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Enhancing Professionalism Using Ethics Education as Part of a Dental Licensure Board's Disciplinary Action

Part 2. Evidence of the Process

Muriel J. Bebeau, PhD, FACD

Abstract

Pretest scores were analyzed for 41 professionals referred for ethics assessment by a dental licensing board. Two were exempt from instruction based on pretest performance on five well-validated measures; 38 completed an individualized course designed to remediate deficiencies in ethical abilities. Statistically significant change (effect sizes ranging from .55 to 5.0) was observed for ethical sensitivity (DEST scores), moral reasoning (DIT scores), and role concept (essays and PROI scores). Analysis of the relationships between ability deficiencies and disciplinary actions supports the explanatory power of Rest's Four Component Model of Morality. Of particular interest is the way the model helped referred professionals deconstruct summary judgments about character and see them as capacities that can be further developed. The performance-based assessments, especially the DEST, were particularly useful in identifying shortcomings in ethical implementation. Referred practitioners highly valued the emphasis on ethical implementation, suggesting the importance of addressing what to do and say in ethically challenging cases. Finally, the required self-assessments of learning confirm the value of the process for professional renewal (i.e., a renewed commitment to professional ideals) and of enhanced abilities not only to reason about moral problems, but to implement actions.

This is the second of a two-part series that describes a process and results of an effort to provide individualized ethics instruction for professionals who were the subject of disciplinary action by the Minnesota dental licensing board. Part 1 (Bebeau, 2009) presented the process and procedures that were used to interact with these individuals and described the assessment measures used to conduct a baseline assessment of the four ethical capacities that are necessary conditions for reflective, ethical practice.

This article, Part 2, provides an analysis of the effectiveness of the instructional programs described in Part 1. Specifically, it compares pretest scores for 41 professionals referred by the Minnesota Board of Dentistry between 1990 and 2005 with the mean scores of graduates from the University of Minnesota School of Dentistry. It also examines the effectiveness of the specially-designed ethics courses for the 38 referred professionals who completed one or more of the assessments following instruction and summarizes their perceptions of the value of the process. A secondary analysis relates deficiencies in the capacities assessed (sensitivity, reasoning, role concept, and ethical implementation) to the reasons for referral.

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The process had been initiated by a request from the Board of Dentistry, developed by the author, and collaboratively refined over the years. The board's roles were to review the pretest report and approve or suggest modifications to the course of study and subsequently to reflect on the posttest report and other information they may have gathered from other course work or office inspections, in order to judge licensure reinstatement. Periodically, the board invited me to describe the process, partly for the benefit of new board members, but also to reflect on the effectiveness of the endeavor and to consider modifications. The analysis presented in this article is a summative evaluation of the effectiveness of the curriculum presented to the Board of Dentistry in June 2006. The size of the data set enables summary judgments about course effectiveness.

Methods

Performance data for 41 professionals (11 dental auxiliaries, 25 general dentists, and 5 specialists) tested for ethical decision-making abilities following the board's disciplinary action, were available for analysis. Data sources for the quantitative and qualitative analyses included: (a) public records for 41 referrals detailing violations of the Minnesota Dental Practice Act and stipulating the ethics course requirement; (b) pretest data on five well-validated measures–described in Part 1 of this series–for all 41 referrals; (c) posttest data (i.e., change scores) for 38 referrals who completed instruction and the posttest assessments on one or more of the moral capacities assessed; (d) participants' self-assessments of learning; and (e) a final assignment that requested a rethinking of the issues for which disciplinary action was taken.

Classifying Infractions

Whereas the identity of each individual referred for ethics instruction is a matter of public record and is not protected by confidentiality requirements, I have assumed a higher standard of privacy in reporting the findings. First, all identifiers (except for professional status) were removed prior to coding the data. Coding of both the public record and participant's self-assessment of learning was accomplished by a research assistant and the author. Second, recent referrals were excluded because time had not elapsed to judge recidivism and because the board began posting recent stipulations and orders on its Web site, making is somewhat harder to meet our privacy standard.

Public records for each referral cite one or more infractions as reasons for action, but the language to describe the infractions varied over time. The first task was to develop a set of categories for classifying a wide range of infractions. The following categories of infraction were devised: (a) allowing auxiliaries to perform duties that exceeded the limits set by the Dental Practice Act (DPA); (b) performing duties that exceeded the limits set by the DPA; (c) insurance or Medicaid fraud; (d) complaints about competence; (e) poor interpersonal skills (ranging from a failure to communicate to communication that was ineffective or disrespectful); (f) violation of infection control standards; (g) performing specialty care (e.g., orthodontics, prosthodontics, oral surgery, endodontics) below the standard of the specialist; (h) failure to maintain competence; (i) inappropriate physical contact with patients; (j) inappropriate relations with patients or staff; (k) misuse of nitrous oxide; (l) writing prescriptions for oneself or family members that were not dentally related; (m) poor record-keeping; (n) unprofessional conduct reported by either a patient, a colleague, or a subordinate; (o) failure to refer to a specialist; and (p) malpractice judgments.

Helping professionals see that their peers are less willing than they are to act without the approval of professional colleagues is a useful way to raise consciousness about professional standards.

Although malpractice judgments are not specifically cited in the stipulation and order from the board as a reason for disciplinary action, such judgments were often a precipitating cause for involvement by the Board of Dentistry. This category was included based upon interviews with the referral. Table 1 lists each referral and the number of infractions that resulted in disciplinary action.

Analysis of Pretest and Posttest Data

All but two of the 41 professionals tested were required to take a specially designed ethics course (See Part 1; [Bebeau, 2009]), based on identified deficiencies in one or more of the abilities during pretesting. Of the two that were not required to take a special course, one (DDS #29) asked to do so anyway. He cited, as reasons, his interest in the topic and his desire to further expand his abilities. Though not required to take the posttest, this individual provided an extensive self-assessment of learning. His articulate reflection on his experience (see Sidebar) provides insights as to what referrals often state they experience in the assessment process.

For 38 participants who completed both pretest and posttests, change scores were computed. After establishing that statistically significant differences existed between pretest and posttest mean scores, effect sizes (Cohen's d) were calculated to judge the magnitude of the change for each measure. This statistic is defined as the difference between mean scores divided by either the pretest standard deviation or the pooled standard deviation. Following Borenstein's (2009) recommendation, I adjusted the pooled standard deviation by an estimate of the correlation between the pretest and posttest. Effect sizes can be interpreted as a representation of the mean differences in standard deviation units. Thus, a d = 1.0 indicates that the two means differ by a full standard deviation. For the referred professionals, pretest mean scores were typically about one standard deviation below the mean for Minnesota dental graduates who had participated in an ethics curriculum of demonstrated effectiveness (Bebeau & Thoma, 1994; Bebeau, 2006). For example, in the case of moral reasoning, mean DIT pretest scores for referrals were below the average score of 46 for entering Minnesota dental student (with cohorts ranging from 42 to 49 across 15 classes tested), but posttest mean scores were within the range of dental graduates (cohorts ranging from 47 to 55 with a mean of 51.4 [Bebeau, 2002]).

Effect sizes, as Cohen (1988) recommends, can also be used to compare treatment effects in a domain of interest where meta-analysis of intervention studies have been conducted. In a review of intervention effects for DIT scores, Bebeau (2002) noted that the largest effect size observed for a four-year liberal arts college program was .80. Yet, growth in moral reasoning is not evident in post baccalaureate professional education programs (medicine, veterinary medicine, dentistry, and law) in the absence of a validated ethics curriculum. Even then, effect sizes tend to reflect moderate gains. Bebeau & Thoma, (1994) report an average effect size of .36 (with a range of .12 to .71) across four years for the Minnesota dental ethics curriculum. Schlaefli, Rest, & Thoma (1985) observed an average effect size of .41 (with a range from .28 to .56) in a meta-analysis of 23 intervention studies.

Analysis of Participants' Self-Assessments

Also available for analysis were participants' self-assessments of learning and final assignments reflecting a rethinking of the issues for which disciplinary actions was taken. The self-assessments included responses to the self-assessment taken at the conclusion of the learning experience and consisted of approximately 80 pages of single-spaced material. These were analyzed for themes following a three-stage iterative process. The first stage involved identification of themes running through responses to each of three questions. Data from the smaller data set (the auxiliaries), were analyzed first, by the investigator and a research assistant who independently read and agreed upon themes for Question 1: What do you think you learned from the ethics course? and Question 3: What changes will you make (in the practice of your profession) as a result of the experience you had with the State Dental Board?

The second stage involved an additional review to assess the extent to which the participants' responses supported each theme. A third stage involved selecting quotes that exemplified different dimensions for each theme. Because cases were extensively used during the instructional phase, some comments referred to lessons learned from particular cases or to lessons learned from completing the final assignment where the individual needed to devise a case and commentary reflecting the issues for which disciplinary action was taken. For Question 2 (Which cases had the greatest impact on your learning?), a simple tally was calculated to determine whether the full range of cases presented during instruction were evenly represented in the responses. Quotes were then selected that reflected perceptions of the value of the case or cases.

Results and Discussion

Themes from the Self-Assessments

For auxiliaries, three themes were apparent in review of Question 1 (What do you think you learned from the ethics course?): (a) feeling renewed about their profession; (b) enjoyment of the individ-

Table 1. Specific infractions resulting in disciplinary action for each referral.

Referral	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sum
DDS 1	Y						Y	Y									3
RDA 1		Y															1
RDA 2		Y															1
RDA 3		Y															1
DDS 2	Y										Y					Y	3
DDS 3	Y															Y	2
RDA 4		Y															1
RDA 5		Y															1
RDA 6		Y															1
RDA 7		Y															1
DDS 4	Y		Y										Y				3
DDS 5	Y																1
RDA 8		Y															1
RDA 9		Y															1
RDH 1		Y															1
RDA 10		Y															1
DDS 6	Y																1
DDS 7	Y																1
DDS 8	Y																1
DDS 9	Y																1
DDS 10	Y			Y				Y			Y	Y	Y		Y		7
DDS 11	Y		Y	Y				Y					Y				5
DDS 12	Y		Y	Y		Y	Y						Y			Y	7
DDS 13	Y		Y	Y		Y		Y					Y		Y	Y	8
DDS 14			Y	Y		Y		Y					Y	Y			6
DDS 15	Y		Y	Y		Y		Y					Y				6
DDS 16	Y		Y	Y			Y	Y				Y	Y	Y			8
DDS 17			Y	Y		Y		Y								Y	5
DDS 18	Y		Y	Y				Y									4
DDS 19			Y											Y			1
DDS 20			Y	Y				Y				Y		Y			5
DDS 21					Y				Y	Y	Y	Y					5
DDS 22				Y	Y								Y			Y	4
DDS 23				Y		Y					Y		Y			Y	5
DDS 24					Y										Y		2
DDS 25			Y	Y	Y		Y	Y					Y	Y		Y	8
DDS 26			Y	Y			Y	Y					Y			Y	6
DDS 27					Y		Y						Y			Y	4
DDS 28			Y				Y	Y					Y				4
DDS 29					Y		Y					Y	Y	Y		Y	6
DDS 30			Y											Y			2
Totals	16	11	15	14	6	6	8	13	1	1	4	5	15	7	3	11	136

Infractions included: (1) allowing auxiliaries to perform duties that exceeded the limits set by the Dental Practice Act (DPA); (2) performing duties that exceeded the limits set by the DPA; (3) insurance or Medicaid fraud; (4) complaints about competence; 5) poor interpersonal skills; (6) violation of infection control standards; (7) performing specialty care (e.g., orthodontics, prosthodontics, oral surgery, endodontics) below the standard of the specialist; (8) failure to maintain competence; (9) inappropriate physical contact with patients; (10) inappropriate relations with patients or staff; (11) misuse of nitrous oxide; (12) writing prescriptions for self or family members that were not dentally related; (13) poor record keeping; (14) unprofessional conduct reported by either a patient, a colleague, or a subordinate; (15) failure to refer to a specialist, and (16) malpractice judgments.

Table 2. Pretest scores on measures of ethical development for dental professionals who completed a remedial ethics course

	Remediating Professionals				Comparison Group Dental Graduates	
Ethical Abilities	n*	Mean	S.D.	Range	Mean	S.D.
Ethical Sensitivity (DEST Scores)	38	48.8**	8.4	31.7 – 68.5	50.0	7.6
Moral Reasoning (DIT Scores)	41	37.5	12.2	18.0 – 66.7	51.4	13.3
Dental Ethical Reasoning (DERJT)	19	41.8	11.7	20.0 – 65.0	59.2	13.1
Action Choice	19	40.6	15.0	9.4 – 63.5	59.7	20.8
Justification Choice	19	43.1	16.5	3.5 – 66.5	58.6	14.6
Role Concept (Essay Scores)	38	3.8	1.9	0.0 – 8.0	—	—
PROI Scores						
Authority	24	35.6	4.4	26.0 – 43.0	36.4	4.5
Responsibility	24	44.0	5.9	36.0 – 55.0	42.7	4.6
Agency	24	43.1	8.0	22.0 – 54.0	38.6	6.0
Autonomy	24	40.3	7.3	27.0 – 58.0	34.8	7.4

**All participants completed the DIT, but initially the Role Concept essay was not required, and the PROI and DERJT were introduced in later years.*

***DEST scores are reported as standard scores, as Form A has more items than Form B.*

ual sessions and enjoyment of the course as a whole; and (c) broadening of perspectives or the processes learned for thinking about complex issues. Quotes judged to be representative of points of view expressed in responses by the 11 auxiliaries form the bases for conclusions described in the following sections.

For dentists, four themes were apparent in responses to Question 1: (a) enjoyment of the class sessions; (b) broadening of perspectives derived from thinking about complex issues; (c) sense of renewal; (d) enhanced communication and implementation skills. Notice that three themes were similar to themes for auxiliaries, but for dentists, the theme related to a sense of renewal, was extended to include "new understanding of the profession and the code of ethics." The fourth theme–present in some auxiliaries' responses though not as prominently–was the empowerment felt by dentists as a result of improved communication and implementation skills. Quotes judged to be representative of the points of view of the dentists form the bases for conclusions.

Change Reflected on Measures of Ethical Abilities

Table 2 shows the range of performance scores for each of the measures. Instruction was required for those professionals whose pretest score was lower than the mean score for dental graduates on a particular measure. Table 3 reports change scores for those professionals required to complete instruction specific to an identified deficiency. Statistically significant change, with effect sizes greater than 1.0, was evident for ethical sensitivity, moral reasoning, and role concept essays. More importantly, posttest scores indicate that referrals caught up with dental graduates who had benefited from an ethics curriculum of demonstrated effectiveness (Bebeau & Thoma, 1994; Bebeau 2006) and in some cases exceeded the scores achieved by recent graduates. Such gains are impressive, especially when compared with the average effect sizes reported for ethics interventions.

Statistically significant change was also evident for the Authority and Responsibility dimensions of the PROI (Professional Role Orientation Inventory [Bebeau, Born, & Ozar, 1993; Bebeau, 2006]), but not for the Agency and Autonomy dimensions. Whereas highly significant change scores were evident for some individuals whose pretest scores demonstrated a perception of agency or autonomy that was aberrant (i.e., either much higher or lower than the norm group), the reporting of means

Table 3. Change scores on measures of ethical development for dental professionals who completed a remedial ethics course

Ethical Abilities	n*	Pretest Mean	Pretest S.D.	Posttest Mean	Posttest S.D.	p	Cohen's d**
Ethical Sensitivity (DEST Scores) ***	24	43.9	5.3	58.4	10.1	<.0001	2.50
Moral Reasoning (DIT Scores)****	30	36.9	11.8	51.8	14.5	<.0001	1.28
Role Concept (Essay Scores)	36	3.7	1.9	11.2	1.1	<.0001	6.55
PROI							
Authority	20	35.5	4.4	38.0	5.3	<.0057	.38
Responsibility	20	43.0	5.7	47.1	4.8	<.0020	1.72
Agency	20	43.8	8.6	43.7	8.6	<.5883	
Autonomy	20	40.4	7.2	39.1	6.8	<.9625	

**41 professionals completed the pretest; 39 professionals took the course and completed one or more of the posttests. Change scores are reported for participants required to complete both pretests and posttests.*

***The effect size reported here for DIT scores exceeds the average effect size of d=.41 (with a 95 percent confidence interval ranging from .28 to .56) reported by Schlaefli, Rest, & Thoma (1985) in a meta-analysis of 23 intervention studies. It also exceeds the average effect size of d=.36 (with a range of .12 to .71) reported by Bebeau and Thoma (1994) for eight classes of dental students who completed an ethics curriculum.*

****Form A is used for pretest; Form B was used for posttest. Scores reported are standard scores.*

*****DIT-1 is used for the pretest; DIT-2 is used for the posttest.*

masked these changes. Nonetheless, aberrant scores on the Agency and Autonomy dimensions were useful in providing feedback to referrals as to possible reasons why they failed to do what "others"–e.g., the board and peers–thought they ought to have done or to have refrained from doing. Helping professionals see that their peers are less willing than they are to act without the approval of professional colleagues is a useful way to raise consciousness about professional standards.

Whereas professionals varied greatly in their sensitivity, reasoning, and ethical implementation abilities, one shortcoming was noted for 39 of the 41 referrals: an inability to clearly express societal expectations of the dental professional. Thus, as seen in Tables 2 and 3 in the scores for Role Concept essay, points were assigned for full expression (2 points), partial expressions (1 point), or omission (0 points) of each of six concepts (Bebeau, 1994). At pretest, the scores of individuals (Table 2) ranged from 0 to 8 out of a possible 12 points, with a mean of 3.8. In contrast, at posttest (Table 3), the mean was 11.2. Whereas change in the ability to articulate responsibilities that resulted from instruction and was also a valued part of the instruction, it was helpful to observe the frequency with which these concepts were omitted at pretest in order to provide insight into reasons for moral failings. This is illustrated in Table 4, which shows: (a) the responsibility to abide by the profession's code of ethics was cited least (76.3% made no reference to this concept); (b) the responsibility for lifelong learning was next (68% made no reference to this concept); (c) the basic ethic of the profession (to place the interests of patients before the self and the interests of society before the interests of the profession)–55% made no reference either to placing the interest of patients before the self or the profession's collective responsibility to society while 42% articulated the obligations to put patient interests before self, but only one individual articulated the broader sense of commitment described by Rule and Welie (2009); (d) a sense of responsibility for self-regulation and monitoring of one's profession (39.5 % omitted this concept, whereas 47% partially attended to the responsibility); (e) a responsibility to acquire the knowledge of the profession to a set of external standards (44.7% made no reference to this concept); and (f) a sense of responsibility to serve society. For the latter responsibility, 34.2% professionals failed to mention any responsibility over and above serving

Table 4. Presence of six concepts at pretest for 38* referrals who completed the Role Concept Essay

	Omitted		Partial		Full		Total	
Acquire Knowledge	17	44.7%	8	21.1%	13	34.2%	38	100%
Lifelong Learning	26	68.4%	5	13.2%	7	18.4%	38	100%
Serve Society	13	34.2%	16	42.1%	9	23.7%	38	100%
Abide by Code	29	76.3%	6	15.8%	3	7.9%	38	100%
Ethic of Profession	21	55.3%	16	42.1%	1	2.6%	38	100%
Self-Governance	15	39.5%	18	47.4%	5	13.1%	38	100%

**Three of the 11 auxiliaries were not asked to complete the role concept essay.*

those who can afford care. Whereas service was the most likely to be expressed responsibility, some expressed an unbounded sense of responsibility toward others—a willingness to compromise the self that bordered on martyrdom.

Of particular interest was the number of referrals who, on the DERJT (Dental Ethical Reasoning and Judgment Test [Bebeau & Thoma, 1999; Thoma, Bebeau & Bolland, 2008]), selected certain action choices as the best option when ethics experts deemed them as the worst choices. Typically, such individuals also had low DIT (Defining Issues Test, [Rest, 1979; Rest, Narvaez, Bebeau, & Thoma, 1999; Thoma, 2006]) scores. The correlation between DIT scores and DERJT scores (both measures of moral judgment) is .41 (Thoma, et al., 2008), whereas the correlations between DIT scores (or essay scores) and DEST scores are in the range of -.06 to .1 (You, 2007). Low scores on the DIT and DERJT were particularly helpful in explaining violations 1, 2, 7, 8, and 16 (Table 1). Low scores on the DEST (Dental Ethical Sensitivity Test [Bebeau, Rest, & Yamoor, 1985; Bebeau, 2006]) were particularly helpful in explaining violations 1, 3, 4, and 5. Following are specific examples of the explanatory power of the deficiencies in the measured abilities that help explain moral failings.

Linking Violations of the Dental Practice Act with Ethical Abilities

In almost every case, low scores on one or more of the performance assessments provided insight as to why the professional had gotten into difficulty with the board, and each referral was provided with that insight. However, this section will attempt to find commonality across cases. In some instances, data from the self-assessment of learning are cited to support the perspective.

Fraud. Some version of insurance or Medicaid fraud was cited for 15 of the referrals, but serious infractions requiring substantial financial restitution were cited for five individuals. These five dentists characteristically predated or postdated insurance forms or submitted claims for a different procedure than the one performed. Each of the practitioners involved with fraud exhibited an unusually high score on the responsibility dimension of the PROI, and (as expressed in the Role Concept Essay) a paternalistic and an unbounded, yet heartfelt, positive responsibility to serve those in need of care. The evidence seemed to support the referrals' assertions that actions were motivated by a desire to help a patient who seriously needed care for which they were unable to pay. In these cases, instruction focused on helping the professional empower patients to take responsibility for their own care, improve their personal assertiveness, and work within legal and ethical boundaries.

Providing Specialty Care Below the Standard of Care. Of the eight dentists (one of whom was a specialist) cited for providing specialty care (either orthodontics, prosthodontics, oral surgery, periodontics, or endodontics) below the standard of care, all but one (a generalist) were also cited for poor record-keeping. In most of these cases, the dentist found he or she was unable to support his or her clinical decisions because of a lack of documentation. In some sense, lack of evidence to support one's decisions served as an easier bridge (perhaps as a face-saving device) for addressing incompetent care, rather than having to come to grips with whether the care actually failed to meet specialty standards. In each of the cases of "probable incompetent care," the

board required a course to address the specific clinical competence in question together with a course in record-keeping. All eight of these dentists had acceptable ethical sensitivity scores, but seven of the eight (DDS #29, described in the sidebar was the exception) had moral reasoning scores below the mean for dental graduates, and five of the eight had very low reasoning scores (P scores in the low 30s for the DIT). Two of the five cases with very low reasoning scores, but acceptable scores in ethical sensitivity, were dentists cited for providing orthodontic care that failed to meet specialty standards of care. In fact, patient complaints following malpractice judgments brought these cases to the attention of the board. Both of these individuals were susceptible to patient complaints about the high cost of orthodontics and took on cases that were beyond their competence–though at the time they did not realize it. Orthodontists often argue that one of the difficult distinctions in providing orthodontic care is distinguishing easy from difficult cases: something that gets generalists into difficulty. Both individuals resolved, as a result of instruction that provided an opportunity to reflect on the orthodontist's perspective, to discontinue providing orthodontic care in the future.

Misuse of Auxiliaries. Sixteen dentists were cited for misuse of auxiliaries. For nine of these dentists, misuse of auxiliaries was the primary reason for disciplinary action. A review of these cases revealed some idiosyncratic reasons for their failures, rather than common ethical shortcomings. Four examples are provided.

First, in two of the cases, the dentists were unassertive solo practitioners who allowed the staff to perform procedures that were both outside their level of training and prohibited by the Dental Practice Act. In both cases, the profes-

A Prototypical Reflection on the Assessment Experience

When asked what he learned, DDS #29 shares what many of the referrals say they experience in the assessment process: "I feel I learned an incredible amount concerning ethics and the dental profession. First of all, I learned a volume of information about myself concerning ethics and the profession. The "Assessment" portion of the course came as a total surprise to me because I had no inkling of what this process would be. At my first meeting with Professor _____, I was a little nervous about what this process would entail. The first half hour was an interesting discussion/lecture concerning moral development and the moral reasoning process. I found this interesting and fascinating in that it had never been presented to me in this manner. The next task was the "Evaluation" phase for me. A brief description was given to me with respect to the separate measurement instruments, and I was led to a seminar room to begin this daunting task. I had no idea how long this would take and in what depth it should be done. I really felt rushed concerning the amount of material. Then I was left waiting for weeks for the results. I anxiously waited in fear, not knowing where I stood in terms of my ethical knowledge and skills. I learned a little about being patient in waiting for the results. When the results were provided to me, I was actually totally overwhelmed by the volume of information and analysis that these measurements provided. My prior knowledge and skills in ethics are reflected in Professor _____'s pretest report to the board. I feel that level of knowledge was enhanced tremendously through these course activities and interactions."

A second excerpt reveals his assessment of what was learned from feedback on one of the measures: "I learned a lot about my personal level of 'Ethical Sensitivity.' I learned how I compare to students and other professionals regarding this measurement. Using the four cases of this test, I learned that such situations are highly complex and must be approached from a different viewpoint with ethical principles and skills rather than from a casual standpoint. These four hypothetical cases were reexamined later in the coursework to provide a learning experience with respect to how to use language that avoids shame or blame to the patient. I learned how to distinguish between descriptive language and evaluative language and how to attempt to use descriptive words and phrases when speaking with patients. I learned how to try to enhance my respect for patients and their ability to understand explanations and make the best decisions in accepting care and treatment recommendations. I learned where I stood at the start with respect to my level of respect for the patients' rights to choose and when these choices have been compromised. I learned where I stood, based on my hurried responses to the patients and dentists in these cases under the test circumstances, with respect to my presentation of positive and negative consequences of various treatment options."

Each of the practitioners involved with fraud exhibited an unusually high score on the responsibility dimension of the PROI, and (as expressed in the role concept essay) a paternalistic and an unbounded, yet heartfelt, positive responsibility to serve those in need of care.

sionals expressed embarrassment about being disciplined. Whereas both dentists exhibited reasonable sensitivity to ethical issues, reasoning about moral issues was not well developed. In one of the cases, both the dentist and three of his office staff were all referred for instruction, as specified by the board as permissible sanctions for registered dental assistants (RDA) and registered dental hygienists (RDH). What became obvious during the problem-solving sessions was the dentist's lack of assertiveness. He would allow the staff to decide on a course of action even when he did not agree with it. Much of the course was devoted to helping the auxiliaries see the shortcomings of their thinking and building respect for the perspectives of the dentist. Both of the dentists involved in these cases were encouraged to seek further assertiveness training.

In a second example, a group practice involving two specialists and four auxiliaries was referred for an ethics course because auxiliaries were performing prohibited duties. In this case, the dentist who trained the auxiliaries to perform the prohibited practices exhibited exceptionally low scores on moral reasoning, but very high scores on ethical sensitivity. In contrast, his associate (who joined the practice after the prohibited practices were instituted) exhibited high scores on moral reasoning but exceptionally low scores on ethical sensitivity. Deficiencies in these two abilities illuminated both the reasons for the problem and the dentists' reaction to disciplinary actions by the board. In the intake interview, the dentist who trained the auxiliaries said he knew the procedures were prohibited, but offered justifications for his actions: others did it (including board members, he thought), the rules were archaic (some states allowed the prohibited procedures), he was working to change the rules, no patient had been harmed (though malpractice charges had been filed), and so on. In contrast, his associate said he honestly did not realize the duties were prohibited. In discussions, he was quick to see the fallacies in his partner's arguments. He was also less angry about the disciplinary action–as he did not see himself being "above the law."

A third example also involved a specialist and his staff–three RDAs and one RDH. The specialist had very low scores on the DIT and moderate scores on ethical sensitivity, but of all the referrals, he made the most remarkable progress, both on measures of the abilities and in attitude. Initially, he challenged the validity of the measures and seemed very wary of the benefits of instruction. He also had to pay the costs for all his staff. A clearly gifted individual, he had not developed his ethical abilities, but when given the opportunity he spent a great deal of time reading and reflecting on professional practice. He expressed particular gratitude for a case discussion during the instruction period involving a decision by a generalist as to whether to offer orthodontic care. This common dilemma has been a powerful case for discussion in the University of Minnesota dental ethics curriculum. It asks a student to consider whether to expand his or her practice to offer orthodontic care. Many generalists offer orthodontic care, which is a great source of irritation to the orthodontic community–principally because of the potential for substandard care that often results in irreversible harm. Generalists often fail to appreciate the complexity of care and describe specialists as greedy purveyors of dental services. The case enables students to consider the perspective of the specialist and to consider the importance of the generalist-specialist relationship.

The specialist, DDS #5, remarked: "The case in which the young dentist had to decide whether he should do ortho-

dontics or not was most enlightening. The conclusions reached in our discussions were similar to the conclusions I had always reached, but was unable to voice or express a firm conviction about. I always felt he should not, but felt my opinion was not very good because of 'prejudice and self-interest.' The principles of developing a good moral argument were very helpful in giving me the confidence to change my mind from 'he should not, but he has a right to' to 'he should not and he has an obligation not to.'"

In the fourth example, four dentists from a group practice were referred for misuse of auxiliaries. The intervention from the board was the result of employee complaints. Within this group, there was variation in reasoning and in ethical sensitivity that would not account for either a failure to recognize the ethical issues or to reason well about them. However, the dentist who assumed management responsibilities for the practice was particularly low on both ethical sensitivity and reasoning, and it became evident that because of his effective interpersonal style, the others deferred to his judgment. Further, the four did not appear to collaborate on decision making; rather each seemed to run a private practice with little interaction among them. None of them were particularly effective in empowering patients or achieving consent for treatment. This group was particularly influenced by discussions of professionalism and the exercises on ethical implementation. Their comments reflect this.

DDS #7: "As you may already be able to tell from my previous responses, this concept of empowerment has moved me. The characteristics, especially those of knowledge, promises, professional ethic, a duty to the ethic, when understood, yield tremendous power and responsibility through our successful ability to empower patients to be able to take responsibility for their care. I see it every day–misunderstandings arise when the patient did not understand and therefore did not take responsibility. I would like to get better at this by continuing the development of these skills. It would help me also with staff and at home. I don't need to be a caretaker in the sense of being responsible for everything and everyone. It makes me tired!"

DDS #8: "The course was an awakening. It made me realize that I had a 'right' to practice, with many more obligations and duties than I have professed over the past years. It has made me realize that in every phase of practice, one must take into account moral and ethical issues, the affected parties, and the consequences of each action. I am far more sensitive to the effects of the interrelationships between the profession, colleagues, society, family, and myself."

Responding to questions about which case had the greatest impact, DDS #8 said: "I think all of the cases had a great impact. In both the moral judgment and ethical sensitivity cases, I was very saddened to learn that my scope as a professional was quite narrow, and received much help in this dilemma in reviewing all of the cases. The basic concepts of how a professional should handle each case instilled in me a new sense of total responsibility to the profession, society, patients, and family."

With respect to changes, DDS #6 remarked: "I believe the most important change is an improvement on informed consent of the patient. I have learned what the patient relationship means to me, and I want to educate and empower the patient in my practice. Before this class, informed consent was a patient's signature on a piece of paper. Now, I realize informed consent is the profession educating the patient well enough for that patient to make an informed decision and consent to the work. I have also learned to 'regulate myself' and my peers and have had open conversations with my employees concerning the Dental Practice Act, what it means, and that I want to be informed of any problems they see with conforming to the Act. I realize that I am the ultimate sentinel on my practice and will also help others who need to be reminded of their obligations.

Professionals' Self-Assessment of the Elements of Instruction that Facilitated Learning and Change

The qualitative analysis of the self-assessment data indicated that professionals found the lectures and discussion of the societal expectations of the professional the most uplifting and helpful in restoring a sense of pride in their chosen work.

Nearly all made statements such as this specialist (DDS #19): "I learned so much about ethics and dentistry. The most important for me was the real definition of a professional. That has changed my outlook on dentistry. I realize that my being a DDS is a privilege, that I have a role to serve the community and, as such, will begin volunteering at a free clinic in the fall. I also am much more aware of professional monitoring of colleagues' treatment. I feel much more comfortable in calling colleagues after seeing one of their patients and informing him or her of findings on their patient (i.e., amalgam overhangs, periodontal disease noted on panoramic

radiographs, etc.). This course has given me a far better outlook on the dental profession as a whole."

A general dentist (DDS #17) commented: "What I have learned is vast. The experience, though traumatic, has been wonderful. Learning a new way of looking at things has been rewarding. As an experienced practicing dentist, I feel (felt) that I had a very good ethical basis. I know that the 100% commitment to the 'basic ethic' of the profession has been practiced all along– do no harm, put the health interests of the patient above self and the interest of the profession. I have done a good job at that. What I have not been so aware of is how my actions have affected others, and that there are 'issues' that I needed to be more open to, those issues that were not 'formerly taught,' but were learned in passing. I was aware of the basic 'six attributes' of a professional, but had not thought too deeply before about self-regulation, how the dental profession rose to where it is today, and our role as professionals in society as a whole. What I learned was vast, but the organization of it was fascinating–that there was a 'substructure' to ethical 'learning.' There was no question that what I did to get here was deserving of the stipulations. What was hard to deal with was 'who' put me here. I accepted that challenge and I feel good about what I have learned."

The sense of empowerment and renewal was most evident for this auxiliary's response–but was not atypical. RDA #7: "I learned that there is much more to being a professional than saying that you are, or just doing a job. Even though I'm 'only' a dental assistant, I believe that in most ways we have some of the same duties and responsibilities that a DDS does. We must acquire as much knowledge about our profession as possible. We must abide by a code of professional conduct. We must also put rights of patients above self-interest. I realize that we are here to provide a service to society, maybe not on as much of a grand scale as a DDS, but nonetheless the rights of society must come before the rights of a profession."

Later, when asked what changes she would make as a result of her experience with the board, RDA #7 said: "I will start to act and think as a professional. Before this course I thought of my work as just that, 'work' or that it was only a job comparable to any other job. I have come to realize that I don't just have a job. I have a profession. To be a member of a profession, there are certain concepts that I need to uphold." (At this point, she reiterated her very thorough understanding of the expectations of a professional.)

When asked what case was the most interesting, both dentists and auxiliaries often commented on the practical value of what was learned and, rather than singling out a particular case, commented on the practical value of all the cases. DDS #17: "All of the cases had impact on my learning–the discussions that followed with Dr. ____ were more involved and helpful for 'every day' use than I thought they were going to be. Things that I took for granted popped out at me. Some cases took an hour just on one small facet. Lots of 'vernacular' was discussed. I am an expert on the physical side of dentistry. I thought I was also very good at patient relations. I found out through case discussion what a truly gifted person sounded like, picked up on ('That must have been horrible for you! Tell me about it.'). I was duly impressed and took a lot of insight with me (not as much as I would have liked). The most difficult case: 'The Sandy Johnson Case'–how to deal with potentially life threatening situations–how potentially complicated they can be ('California Disclosure Case'). The most difference of opinion was 'The Margaret Herrington Case'–as an introvert what to do was clear after discussion–talk to the dentist who did work, get action, or help patient to a better solution."

Of particular interest, from the perspective of the Board of Dentistry, would be DDS #30's perspective on the value of the capstone assignment wherein the referral had to develop a personal dilemma reflecting the circumstances for which his or her disciplinary action was taken, and develop a well-reasoned argument on a more defensible course of action. [For me, the most important case was the "Dr. Sanders Case"], "because it was the culmination of everything I learned in the course as applied to my individual situation–a real-life intellectual study that had very much meaning for me. I could re-read my own analysis and answer my own questions as to what was 'wrong' with what I did regarding this whole DDS #30-Board-Medicaid Issue. The Dr. Sanders case is a feather in Dr. _____'s cap in that it is the distillation of all she was trying to teach me. Moreover, the lesson was learned, articulated, and greatly appreciated. The paper says it all."

When asked what changes the professionals would make as a result of the instructional programs, their responses cited particular professional responsibilities and often expressed ways the course helped the professional overcome anger about the disciplinary action. A typical example: DDS #19: "I am much more aware of the issues involved in my dealings with the board. I am very aware of insurance reporting and will make no more mistakes with that. I am also very aware of the need for self-policing

within the profession. I know my responsibility in dealing with colleagues who consistently perform sub-par treatment. In addition to being enlightened by the board as to my responsibilities as a professional, I am also grateful for the requirement to take the ethics course. I wish this had been available when I went to dental school; I probably would not have had my experience with the board. I also now have a new respect for the board and the tremendous responsibility that they hold."

For the auxiliaries, the sense that they were involved in a profession seemed to be most empowering, and this realization contributed to a sense of renewal and self-worth. As with the dentists, the course experiences were broadening—often enabling them to change their minds about prior beliefs and to engage their colleagues in addressing issues of professionalism.

RDH #1: "I will not perform tasks that are not specifically designated by the state Dental Practice Act. In addition, I will inform other auxiliaries so they are aware of what the Dental Practice Act states, and encourage them to refrain from doing prohibited procedures. In the future, I will try to critically analyze specific procedures and think about what is best for the patient, society as a whole, and the profession, and then will work within the system to change and/or establish laws that are in the best interest of all concerned."

Educational Significance

Most practitioners came to the session readily admitting their own shortcomings, even though they may have been angry about what happened to them. Some of the main outcomes of the course are the opportunity to reflect with others on mistakes and missteps, to assess the personal shortcomings that make one vulnerable to patient dissatisfaction and subsequent disciplinary action, and to implement action plans to address the issues.

Based on a review of both the change scores and self-assessments of learning, several things stand out. First, the various assessment measures employed (ethical sensitivity, etc.) helped the practitioners gain insight about those personal shortcomings in ethical abilities that contributed to their moral failings (see Sidebar for an example). Second, based upon practitioners' reactions to assessment and instruction, it is evident that the framework of ethical abilities (Rest's Four Component Model) provides a powerful foundation for engaging in learning. As was evident from the self-assessment data, beginning the instructional process with a discussion of the distinguishing features of a profession and the expectations that follow is uplifting and renewing. Further, the cases used to facilitate ethical sensitivity and reasoning clearly were viewed as relevant to professional practice. Finally, it appears that practitioners highly valued the emphasis on ethical implementation. Instead of stopping with "What is happening?" and "What ought to be done?" as is typical of much ethics instruction, the courses spent time focusing on how to implement an action plan, including what to say and how to say it. This is a neglected area in much of ethics education—what Fisher and Zigmond (2001) working in research ethics refer to as "survival skills." For students and practitioners alike, there is a clear hunger for help with strategies and language to deal with human interaction problems that have clear ethical implications. For a more extensive discussion of curriculum and resources to promote ethical implementation, see Bebeau and Monson (2008).

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Reflecting upon both the qualitative and quantitative data, it is important to ask whether the observed changes in performance and perspective on learning represent real change that will have a lasting effect. Certainly the circumstances under which respondents completed the course are important to consider. All practitioners were required to complete the course, the assessments, and the self-assessment of learning–often at great personal expense. Since reinstatement of their license was at stake, one would expect referrals to engage in a certain amount of impression management, i.e., to say positive things about the course and the instructor.

It is certainly possible that as designers of the experience, we have been duped into thinking the benefits were greater than they actually were. To address this concern, we asked ourselves about overall impressions. What stood out–after reviewing approximately 80 single-spaced pages of self-assessment data? For the research assistant who has also analyzed several years of self-assessment data for dental students' reactions to ethics instruction (using similar questions), the following things stood out. First was the large number of comments about enjoyment of instruction, coupled with the detailed responses indicating how particular activities and cases were of benefit. Second was an overwhelming impression that the referrals really appreciated the educational experience. This was particularly impressive in cases where the individual exhibited some residual anger about the disciplinary action. Also impressive were the number of referrals who commented about their newly acquired understanding and appreciation for the role of the Board of Dentistry, and the number of referrals who commented about future intentions–to be more involved in organized dentistry and to be more involved "giving back to their communities" by providing pro bono care.

Anecdotal evidence gave credence to these impressions. The course seminars, scheduled in two-hour blocks, rarely ended on time–not because the instructor was expounding on some fine point, but because participants were actively engaged in discussion and resisted efforts to bring things to a close. There appeared to be a kind of hunger for engagement with others around ethical issues of the profession. Other anecdotal evidence comes from the number of practitioners who have maintained a friendship with each other and with the course director since the experience. It is not uncommon to receive notes of appreciation years after the experience. Further, for the last several years, referrals have volunteered to speak to dental school classes about their experience and about the professional expectations they found most difficult to fulfill. The most important message they have delivered is a willingness to admit to personal shortcoming and to address the importance of self-regulation and engagement with their professional association.

Sadly, two individuals who completed instruction have encountered subsequent problems. One decided to retire his license–following repeated misuse of auxiliaries; one was disciplined for subsequent unprofessional conduct. On

the other hand, 38 individuals have not had a second encounter with the board. To date, we have been unable to identify comparable data to our findings.

Conclusions

Findings from this study support the explanatory power of measures based on Rest's Four Component Model for understanding moral failings and the power of a remedial course for improving ethical decision-making abilities and for restoring a sense of professionalism. An important take-away message for ethics education is the clear need to focus more attention on ethical implementation. What practitioners actually say and do is where the rubber hits the road. Having an opportunity for guided reflection on a significant event, like a disciplinary action by a licensing board, has real potential for helping the practitioner make improvements in practice that bring enhanced personal satisfaction and improved practice.

What began as a pilot project to remediate problems board members sensed in their colleagues who had experienced disciplinary action, has matured into a working program with a beneficial effect. This analysis, undertaken to evaluate the program, supports its effectiveness. Both the board and the practitioners who have experienced the program support its continuance. As one referral wrote me following his hearing for licensure reinstatement: "Thank you for making a difference in my life... I will remember that time always." ■

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