There is a renewed sense of urgency for reflection on what the dental profession is and what it ought to be.

Three models of professionalism and professional obligation in dentistry

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The relationship between the dental profession and the lay community, both at the individual level and more broadly, is, without doubt, undergoing significant changes. Therefore, the need for members of the dental profession to deepen their understanding of their status as professionals grows more and more insistent. Some signs of these changes are obvious: the success of denturism in Oregon; the emergence of retail store dentistry; and the increase in the number of malpractice suits and the size of awards in such suits. But the most important changes taking place are of a deeper and subtler sort than these superficial advances of dental commercialism. The most important and underlying changes affect the basic relationship between the dentist as a professional and the patient as a layperson seeking professional services.

These changes are difficult to understand and, consequently, will remain difficult to affect, without a clear understanding of the nature of professionalism in a profession as it is and as it might be. To assist this understanding, three models of the dental profession and of the relations between professional and layperson, and between the profession and the lay community are described in this paper. In each case, the model will be described somewhat singlemindedly to highlight the differences between the three models. This means that none of the models will describe exactly the profession as it is today or as it ever was or might be. However, a careful development of the three models, together with a careful examination of what is known and what can be envisioned about the profession, will identify and illuminate the most important features of the dental profession as it is, and as it might be. The three models are: the commercial model, the guild

Commercial model

Guild model

Interactive model
model, and the interactive model.¹

Commercial model—dental care as a commodity

One possible way to examine dentistry is as a purely commercial enterprise. From this perspective, dental care is simply a commodity that dentists sell and patients buy. The dentist is a producer, the patient is a consumer, and the interaction between dentist and patient is simply one of many transactions in the commercial marketplace. On this basis, the entire relationship between dentist and patient consists of communications about the commodity and its price and then the actual exchange of that commodity for the price that is agreed on.

From the commercial point of view, the dentist and patient must be considered, first and foremost, competitors. Each is trying to obtain from the other the greatest amount of what is needed while giving up as little as possible of what is being offered in exchange. Thus, the criterion by which the dentist determines what sort of dental care to give the patient is not the patient’s need, but rather what services the patient is willing to pay for, and which give the dentist the greatest return for the least cost in time, effort, and materials.

Need has only an indirect role as a determinant of dental care. It functions above all as the patient’s motivation to part with money for the sake of increased well-being or comfort. Consequently, although the dentist will offer judgments regarding the patient’s need for care, the patient’s own judgment of his or her needs is alone authoritative. For it is essentially a consumer judgment in which the patient weighs needs and discomforts against the costs of the purchase. The dentist’s comments regarding the patient’s need for care must be viewed in the commercial model primarily as efforts by the dentist to motivate the patient to purchase dental services. They are marketing activities, similar to the salesperson’s comment that the client will look good in an item of clothing that is being considered.

For some dentists, this model may already sound appalling. But it needs to be developed fully to learn from it. Other dentists, of course, have argued that this is precisely the model that accurately describes the essence of dental practice, or that will solve dentistry’s problems.

In the commercial model, a dentist’s primary relationship to other dentists is that of competition. They are all purveyors of the same commodity to the purchasing public; each is interested in selling as much as is possible and for the best price. Dentists will therefore price competitively, seeking not only to attract new consumers to themselves rather than to other dentists, but also to attract other dentists’ patients to themselves by offering, for example, the same services at a lower cost. Dentists will also compete with one another in the quality of basic care they provide, in special services, in ambience, and in any other features of dental practice that might attract dental consumers to themselves and away from other dentists. If one dentist discovers a new mode of diagnosis, therapy, or patient management, he or she keeps the discovery secret from competitors.² In this model, the proper measure of a dentist’s practice is not how well it meets the patient’s needs, but the performance of the package of goods and services, together with the price commanded in the dental marketplace.

Dentists, of course, have interests in common as they deal with various centers of power in the larger community, especially with government agencies. Consequently, although they are primarily competitors, dentists will have sound, self-interested reasons for forming trade associations to perform functions such as lobbying and public relations in behalf of their common concerns and interests. In the commercial model, these are the primary functions of the American Dental Association and its constituent societies. Dentists join such organizations not to compete with one another less, but to compete more effectively as a group with other sectors of the economy and other centers of power in the society.

In the commercial model, then, there are no obligations or commitments between individual dentists and individual patients, or between dentists, or between the profession and the lay community as a whole, except those obligations and commitments for which the individuals involved have deliberately bargained and committed themselves. Therefore, there is absolutely nothing about the profession of dentistry that would provide a basis for saying to a dentist: “You have an obligation to...” or “You must refrain from doing... because you are a dentist.”

In this model, no one has obligations of any particular sort simply because he or she is a dentist. It is arguable, of course, that there are obligations that all bargain- ers have toward one another whether they agree to them or not, namely, obligations to speak truthfully or to keep their contractual commitments. But these are not obligations which dentists would have as dentists or as professionals. Although important in practice, obligations of this sort do not specifically help us understand dentistry as a profession.

Some people may object that this model fails to describe dentistry because in actual practice dentists cooperate with one another much more than they compete. The ADA, it might be argued, is not a trade organization of the sort just described. It is important to note, however, that producers are always interested in agreements with other producers if they will strengthen bargaining positions in relation to consumers. The risk among cooperators is that one will break out of the pattern, underselling the rest of the group or offering a product of significantly higher quality than the rest and attracting a high volume of business away from the rest of the group, who are refrain- ing from competition for their mutual benefit. But if the benefits of cooperation significantly exceed those of competition, there will be little motivation to break ranks in this way. As dental care is something that most consumers value as highly, and as dentists have won, through a state licensing laws, a legal “monopoly” on their product, the value of cooperation rather than competing is even greater. This means that the fact that dentists now actually cooperate more than they compete does not in itself invalidate the commercial model as a description of the dental profession and current dental practice.

Finally, we should mention the placement of dental schools in the commercial model. A dental school is, in this view, simply a marketplace where dentists sell the knowledge and skills needed to provide oral dental care. The consumers of that commodity, the students, are simply people who would themselves like to sell dental care to patients. Here again, the relationship between the two parties consists entirely in bargaining the terms of, and carrying out, contractual commitments. In this case, to exchange knowledge and skills for an agreed on price. Lucky for those who sell this product that dentists currently hold a legalized “monopoly” on dental knowledge and skills, so that the only place that would-be dentists can acquire them is in the dental school.

profession is the basis for a obligatory professional relationship. The obligations of a dentist are not just derived from professional relationships, but from the significant and mutually beneficial relationships between the patient and the dentist. This is a departure from the professional model, where the dentist's obligations are derived from a passively received position in the profession. Instead, the dentist's obligations are derived from an active role in the profession, as defined by the needs of the patient.

The focus of the dentist's professional obligations is indeed the patient's need for dental care. However, because the patient is a layperson, the need for care is to be determined by the dentist. Dental care is a privilege, a gracious response by the profession, through the person of the individual professional, to the needs of the passive, uninformed, and needy layperson.

Thus, while dentists have powerful obligations to their patients, it is not by reason of any special moral status of the patient. The dentist's obligations derive from his or her membership in the profession and from the commitments which he or she makes when accepted into it. They derive from the fact that patients' needs are the reason that the profession exists and the fact that this particular patient has such needs. The dentist's obligations do not derive from any moral status of individual patients or from the collective moral status of the lay community.

In addition, the profession does not have any other sort of prior obligations to the lay community as a whole (for example, based on some contractual model of relationships between the profession and the larger community). The relation of profession and community is a one-way relationship in this model, a relationship in which the profession, as guardian of dental knowledge and skills, graciously responds to the needs of the community. The reason for this deep inequality of status in the guild model is that the practice of dentistry depends on expertise, and the lay community is made up of laypersons, untrained in the knowledge and skills of dentistry. Therefore, the lay community is simply unable to determine the tasks and proper role of the dentist.

Thus, in the guild model, the dental profession is viewed as a self-standing moral entity. The profession must create and define itself, because it alone has the relevant knowledge and skills, the obligations of its members with its proper role and relationship to the lay community. The agencies of power within the lay
community may strive and even succeed in restricting and regulating the dental profession as it carries out this task, but such actions on the part of the lay community can be viewed only as intrusions on the proper role and tasks of the dental profession.

In reflecting on this second model, as on the first and the third to come, the reader should remember that each model is somewhat extreme so that the contrasts between them can be highlighted. The relevant question with regard to each model is to what extent the model accurately describes the dental profession as it is and helps us see what the dental profession ought to be.

Interactive model—dental care as a partnership of equals

The interactive model will take a little longer to describe because historical examples are not as easily found. Certain professions (for example, law and architecture) can provide partial examples of the interactive model in operation; and many dentists who read this description may recognize it in certain elements of their own professional practices. As far as can be determined, this model has not been carefully explored in the general theoretical literature on the professions, and even less has been written about this model in relation to dentistry specifically.

In this model, the dentist and patient are equals in that they have roles of equal moral status within the decision-making process in dental care. But this model differs decisively from the commercial model in which the dentist is the client, and in which the patient is a self-interest bargainer dealing with another self-interest bargainer. For in the interactive model, the equal moral status of the dentist and the patient derives from different factors on each side. In a similar way the dental profession and the larger community are also viewed as having roles of equal moral status in this model; and again their equal status derives from different factors on each side. For the moment, however, let us concentrate on the one-to-one relationship between an individual dentist and patient.

In the interactive model, the moral status of the patient in dental decision-making derives from the fact that it is the patient's mouth, health, and functioning at stake. The high value attached to the autonomy of every person requires that matters of such vital interest to the patient be determined by the patient in accord with his or her own values, priorities, and purposes.

But when human beings experience pain and disease, the condition is itself a lessening of autonomy, and a loss of ability to control our own lives on the basis of values. Even when our condition is a consequence of our own negligence, for example, inadequate oral hygiene, we still experience the disease process itself as something which happens to us rather than something we are doing. For the disease process becomes something which is, or at least which has now passed, beyond our control.

This experience of not being in control is made even more acute when the disease process involves significant pain because pain depletes a person's ability to function fully and with full control. People come to dentists, then, because dentists understand the processes that are lessening or threatening to lessen their autonomy, and dentists have the skills necessary to subject these processes to human control by reversing or preventing them, or minimizing their undesirable consequences. Patients come to dentists not only for relief of pain and restoration of function, but also to regain and preserve autonomy.

One consequence of the fact that patients come to dentists without their full autonomy is that the patient is therefore unable to be a coequal bargainer with the dentist in the dental marketplace. The kind of equality stressed in the commercial model is simply not available; for the dentist enters the relationship with the capacity to control the processes that affect the patient and limit autonomy. This unavoidable inequality means that the commercial model cannot possibly represent the dentist-patient relationship adequately.

Because patients do come to dentists to preserve and regain their autonomy, the guild model, which views patients as passive recipients of informed choices of the dental professional, must also be set aside. For the autonomy of the patient does not have a significant place within the guild model. If the dentist's role is not one of choosing for the patient because the patient cannot reasonably choose, but rather of enhancing and supporting the patient's capacity to make choices, then the guild model must be set aside in favor of an alternative account of the dentist-patient relationship, the interactive model.

In this model, the dentist's status within the dentist-patient relationship derives from the dentist's expertise. This expertise is significant because of the dentist's ability to restore and preserve the patient's health and function and to free the patient of pain and discomfort and because it enables the dentist to restore and support the patient's autonomy. The patient's status derives from the fact that it is the patient's mouth and health and functioning that are at stake and because practitioners place great value on controlling these matters according to our own values, goals, and priorities.

Thus, in this model the dentist and the patient have equal moral status in the relationship that binds them; but their status derives from different factors on the two sides. Or more precisely, what derives from the same underlying value, namely, the value of health, comfort, and full human functioning and the value of autonomy, it nevertheless derives from the two parties' differing functional relationships to these values. The two parties' roles are distinct, but they come together in this relationship as moral equals because neither can carry out a role in the achievement of these values without the other being able to do so as well.

This means that the decisions made by dentist and patient together involve a subtle meshing of the expertise of the professional with the choice of the patient, based on the patient's own values, priorities, and purposes. Because of the patient's lack of expertise and experience of self as diminished in autonomy in relation to dental disease, the burden of accomplishing this subtle meshing of two roles falls significantly on the dentist. It is precisely this subtle partnership in decision that is the dentist's first professional responsibility, not simply the provision of technically competent dentistry.

There is another element of contrast between the interactive model and the other two models. This concerns the patient's need for dental care within the dentist-patient relationship. In the commercial model, the dentist has no obligations dependent on the actual agreements with the patient, to give the patient's need any special moral status. In the different sense, the dentist is a bargainer, the dentist has a moral commitment to serve the patient's need: health, comfort, and full functioning. In the interactive model, however, the dentist's commitment to serve the patient's need does not derive from the dentist's membership in the profession of dentistry, but from a relationship between the individual dentist and the community at large. It is the community, rather than the guild, which confers upon the dentist the status of a professional. This special status granted by the community, after the profession has certified the dentist's expertise, is a response to the commitment to serve the community well.

Individually, and as a group, dentists have mastered a body of information and a set of diagnostic and therapeutic skills that the ordinary member of the community grasps only distantly and superficially, if at all. This special knowledge gives dentists the ability to effect personal health, comfort, and ability to function. The community cannot reasonably accord such an exclusive acquisition and control...
The reason for describing these three models is to develop tools by which the members of the dental profession can understand better who they are and who they want to be.