off. Trust is the basis for the relationship, not competition or deception. When the patient is lying nearly naked in the doctor's office, and the doctor is examining him, the patient must trust the doctor to look after that patient's interests. This is not the time to haggle over payment or to wonder about the doctor's intentions. This is one important reason why patients are called "patients" and not customers. Patients rely on doctors to look after their interests, not to make their best deal in a competitive interpersonal context. In exchange, purchasers of health care services act like patients rather than buyers; that is, patients do not assume selfish doctor motivation and do not haggle over the price.

Life or death. There is one final difference between the doctor-patient relationship and that of the customer-salesperson. While not always the case, doctors often deal with matters of life and death, while salespeople rarely do. Dentists can kill patients. When death is not an issue, their decisions or negligence can potentially cause patients' jaws and lips to be numb or filled with electrical tingling for the rest of their lives. They can ruin taste buds or the temporomandibular joint. They could overlook a malignant lesion. Dentists can cause patients to lose strategically important teeth, teeth that will never grow back. The decisions and the work of dentists is often of a level of importance or an order of magnitude more important than a new pair of shoes or a new car.

Because of the ethics of care, dentists do not cold-call prospective new patients; they do not try to solicit patients from the practice of other doctors; they do not offer finders' fees for new patients; and they do not engage in split fees with specialists or provide kick-backs for referrals to their practice. They try very hard to avoid criticizing other dentists, and this courtesy is codified in written form in their codes of ethics.[27] Commercial business practices found in other businesses are not found in the culture of dentistry.

What motivates doctors to care? Why should they be trustworthy? If they do not care, if they are not trustworthy, patients who trust them will be hurt and disappointed, and they may become suspicious of doctors. Dentists, at some

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there are conflicts with the dentist's personal self interest (Beneficence)"); Daniel P. Sulmasy et al., *Physicians' Ethical Beliefs About Cost-Control Arrangements*, 160 ARCHIVES INTERNAL MED. 649, 651 (2000) (reporting a study that surveyed numerous midcareer physicians, over seventy-five percent of whom believed "that personal financial incentives to encourage restraint in testing, treatment, and referrals are not ethically acceptable").

27. AM. DENTAL ASS'N, PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT § 4.C (2005), *available at* http://www.ada.org/prof/prac/law/code/ada_code.pdf ("Patients should be informed of their present oral health status without disparaging comment about prior services."); *see also* Linda J. Hay, *Risk Management: The Top 10 Mistakes Dentists Make*, DENTAL ASSISTANT, Sept.-Oct. 2007, at 36, *available at* http://www.dentaleconomics.com/display_article/259054/76/ARTCL/none/none/Risk_Management:_The_Top_10_Mistakes_Dentists_Make/ ("No dental provider or staff member should criticize other providers in front of patients or in a chart.").

level, are aware that there are personal and professional benefits accrued when they have made patient needs central to their work.[28] They occupy a position of considerable privilege in American society. They make a lot of money, and they are allowed to practice autonomously. These benefits will disappear if patients decide that their dentists are untrustworthy. Citizens will compel legislation to regulate them, and dentists hate regulation. The fast food industry offers a cautionary example. By 1997, there were already more than 41,000 regulations concerning the production, distribution, and sale of cheeseburgers in the United States.[29] In contrast, the Dental Practice Act in California is relatively brief, and most of it is filled with bureaucratic language that says little about the clinical details of dental practice.[30] In reality, the rules and details of dental practice live in the standard of care required by all practitioners rather than in the written code;[31] it is the actions, as well as the collective and informal opinions of practitioners, that define the legal standard.[32] Outsiders do not dictate the standard of care to dentists.

III. When Commerce and Care Intermingle

Unfortunately, the competing interests of commerce and care are not always well understood by doctors and patients. Recent trends in dentistry are alarming.[33] Dentists, unfortunately, do not always understand the dynamics

28. *See* AM. MED. ASS'N, CODE OF MEDICAL ETHICS 8.054 (2006) ("Although physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice."); Mayo Clinic, *supra* note 16 ("The best interest of the patient is the only interest to be considered . . . . [I]n order that the sick may have the benefit of advancing knowledge, a union of forces is necessary." (quoting Dr. William J. Mayo) (alteration omitted)).

29. ROBERT C. SOLOMON, IT'S GOOD BUSINESS: ETHICS AND FREE ENTERPRISE FOR THE NEW MILLENNIUM 316 (1997).

30. *See* CAL. BUS. & PROF. CODE §§ 1600-1976 (West 2003 & Supp. 2008); *see also* CAL. BD. OF DENTAL EXAM'RS, DENTAL PRACTICE ACT WITH REGULATIONS AND RELATED STATUTES (2002). California's Dental Practice Act and its regulations are also available online. *See* Dental Bd. of Cal., Laws and Regulations, http://www.dbc.ca.gov/lawsregs/index.shtml (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*).

31. Joseph Graskemper provides an interesting legal and historical background of the standard of care in dentistry. *See* Joseph P. Graskemper, *The Standard of Care in Dentistry: Where Did It Come from? How Has It Evolved?*, 135 J. AM. DENTAL ASS'N 1449 (2004).

32. BRYAN QUATTLEBAUM, MANAGED CARE IN DENTISTRY 49-57 (1995).

33. *Tooth Wizard Battles Plaqueman During February's Children's Dental Month*, FOX BUS., Jan. 31, 2008, http://www.foxbusiness.com/article/tooth-wizard-battles-plaqueman-februarys-childrens-dental-health-month-makes_459720_1.html (on file with the *McGeorge Law Review*) ("Though professional care is necessary for maintaining oral health, 25 percent of poor children have not seen a dentist before entering kindergarten. Additionally, uninsured children are 2.5 times less likely than insured children to receive dental care."); *see also* Gerald C. Kress et al., *A Survey of Ethical Dilemmas and Practical Problems Encountered by Practicing Dentists*, 126 J. AM. DENTAL ASS'N 1554, 1554 (1995) ("Not only does today's dentist face new practical problems, but the changing conditions of practice have given rise to ethical problems that did not exist until recently.").

described above. Some dentists perceive themselves to be traditional "Doctors" with a capital "D," understanding and honoring the ethics of care, while others see themselves, more or less, as small businessmen or businesswomen, or worse, as entrepreneurs. The results can be *disastrous*, both for individual patients and for the profession as a whole.

Advertising in dentistry was illegal in the United States until 1977, when the *Bates* case opened the door for professionals (physicians, dentists, attorneys, and psychologists) to advertise.[34] Now dental advertisements are ubiquitous, and younger dentists think nothing of them. Dentists use advertisements that offer discounts (time limited) or guarantees or free bleaching.[35] Advertisements warn patients about the practices of other dentists in a competitive context.[36] This contributes to the public perception that dentistry is a commercial enterprise. Patients contribute to the confusion when they behave like customers rather than patients, and dentists hate this behavior. Patients "shop around" and haggle over the price of treatment. They ask for a break in the price or a discount. They compare prices between dentists, and they question and challenge the opinion of the dentist.

The trend toward "esthetic" or "cosmetic" dentistry is an example of how the confusion between commerce and care plays out in the dental world. Older dentists were taught to treat pathology and saw such treatment as the appropriate role of the dental surgeon.[37] Younger, "modern" dentists are much more likely to see cosmetic interventions as central to their role and practice.[38] Innovations by dental supply companies make cosmetic treatments easier to accomplish and more aesthetically pleasing.[39] Increasing patient demand for these treatments results in cash payments for such services.[40] This saves the dentist from

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34. Bates v. State Bar of Ariz., 433 U.S. 350 (1977).

35. *See, e.g.*, California Smile, Current Promotions @ California Smile, http://www.calismile.com/promotions.html (last visited Mar. 16, 2008) (on file with the *McGeorge Law Review*) (promoting free teeth whitening); Dental Arts Ctr., New Patients, Free Teeth Whitening, http://www.dentalartscenterpc.com/questionswehaveanswers1/ (last visited Feb. 26, 2008) (on file with the *McGeorge Law Review*).

36. For example, a dentist's office may indicate that its x-rays use less radiation or that it provides only mercury-free fillings.

37. *See* Jeff Morley, *The Role of Cosmetic Dentistry in Restoring a Youthful Appearance*, 130 J. AM. DENTAL ASS'N 1166, 1167 (1999) ("The dental profession's traditional domain, centered around the eradication of disease, now finds itself on the threshold of unchartered territory: the enhancement of appearance.").

38. *Id.*; *see also* CHERYL FARR, HIGH-TECH PRACTICE: THRIVING IN DENTISTRY'S COMPUTER AGE 16 (1996) ("New technology coupled with new materials and techniques not only brings the functionality and reliability of aesthetic material to higher levels, but is increasing the demand for it."). *But see* Roger Levin, *The Challenge of Esthetic Dentistry and Elective Services*, 136 J. AM. DENTAL ASS'N 515, 515 (2005) ("Despite the exposure to esthetic and elective procedures, most dentists still are focused on specifically needed procedures.").

39. *See, e.g.*, Net32, Cosmetic Dentistry Products, http://www.net32.com/ec/cosmetic-dentistry-products-t-531 (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*) (providing a list of cosmetic dentistry products); *see also* Levin, *supra* note 38, at 516 ("New materials and products have advanced the dental profession far beyond dentistry in my father's and grandfather's day.").

40. *See* FARR, *supra* note 38, at 16 ("Affluents are becoming an even more important part of the fee-for-service market, and they tend to be good candidates for aesthetic dentistry.").

inconvenient interactions with dental payment plans and managed care systems.[41] In turn, cosmetic procedures turn into "profit centers" for the dental practice. Patients continue to request all sorts of elective procedures including facial surgeries, jaw surgeries, labiaplasty, and bright veneers or crowns across the entire smile. A recent national study revealed that it generally takes significantly longer to get a dermatology appointment to have a suspicious mole checked for cancer than it does to get an appointment for a Botox injection to cure wrinkles.[42]

The demographic economics of dental practice certainly contribute to this evolving problem. While there is a deficit of dental practitioners in isolated or poor rural areas of the United States, there is a surplus of dentists in attractive urban and suburban centers.[43] Dentists who want to thrive in upscale communities must find ways to break into crowded markets and support their lifestyle after covering high overhead expenses. Overhead rates of fifty to sixty-five percent are common and considered acceptable in mainstream dental practice.[44] The actual numbers can be alarming. Bill Blatchford provides the following example of the changing economics in dental practices:

> It is sad to see practices producing $1.2 million, and the solo operator taking home $200,000, which is a 16 percent net. What that means is this busy, successful practitioner has to produce $84,000 a month before he or she sees a profit. In a 15-day work month, the first $5,600 produced each day pays the overhead. How do you feel when you get to keep $3,900 and were very busy doing it?[45]

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41. *Cf.* Natasha Singer, *Botox Appointments Faster Than for Moles, Study Finds*, N.Y. TIMES, Aug. 29, 2007, at A17 (explaining that financial incentives may explain the longer wait time for an appointment for patients with a potentially cancerous mole than individuals seeking Botox for wrinkles).

> Other dermatologists said financial incentives to perform cosmetic treatments coupled with bureaucratic obstacles in obtaining insurance reimbursement for medical treatments might also have a role in the varying wait times. Dr. Michael J. Franzblau, a dermatologist from San Francisco, said doctors typically charged $400 to $600 for a Botox antiwrinkle treatment, for which patients pay upfront because insurance does not cover it.
>
> Meanwhile, doctors have to wait for health insurance to reimburse them for mole examinations, for which they receive an average of $50 to $75 . . . .

Id.; *see also* DocShop.com, Cosmetic Dentistry Financing, http://www.docship.com/educatoin/dental/cosmetic-dentistry/financing/ (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*) (outlining financing options for patients who "cannot afford to pay for treatment up front in cash").

42. Singer, *supra* note 41.

43. Thomas C. Ricketts, *Workforce Issues in Rural Areas: A Focus on Policy Equity*, 95 AM. J. PUB. HEALTH 42, 44 (2005) ("There is growing acceptance that there is a relative shortage of dentists in rural areas . . . . In 1998, rural counties had 29 dentists per 100,000 population, as compared with 43 per 100,000 in urban counties."); *see also* Jacqueline E. Chmar et al., *Annual ADEA Survey of Dental School Seniors: 2005 Graduating Class*, 70 J. DENTAL EDUC. 315, 331-32 (2006) (explaining that over two-thirds of 2005 dental school graduates would begin practice in metropolitan areas).

44. *See* Jeffrey M. Goldstein, *Ask the Expert: How Much Overhead Is Too Much?*, 131 J. AM. DENTAL ASS'N 246, 246-47 (2000).

45. Bill Blatchford, *You Choose Your Overhead*, DENTAL ECON., Feb. 2004, at 33.

The feelings that Blatchford describes are the same feelings that cause some dentists to see their professional world from a commercial point of view. Dentists must pay the rent. They obviously cannot go to the landlord of the building where they practice with news that they cannot make the rent because they took excellent care of patients who had insufficient money during the past month. The landlord needs to be paid, period.

At the same time, large corporate dental clinics are penetrating the practice market, and these companies tend to have motivations more akin to those of the competitive commercial world.[46] Young dentists carrying large student loans often find that the best immediate opportunity available to them is in these dental chains.[47] These chains rely on economies of scale so that they can compete on a cost basis, and they are driven to be efficient.[48] They move fast and may not offer all of the amenities or attention that a patient might find in a solo practitioner's office.[49] Operations are streamlined, seeking the advantages of scale and assembly-line efficiencies. Young dentists often carry out treatments that were previously diagnosed by older dentists who have a financial interest in the clinic. These treatments are sometimes conspicuously more aggressive than the treatments these young dentists learned in school, and they serve to enhance the clinic's bottom line.[50] Patients, of course, have no idea about what is going on.

Dental care is substantially funded by dental plans (often referred to as "insurance" or "dental insurance").[51] While some of these plans are run on a not-for-profit basis, many are for-profit organizations. PPO (Preferred Provider Organization) and HMO (Health Maintenance Organization) configurations are common, and most "insurance" companies take a commercial view into the dental marketplace as they are corporate entities.[52] Dentists sometimes perceive that dental plans actually drive practice decisions, especially when patients

46. *See* Amy Fletcher, *Dental Chain Goes After High Volume*, DENV. BUS. J., Apr. 13, 2001, http://www.bizjournals.com/denver/stories/2001/04/16/story2.html (on file with the *McGeorge Law Review*).

47. *See* Chmar et al., *supra* note 43, at 328-30 ("Among students entering private practice, 29.4 percent indicated that debt was a major factor in their decision."). Debt was a factor (although not a major factor) for 29.8 percent of students entering private practice. *Id.* at 329 tbl.24. *Cf.* IRENE R. WOODALL, LEGAL, ETHICAL, AND MANAGEMENT ASPECTS OF THE DENTAL CARE SYSTEM 123-31 (3d ed. 1987) (providing a list of factors for graduates of a health care industry in selecting a practice setting and explaining that "[t]he new graduate is eager to earn some money for a change and to have a reasonably comfortable and secure position in employment").

48. *See* RISTO TUOMINEN, HEALTH ECONOMICS IN DENTISTRY 53 (1994) ("The benefits of mass production mean that one large clinic can produce the same amount of services at lower average costs than several small clinics combined. On the other hand, with decreasing economies of scale, smaller units are more efficient than a single large clinic.").

49. *See* Fletcher, *supra* note 46 (discussing Comfort Dental Group, "a growing franchise with the philosophy of providing moderate, efficient treatment at lower costs").

50. *See* ELLEN DIETZ, DENTAL OFFICE MANAGEMENT 305 (2000).

51. *See* Ronald Inge, *The Ins and Outs of Dental Insurance*, 136 J. AM. DENTAL ASS'N 204, 204 (2005).

52. *See* FRED D. GREENBLATT, TEN PRACTICAL STEPS TO GREATER PROFITS IN DENTISTRY 96-97 (1992); *see also* Inge, *supra* note 51.

request that the dentist "treat (only) what the plan covers."[53] Dentists are well aware of the plan's payment configuration and must pass any charges on to patients that are not covered by the plan.[54] There is a clear temptation, often supported by patients, to carry out treatment A when it is covered by the plan, especially when treatment B is not covered, even though treatment B is clinically or technically preferable. For the "system" to work properly on behalf of vulnerable patients, the dentist must act as a buffer between the commercial motivations of dental plans and the actual dental needs of the patient.

Dental supply companies are most certainly run for profit, and their methods are strictly commercial.[55] They do whatever they can to attract dentists to their products, which include instruments, equipment, materials, anesthetics, and drugs. They offer inducements such as frequent flyer miles to dentists who choose to put their products into patients' mouths and teeth.[56] They produce and distribute glossy magazines that appear to be scientific but are filled with endorsements by well-known dentists and patients.[57] Essays and articles are typically not peer-reviewed, yet they are influential in the dental world. Nonetheless, dentists must wade through the products and claims to make wise purchases of essential instruments, equipment, and materials for their ongoing practice. The materials they choose end up in patients' mouths for many years.

Commercial influences confuse dentists and patients. Dentists must practice with one foot in the world of "care" and one foot in the world of commerce. On the one hand, they must make treatment decisions that are best for the long-term health of their patients. On the other hand, they must pay their staff and overhead and have money at the end of the month to pay themselves. There are conflicting forces in each of these two worlds, and we rely on dentists to manage this conflict, even as the world of dental care becomes more and more subject to commercial and corporate forces. We must rely on the integrity and orientation of the individual dentist, and "modern" dentists are profoundly influenced by commercial forces.

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53. QUATTLEBAUM, *supra* note 32, at 95.

54. *Id.* at 116-17.

55. *See* Corey Hajim, *Stocks to Sink Your Teeth Into*, FORTUNE, Nov. 2005, at 258.

56. For example, Iowa Dental Systems (ids) offers a reward program based on a dentists' monthly purchase amount. *See* Iowa Dental Supply, ids Rewards Program, www.iowadentalsupply.com (last visited Apr. 7, 2008) (on file with the *McGeorge Law Review*); *see also* Henry Schein Dental, Privileges, http://www.henryschein.com/us-en/dental/services/privileges.aspx (last visited Jan. 20, 2008) (on file with the *McGeorge Law Review*) (describing Henry Schein Dental's "Privileges Program.").

57. *See, e.g.*, Michele Brown, *A Laser to Meet Your Needs: KaVo Introduces the GENTILEray 980 Diode Laser*, DENTAL PRODUCT SHOPPER, Jan./Feb. 2008, at 36; Robert Tracey, *Soft-Tissue Surgery: Use of the Er,Cr: YSGG Laser*, DENTISTRY TODAY, Feb. 2008, at 156; *Product Launches*, INSIDE DENTISTRY, Feb. 2008, at 12.

IV. CONCLUSION: THE POWER OF THE SITUATION

To rely on the individual integrity and conscientiousness of individual dentists is a tenuous position, to be sure. Social psychology warns us about the "Fundamental Attribution Error."[58] This error occurs commonly when we attribute too much power to individual forces and not enough to the "power of the situation."[59] Experimental social psychologists have demonstrated convincingly that humans can be made to do almost anything if researchers are allowed to structure the environment properly.[60] This implies that individual dentists will not, in the end, be able to hold off the commercial influence of the competitive marketplace.

Corporations represent a way to organize resources and human energy to create efficiencies and profit. It may well be that the future of dentistry and medicine will have a corporate structure in the United States. If this is so, how will patients be protected from self-interest, greed, and the natural tendency of the competitive marketplace to take advantage of those who cannot compete? One answer may be found in professional organizations such as the American Dental Association and the American Medical Association, although these groups have doctors as their primary constituency. Patients are only of practical concern insofar as they must be cared for so that doctors are seen in a positive light. Doctors prefer that their own professional organizations handle difficulties between doctors or between doctor and patient so that governments and legislatures do not, with their heavy hand, play a significant role.[61] Dental schools typically perceive a role in indoctrinating students to their professional responsibilities and identity as a caregiver.[62] Older dentists teach younger dentists the older way of thinking.[63] This training may not suffice to maintain the traditional doctor-patient relationship as dental school faculties begin to

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58. *See* Daniel T. Gilbert & Patrick S. Malone, *The Correspondence Bias*, 117 PSYCHOL. BULL. 21, 27-28 (1995).

59. *See id.* at 34 ("[P]eople may incorrectly estimate the power of certain situations to induce certain behaviors.").

60. BRUCE PELTIER, THE PSYCHOLOGY OF EXECUTIVE COACHING 136-38 (2001).

61. DIANA J. MASON ET AL., POLICY AND POLITICS IN NURSING AND HEALTHCARE 113-19 (2002). *See generally* Craig Palmer, *Dentistry and Government: Evolution of Relationship*, 127 J. AM. DENTAL ASS'N 449 (1996) (discussing the sometimes tenuous relationship between dentists and the government).

62. *See* Mahyar Mofidi et al., *Dental Students' Reflections on their Community-Based Experiences*, 67 J. DENTAL EDUC. 515 (2003); *see, e.g.*, *Statement on the Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans*, 68 J. DENTAL EDUC. 759, 759 (2004).

> [E]ducational institutions, dental schools, allied dental education, and advanced dental education programs are the source of a qualified workforce . . . . The interlocking missions of education, research, and patient care are the cornerstones of academic dentistry that form the foundation upon which the dental profession rises to provide care to the public.

Id.

63. *See, e.g.*, Ctr. for Aesthetic Restorative Dentistry, Testimonials, http://www.centerforard.com/testimonials (last visited Mar. 27, 2008) (on file with the *McGeorge Law Review*).

assimilate younger teachers who are likely to have a more commercial view of the profession.

Efforts at socializing dentistry do not seem to have resulted in attractive outcomes. There are clear signs that the National Health Service is increasingly unable to adequately address British dental needs, as patients have taken to extracting their own teeth as dentists withdraw to private practice.[64] Doctors from former Soviet republics report having participated in two levels of care: the official, modest dentistry available at no fee, and the better level of care that patients paid for out-of-pocket and under the table.[65]

If dental care takes on corporate and commercial aspects, perhaps the only way that patients will be protected is by enlightened corporate views that see the long-term relationship with patients as intrinsically valuable. Robert Solomon's view that good ethical behavior forms the basis for all successful business provides a possible long-term answer to the question of patient care in a competitive market economy. He asserts the following: "Business ethics is not ethics applied to business. It is the foundation of business. Business life thrives on competition, but it survives on the basis of its ethics."[66]

One can always hope.

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64. Sarah Lyall, *In A Dentist Shortage, British (Ouch) Do It Themselves*, N.Y. TIMES, May 7, 2006, § 1.

65. *See* Matthew S. Slivka, *Dentistry and Oral Health in the Post-Soviet Ukraine*, https://orca.byu.edu/content/jug/2002reports/_ba/slivka.pdf (last visited Apr. 7, 2008) (on file with the *McGeorge Law Review*).

66. ROBERT C. SOLOMON, IT'S GOOD BUSINESS: ETHICS AND FREE ENTERPRISE FOR THE NEW MILLENNIUM 38 (1997).