Are dentists influenced by gifts and incentives?

**Expert opinion in the latest issue of Journal of Law and Medicine**

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Compared to the medical profession, there is less discussion and scrutiny of gift-giving and incentives, and their potential to influence the behaviour of dentists, argue two University of Sydney experts in the latest issue of the Journal of Law and Medicine. [1]

Dr Alex Holden and Professor Heiko Spallek from the university’s Faculty of Dentistry argue that while there may be scenarios where dentists are conscious of influence and subsequent bias in their decision making, evidence suggests that many times, dentists may be unaware of such influence and bias.

They refer to this phenomenon as a “bias blind spot”.

They say influence and incentives come from three main sources: professional colleagues, patients, and industry, especially the pharmaceutical and medical devices industries.

On the subject of gift-giving, for example, The Dental Board of Australia says dental professionals may accept small gifts of, “minimal value such as flowers or chocolates.”

In the journal paper, Dr Holden and Professor Spallek say existing guidelines for managing conflicts of interest are insufficient, and that “there is little to be found in the way of a professional discussion about this issue within dentistry.

“Dental professionals have a duty to place patients first overtly and to provide care that is based upon solid evidence. Industry, both pharmaceutical and otherwise, has a role in supporting this and must scrutinise any practice which could call the profession’s integrity into question,” say the authors.

**MEDIA ENQUIRIES**

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Looking Gift-horses in the Mouth: Gift-giving, Incentives and Conflict of Interest in the Dental Profession

Alexander C L Holden and Heiko Spalik

Within medicine, there has been a protracted conversation relating to the appropriateness of accepting gifts and incentives from industry, professional colleagues and from patients. The general principle and anxiety in this debate relates to answering the question of whether accepting gifts or incentives compromises a health professional's duty to provide quality care. Within the dental profession, there is noticeably less discussion as to the effects of gifts and incentives upon the practice of dentistry. Given that dentistry is, like medicine, part of health care this status quo is not one that should persist. The authors hope that this article will stimulate discussion around dentistry's relationship with those who might seek to make commercial benefit out of our practice and how dental professionals should respond to patients bearing gifts – letters to the editor are explicitly invited; personal communication to the authors to compile a follow-up publication is welcome.

Keywords: conflicts of interest; gift-giving; dentistry; professionalism; ethics

INTRODUCTION

Lo and Field define conflicts of interest in health care to be “circumstances that create a risk that professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest.”1 Primary interests are role-related (e.g. acting in the best interests of patients) while secondary interests are not directly related to fulfilling this professional role. An example of a secondary interest could be accepting a fee or reward for referring a patient to another provider. Using this definition, conflicts of interest have the potential to develop on a regular basis within dentistry in a wide variety of ways: from industry representatives offering “lunch and learn” sessions in exchange for access to the dental team to promote a product, to needing to balance obligations to patients and their oral health with the need to run a viable business. While medicine and its allies are in modern standards grounded more within fiduciary rather than transactional obligations, it is important not to forget that the Hippocratic medical tradition was born in the marketplace. It is a recent and artificial construct that medicine has been seen to attempt to elevate itself away from its commercial beginnings through formal professionalisation. The success with which this is accomplished is arguable; in the end everyone needs to be compensated for their time and skill. Dentistry is a branch of medicine that intrinsically is heavily commercialised and sensitive to the economics of wider society. While there needs to be an acceptance of the manner in which dentistry is practised and organised, this must be reconciled with professional duty and primary obligations to patients.

GIFTS FROM PATIENTS

It is not unusual for healthcare workers to find policies and ethico-legal guidance relating to gift-giving from patients to be overly bureaucratic, mean-spirited and offensive.2 While being shown appreciation

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1 B Lo and M J Field, Conflict of Interest in Medical Research, Education, and Practice (National Academies Press, 2009).

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Looking Gift-horses in the Mouth

from those we treat contributes to job satisfaction, it is important to consider the implications of accepting gifts from patients upon professionalism from a wider perspective. Gift-giving within health care has a rich history of attracting criticism. Recently, the ethics of accepting gifts from patients took a darker turn as part of the fallout of the case of Harold Shipman. Shipman was an English general medical practitioner who was found guilty of murdering 15 patients (although later as part of a subsequent inquiry it was confirmed that the actual number was at least 218). Of relevance to gift-giving and the professional–patient relationship is that in one case he was found to have fraudulently written himself into the will of one of his victims. The imbalance of power between health professionals and patients means that actual and perceived conflicts of interest are increasingly in need of discussion and their relevance to the caring relationship to be explored.

The Dental Board of Australia states that dental professionals may accept gifts of, “minimal value such as flowers or chocolates”.4 This is mirrored by guidance from other regulators such as the General Dental Council of the United Kingdom: “You must refuse any gifts, payment or hospitality if accepting them could affect, or could appear to affect, your professional judgment.”5 Despite what might seem to be clear guidance, codes of conduct struggle to really deliver objective advice. A bunch of daffodils will cost much less than a potted orchid and a selection of Lindt chocolates significantly more than a box of Cherry Ripes. Furthermore it is necessary to consider the cost relative to the giver and receiver; what might be a minimally expensive gift to a dental professional could be a significant expenditure for a patient or vice versa. Gifts might also be in the form of experiences that are difficult to place a value upon: a patient’s invitation to join them on their boat for an afternoon’s fishing in contrast to joining a patient on their yacht for champagne as an appreciation for good care. The guidance cannot cover every eventuality, nor should it try to. For this reason it is important that the dental profession as a whole develops a dialogue that might go further towards defining principles to dictate how gifts and demonstrations of appreciation might be managed.

Why should it matter if a patient chooses to give a gift? It could be argued that so long as gifts are not solicited by a dental professional and that a patient has autonomously chosen to show their appreciation in this manner, there is no ethical dilemma. The Code of Conduct of the Dental Board of Australia addresses this in stating that it is not only genuine conflicts of interest that must be considered, but also circumstances where a perceived conflict with the duty to a patient by a third party might exist.6 Some policies might suggest a blanket refusal of all gifts is necessary.7 This approach may be criticised for potentially leading to embarrassment in refusing a gift and that such refusal might damage good will within the dental professional–patient relationship.8 Some cultures would find the rejection of a gift from a patient to a clinician to be highly irregular and offensive. Australia is a diverse polyclute and some patients may not be attuned to a Western, non-paternalistic model of care. The widely cited bioethicist, Weijer9 gives four reasons for the universal rejection of gifts. First, the clinical relationship between clinician and patient is a fiduciary one; the patient’s best interests hold primacy over any other feature. Accepting reward outside of the established and accepted levels of reimbursement defies this fiduciary nature and erodes the special moral character of the patient-professional relationship. Second, there are differing motivations for the giving of gifts. It would be far too cynical to suggest that gaining favour is the only motivation for patients to give a gift and one must assume that this is far from the minds of the majority. However, in the presence of such uncertainty, all gifts should be refused. Third,
in accepting a gift, how might a clinician make other patients feel? Should they also buy a gift to receive the same standard of care? Lastly and in Weijer’s eyes most importantly, accepting gifts from patients debases the true value of the care that clinicians give to patients; he states that rather than a bottle of scotch (sic) more appropriate tokens would be a heartfelt “thankyou”, a letter of appreciation or a photograph showing how the treatment had enhanced that patient’s life. Despite these items not causing a financial or material conflict of interest, they may arguably still cause an unconscious bias, Weijer does not address this. It is important in this discussion to consider unconscious bias and the potential that gift-giving may create feelings of having an obligation to treat. In accepting any gift from a patient, a dental professional must also consider how this might appear were the acceptance to be made public, especially to that professional’s other patients. If any doubt exists as to whether a conflict of interest might exist when accepting gifts from patients, imagine a board in the waiting room listing that year’s top five gift-givers; few might consider this to be acceptable.

There is a dearth of literature examining the attitudes of dentists to gifts and unconventional payments from patients. Reid et al found that a large proportion of dentists surveyed would be happy in accepting high value gifts from patients (34.9%) and accepting a dinner invitation (79.7%). The acceptance of high value gifts and personal invitations has been criticised by Weijer who states that the dentist’s position as a friend is untenable as the model of friendship does not do justice to the essence of the therapeutic relationship between patient and treating dentist. It is difficult to suggest how this might fit into a model of patient care in a rural setting where it could be very difficult for a dentist not to have relationships outside of patient care and where they may be integral members of the local community. Whatever a dental professional’s working environment might be, it is crucial that personal friendships with patients (if they should exist) do not create perceptions or realities of obligations to preferential treatment.

Currently in the United States, the Physician Payment Sunshine Act 2010 (US) (often simply referred to as the Sunshine Act) does not cover the giving of gifts from patients to their clinicians. Similarly, the Bribery Act 2010 (UK) is more concerned with the relationship between clinicians and industry. Despite this, medical indemnifiers have recommended that physicians within the National Health Service in the United Kingdom start to document gifts that they receive from patients as future changes to include gifts from patients within anti-bribery legislation are anticipated. Australia is yet to address formally the issue of health professionals receiving gifts from those who they treat through legislation. Since 2007 the Australian Competition and Consumer Commission, backed by the Australian Competition Tribunal, has placed requirements upon Medicines Australia to disclose details of pharmaceutical sponsorship. Australia was the first jurisdiction to place such requirements on the pharmaceutical industry. The relationship between the dental profession and industry will be explored below. The Australian Dental Association does not have any guidance relating to the receiving of gifts from patients and how this might affect the dental professional–patient relationship.

**INCENTIVES FROM INDUSTRY AND PROFESSIONAL COLLEAGUES**

There are substantial concerns about how the pharmaceutical industry interacts with health professionals. One of the bedrocks of professionalism is that patients should be able to trust that their interests will be placed ahead of any commercial interest held by those who are responsible for their care. There is an
Looking Gift-horses in the Mouth

important question surrounding the concept of gift-giving within the dental profession as to whether the giving of gifts could have the potential to damage this trust. This may contribute towards bias in clinicians’ judgments that impacts upon essential components of professionalism such as the quality of dental care, the rights of patients to make autonomous decisions and social justice. When clinicians and the public have been asked for their views on the acceptability of gift-giving, the data show that acceptability is correlational to applicability; the highest acceptability rankings were given to gifts that were seen to be useful to patient care. Examples of such items given in the literature are stethoscopes and spirometers for physicians, with branded pens also seen as being acceptable. The lowest rankings were given to high value items that were seen to be irrelevant to clinical care such as tickets to sporting events, dinners, electrical items and holidays. In practice, many companies manufacturing dental products will supply these free of charge to some public institutions to be distributed to patients. Copious amounts of free samples of toothpaste and other dental consumables are delivered to private practices for distribution to patients and staff. It is seldom questioned whether these activities might contribute to bias; often such relationships have become so part of the norm that there is a reliance from some organisations upon these professional–industry relations. Within dental education, it is common for students to be targeted by companies distributing free electric toothbrushes, the recommended retail price of these often being hundreds of dollars. These same students are then placed into clinical relationships with patients to whom they are expected to deliver oral health advice, an essential component of this being which brands might be most suitable for that patient.

While research may support the idea of public and professional acceptability to some ideas of gift-giving, it is necessary to engage with the wider moral debate surrounding the giving of gifts by industry to clinicians. Even small gifts of negligible value have been shown to influence the prescribing habits of clinicians and therefore the idea of placing an arbitrary minimum or maximum amount upon the value of gifts is flawed. Sixty-one percent of physicians stated that industry promotions or gifts do not affect their practice while 16% stated that they believed the same about the practice of their professional colleagues. The contrast in these two statements reflects the existence of unconscious bias, which is unavoidable for clinicians who receive gifts from industry. Similar studies have shown that the prescribing habits of doctors changed following attendance at a sponsored conference in favour of the drugs manufactured by the sponsors. This is despite the participants stating beforehand in a questionnaire that the conference would not change their clinical practice. There is a need to accept that the unconscious bias created by gift-giving is not resolvable through training. Many participants in studies looking at gift-giving and bias were senior clinicians who reported that they were fully aware of the potential for bias and yet proved just as susceptible as their junior colleagues to unconscious influence. Often conflicts of interest become an issue with language; when restrictions are placed upon the marketing activities of industry (especially pharma) these efforts are merely rebranded to be educational. This makes attempts at regulating companies themselves difficult if not futile.

Guidance from the Royal Australasian College of Physicians states that the acceptance of tickets to entertainment events, electrical items for home and office use and travel allowances by members is unacceptable. The Australian Medical Students Association has released a policy statement which states that it does not accept sponsorship or partnerships with pharmaceutical companies due to conflicts

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16 Macneill et al, n 15.
Holden and Spallak

of interest.\textsuperscript{21} In contrast, the Australian Dental Students Association has not taken a similar stance and actively seeks sponsorship and partnership from outside industry.\textsuperscript{22} Guidance from the Federal Australian Dental Association regarding members’ relationship with the dental industry\textsuperscript{23} does not make any reference to gift-giving by industry. The Association does address relationships with pharmaceutical companies.\textsuperscript{24} The guidance, like that of the Dental Board of Australia, is vague. It seems unfortunate that dental profession has not yet fully considered its relationship to third parties and how these entities might influence patient care in the same way that the medical profession has considered the same issue. This article is an attempt to trigger such a discussion. The authors believe that self-regulation is preferable to governmental interference due to a lack of meaningful action in this area.

Specialists or dentists with restricted practice should consider whether offering colleagues incentives to refer is acceptable. Colleagues making referrals should consider the appropriateness of accepting any such offer. The Dental Board of Australia Code of Conduct would seem to take a much harsher stance on relationships between referring colleagues. The guidance states that good practice involves, “not offering inducements to colleagues or entering into arrangements that could be perceived to provide inducements.”\textsuperscript{25} The acceptance of such inducements would also be covered by the same section discussed previously in relation to conflicts of interests that would need to be disclosed to patients. Section 8.11(e) also makes reference to relationships with pharmaceutical and supply companies stating good practice involves “not asking for or accepting any inducement, gift or hospitality from companies that sell or market drugs or other products that may affect or be seen to affect the way practitioners prescribe for, treat or refer patients or clients”. The Dental Board of Australia would appear to expect dental professionals to be aware of how gifts or inducements from industry might affect clinical judgment, the Code of Conduct also reads: “recognising that pharmaceutical and other marketing may influence practitioners and being aware of ways in which practice may be influenced”.\textsuperscript{26} It is important for the profession to consider whether there would be any difference in accepting a gift or some other benefit resulting from a referral to a colleague and accepting a gift or hospitality around the Festive period as a “thankyou” for support. The principles that relate to how a third party might interpret these rewards would suggest that both scenarios could equally cast doubt upon the validity of referrals in the eyes of patients were they to find out about this. It is common for industry representatives and specialists to run, “lunch and learn” sessions. Dental professionals should be vigilant as to whether accepting these offers of reward for exposure could compromise integrity. Arguments that a clinician would be referring to a particular specialist provider anyway and so incentives make no difference seem to fall flat. If this is the case, gifts should still be refused; an aspect of inevitability does not negate the risk of damage to integrity.

CONCLUSION

In considering different situations in which a dental profession might develop a conflict of interest, there are aspects to management of relationships that are universal. While it is possible that choice in decisions where conflicts are present might be conscious, it is more likely that conflicts will have unconscious effects.\textsuperscript{27} This is caused by innate self-serving bias that leads to the discounting of evidence that might


\textsuperscript{22} Australian Dental Students Association, \textit{Sponsorship} \url{https://adas.org.au/sponsorship}.

\textsuperscript{23} Australian Dental Association, \textit{Policy Statement 5.6 – Dental Industry} (16/17 April 2015) \url{https://www.ada.org.au/Dental-Professionals/Policies/Third-Parties/5.6-Dental-Industry/ADAPolicies-5.6-DentalIndustry_V1}.


\textsuperscript{25} Dental Board of Australia, n 3, s 8.11(g).

\textsuperscript{26} Dental Board of Australia, n 3, s 8.11(d).

suggest one’s own susceptibility to conflicts of interest. The phenomenon that this creates has been termed “bias blind spot” and leads to optimistic self-assessment of behaviour. Whether it might be a gift from a patient, an incentive from a specialist or a learning session with samples and refreshment from industry, it is likely that many practitioners would not identify themselves to be consciously influenced. This leads to an impasse where the profession is relatively tacit on the issue of how potential conflicts created through professional relationships might be managed and considered.

Anecdotally there may be widespread resentment towards policies that look to curb the culture of incentives within health care but this would appear to be necessary on the back of research that shows how this affects patient care. The resentment is understandable regardless of one’s own position; dentistry is a stressful job and while well paid, sometimes it is the smaller things that make the difference and can increase job satisfaction more than increased income. It could be held that for a group of dentists to be taken out for a meal by an industry representative is meaningful for those involved. Dentistry can be a lonely profession, populated by clinicians who are innately sociable; social gatherings that are sponsored by industry are most welcome. Some literature shows that many patients have a relaxed attitude to their treating clinicians receiving gifts or having food purchased for them, but the authors warn that this cannot allow complacency when we may know better.

Denial of affect and hostility towards policies seeking to control professional interactions involving gifts and incentives are symptomatic of the aspect of dentistry where such practices have been normalised. If a large proportion of the profession and supporting industry engages in an activity surely it cannot be ethnically problematic? Perhaps indicative of this normalisation is the lack of discussion and guidance on this issue within the profession. Guidelines that exist for the management of conflicts of interests do not exist beyond a bare minimum and there is little to be found in the way of a professional discussion about this issue within dentistry. Dental professionals have a duty to place patients first overtly and to provide care that is based upon solid evidence. Industry, both pharmaceutical and otherwise, has a role in supporting this and must scrutinise any practice which could call the profession’s integrity into question. It is hoped that this article will act as a call to action for the dental profession and dental industry to consider the impact of gifts and incentives upon the often fragile clinician–patient relationship. This discussion has already begun; the Australian Dental Industry Association recently undertook a consultation of key-stakeholders’ views on the giving of gifts and subsequently released guidance on this issue. Public trust is a sine qua non for healthcare professionals to perform their duties and professional integrity constitutes the essential ingredient to developing and maintaining that trust. We, the authors, are convinced that the profession must address concerns surrounding conflicts of interest. It is imperative that this occurs before questions arise from those we treat which may lead to an inhibition of quality patient care and an erosion of trust.


30 Macneill et al, n 15.