FDI World Dental Federation

Dental Ethics Manual 2

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Dental Ethics Manual II

An overview of ethical issues in dentistry

This *Manual* is the combined result of international experts on dental ethics brought together as an FDI Working Group. By holding productive meetings and electronic discussions, this group has tapped into the diversity of its members' experience, expertise, and knowledge of ethics, law, and philosophy in public health, private practice, urban and rural dentistry, wealthy and low- and lower-middle-income countries, traditional and modern dilemmas.

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Preface

Ethics is an integral part of the health professions. Even if dentists rarely deal with popular bioethical topics like trade in organs or assisted suicide, they face ethical challenges and must make ethical decisions in their everyday practice. Many of these challenges are resolved by experience. However, sometimes experience is not enough, and the dentist may need practical tools to assist with ethical decision-making.

The biological sciences and technical competences have important roles in dental education, but the degree to which ethics is taught in dental schools differs widely. There is, however, evidence that knowledge and skills in ethics will help dentists maintain pride in their work, establish a sound relationship with their patients, and sustain public trust in the profession.

In 2007, the FDI World Dental Federation, representing more than 200 member organizations in more than 120 countries, published the first *Dental Ethics Manual*. In the words of Dr. Michèle Aerden, the then president of FDI, the manual aimed to be “an inspiration for everyone in the oral health professions and in the best interests of their patients.” It has since been a valuable resource for dental practitioners, students, and educators alike.

In 2015, the General Assembly of the FDI adopted the Policy Statement, “The Role of the FDI in Dental Ethics.” A recommendation was included that a new, updated manual be produced. In preparation for the updated manual, an international team of experts drafted the “International Principles of Ethics for the Dental Profession,” which were adopted in 2016 by the FDI’s council as the basis for the new publication.

This *Manual* is not intended to be a comprehensive text on dental ethics, but is designed to introduce the reader to current and emerging ethical topics that arise in the practice of dentistry. It has been written in such a way that the reader can directly access an individual chapter of interest. Each chapter illustrates theoretical content with short cases, and an appendix provides an example of how to analyze an ethical dilemma systematically.

Chapters were written by different authors, and terminology may differ slightly throughout the book. Moreover, some terms may differ in their meaning from one author to another. Clarification of the terminology used in this manual is provided in a glossary. Suggestions for further reading are included at the end of each chapter.

The reader is reminded that this *Manual* has been written to be of relevance to an international readership. Therefore, it does not address national codes of ethics or laws of individual jurisdictions, and does not replace the need for seeking ethical or legal advice at a local level.

Chapter 1:
Ethics as a defining characteristic of dentistry

Summary

This chapter argues that dentistry cannot be defined in terms of its scientific foundations and clinical techniques only. Ethics, too, is a defining characteristic of dentistry. For example, the expert who employs dental knowledge and skills to torture a suspected terrorist is not practicing dentistry, let alone good dentistry. The dentist who entices a patient into undergoing orthodontic treatment without clear benefit to the patient is likewise not practicing good dentistry, nor is the dentist who routinely refuses to provide emergency dental care to strangers in need of such care.

Introduction

Both the science and practice of dentistry require dentists to make value judgments. The importance of dentists examining the ethical parameters of their practice is further underscored by the fact that patients are often vulnerable and fully dependent on dentists for their oral healthcare needs. Patients must be able to trust dentists, and the relationship between dentist and patient is generally considered to be a fiduciary one. In turn, individual dentists and the profession at large must warrant the public's trust, which requires (among other things) that dentists allocate scarce oral healthcare resources, including their own time, fairly among patients in need.

Case study

A 12-year-old patient comes with her mother to the dentist. Her maxillary incisors are not properly aligned. The aberration is minimal and does not affect her oral functioning. Although the dentist in recent years has repeatedly counseled mother and child to improve her brushing efforts, the patient's oral hygiene remains poor. The girl wants braces now, so her teeth will look perfect by the time she goes to high school at age 14. The mother supports her daughter's wish. But the dentist is concerned, because the poor hygiene is a contraindication for braces.

This case shows how dentistry inevitably evokes ethical questions. For example: Would a refusal to commence the orthodontic treatment be justified, and why? How should medical benefits and harms be weighed against other aspects of patient well-being, such as good looks and teen confidence? What actually counts as a medical benefit? Do individual dentists or the profession at large have any responsibility to counter the modern consumer culture, which readily capitalizes on teen peer pressure? And then there is the issue of decision-making authority. Who should make the treatment decisions: Dentist, patient, parent? How much weight should the dentist assign to the wishes of the 12-year-old girl? Does it matter that mom agrees?

Some will argue that the answers to these questions will have to come from law, politics, religion, market forces, social convention, or some other moral source outside the practice of dentistry. This chapter adopts the opposite, internalist view: the values, principles, and ethos that guide the practice of dentistry are internal to the practice of dentistry itself. In order to practice good dentistry, it does not suffice to stay abreast of recent developments in the field of dental science, nor does it suffice to continuously improve one's technical competencies. Both of these are necessary to practice good dentistry, but not sufficient. It is equally necessary to adhere to the ethical standards that define the practice of dentistry.

For example, dentists who use their expertise to torture suspected terrorists are not practicing good dentistry; in fact, one could argue that their actions cannot even be called dentistry, let alone good dentistry. The same would be true for a dentist who replaces completely healthy teeth with expensive implants, even if the patient insists on the treatment. The dentist may do so expertly, applying the latest science and technology, but it is not good dentistry.

In past ages, when most dentists were capable of little more than extractions, it was quite evident what was ethically required of them to be a good dentist: do not extract teeth unnecessarily and do not overcharge patients for the service rendered. Things are no longer quite as simple. Dentistry has grown into a very complex practice, and with these advancements have come new and complex ethical challenges.

Can dentistry be practiced without making value judgments?

Critics may acknowledge the reality of these complexities but insist that making value judgments on behalf of patients goes beyond dentists' expertise. By applying the methods of biomedical science, dentists can discover lots of facts about oral diseases. On that factual basis, effective diagnostic and treatment protocols can be developed. Dentists can then inform patients about the various treatment options. But whether such treatments are actually of value to patients, and whether patients ought to undergo them, can only be decided by the patients themselves – or so these critics would insist.

But what do we mean by an effective treatment? Effective for what? To use this term means that there is some state of affairs that does not yet exist but which is desirable. Furthermore, the label *effective* implies that the treatment will not only realize the desired state of affairs, but also do so in a manner that is worth undergoing it. Both of these qualifiers reflect a value judgment. The state of affairs must be of value to somebody in order to be desirable. And somebody must find the manner in which it is realized valuable to say the treatment is worth it. Who makes these value judgments? Only patients?

Contemporary dental textbooks are filled with statements about the effectiveness of diets, drugs, surgeries, and other therapies. Apparently, the dental scientists writing these chapters presume certain values. They take for granted that most patients share the scientists' own values in matters of oral well-being and health. This allows dental scientists to make statements about the effectiveness of all kinds of dental treatments without ever asking what individual patients really desire and want to undergo.

For example, a clinician may tell the patient: "Surgery is the most effective treatment for this oral cancer." This statement would not make any sense if the clinician saying it also claims never to make any value judgments on behalf of patients, for it reflects a particular view about what is truly a desirable state of affairs for this patient (and hence, how that goal can best be achieved). In calling surgery "the most effective treatment," the clinician expresses the view that complete remission of the tumor is a desirable and worthwhile end result.

What if the patient expresses a worry about the postoperative scar and prefers radiotherapy? This response calls into question the clinician's value judgment, and surgery therefore may not be the most effective, or even an effective treatment. In fact, it is quite common for patients not to seek the kind of optimal oral health that their dentists and indeed dental science itself assumes to be the goal of oral healthcare. Instead, patients may have other goals when seeking oral healthcare, such as freedom from pain at the lowest cost available. A treatment that may be effective at optimizing oral health may not be at all effective at achieving freedom from pain at the lowest cost.

We thus find that a simple and seemingly value-neutral statement about an effective treatment necessarily entails a value judgment about what is in a patient's best interests. And what is true about the concept of effectiveness is equally true about other basic scientific terms. Take the concept of health. It does not simply describe a particular physiological state of being. Instead, it suggests a state of being that is desirable and valued. As early as 1948, the World Health Organization (WHO) defined health as "a state of complete, physical, mental, and social well-being and not merely the absence of disease or infirmity." The key term in this definition is the word *well-being*. Clearly, this term entails a value judgment. It reflects a desirable state of being that we ought to protect and foster.

The same is true for many other core concepts in dental science, such as disease, disorder, and abnormality. It is impossible to define any of these terms without making a value judgment about patients' interests, about what ought to be, and about the norm that should be followed. In short, the very science of dentistry is always and inevitably based on value judgments about patients' interests. It is therefore impossible to be a value-neutral dentist.

The fiduciary relationship

The FDI World Dental Federation's 2016 definition of oral health emphasizes that "oral health is multifaceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex." The inability to speak, smile, or swallow renders a person vulnerable. When patients have a serious toothache, when they are no longer able to chew food, or when they suffer a disfiguring facial trauma, their well-being, social functioning, and occasionally even their very life may be at risk. None of these situations are a simple matter of subjective wishes or preferences, which a person is free to act on or set aside. A person with an abscess is not free to postpone treatment until the antibiotics are available at a reduced price; she needs the treatment. That renders the person even more vulnerable, and vulnerability in turn generates ethical obligations on the part of those who are not similarly vulnerable but able to care.

Patients' vulnerability is compounded by their dependence on experts to take care of their needs. Patients cannot treat their own abscess, their own toothache, their fractured filling; patients depend for help on dentists. What is more, patients must be able to trust their dentists. First, they must trust that when their dentists recommend certain treatments, those recommendations are based on the patient's diagnosed needs and not the dentist's own interests. Second, patients must trust that their dentists are actually competent to provide the indicated treatments. The relationship between patient and dentist is therefore also characterized as a *fiduciary* relationship, or a relationship of trust. Warranting patients' trust in the profession of dentistry is an important ethical challenge for each individual dentist.

Some critics may object that most dental patients are not truly vulnerable and dependent in the same way that the child with a broken bone or the woman with breast cancer are. Dental patients' lives are rarely at risk, and with regular preventive care, even raging abscesses and debilitating pain have become rare. Moreover, a continually growing number of dental interventions have purely cosmetic aims and are hence elective.

It is doubtful that this criticism – that most dental patients are not truly vulnerable – is empirically correct, particularly when interpreted globally. Even in the USA, which spends more of its gross national product on healthcare than any other country, children lose more days of school to caries than to any other disease. But the criticism does point to yet another important ethical challenge. To the extent that interventions provided by dentists are purely elective or aim to reach a nonhealth goal (such as beauty), the relationship changes as well from a fiduciary relationship between a healthcare provider and a patient, to a contractual relationship between a businessperson and a client. In turn, that change generates a different set of ethical principles and norms to which the dentist must adhere. We discuss this issue in greater detail in Chapter 9.

Beneficence and nonmaleficence

We have argued that the core element of the fiduciary relationship between dentists and patients is trust. Patients must be able to trust their dentists. But exactly what is it that patients may trust dentists to do or not to do? It is not easy to answer this question, and the answer has evolved across the ages. In fact, this whole dental ethics manual can be seen as an attempt to answer this question. However, two core ideas appear to have survived from the days of Hippocrates to present times.

In the ancient Hippocratic Oath we already find the thesis that healthcare providers are expected to advance the patient's good: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment." Patients must be able to trust that dentists will always seek to advance the patient's well-being and even give priority to the patient's interests (as opposed to the dentist's own interests). This obligation of healthcare providers has also come to be known as the bioethical principle of beneficence.

Nowadays, many ethicists are critical of this principle. They are worried about dentists doing presumably good things to patients without even asking the patients themselves. Beneficence, so these critics argue, necessarily entails paternalism. It is true that throughout history, healthcare providers have behaved very paternalistically. Hippocrates instructed his medical students never to inform patients about the true cause of their disease. This tradition of silence has continued until this century, and there are still dentists who think they know what is best for the patient without ever asking the patient.

However, the principle of beneficence does not itself entail paternalism. All it says is that dentists ought to act in the best interests of their patients. In fact, in most instances the principle of beneficence requires the dentist *not* to be paternalistic. It is very difficult to determine what is in a particular patient's best interest without asking the patient. As already explained, if a dentist wants to decide what treatment is truly in the patient's best interest, the dentist cannot rely on scientific facts only, but must involve the patient in the decision-making process.

The principle of beneficence is paralleled by another principle, the roots of which go back to the Hippocratic Oath as well. The fragment from the Oath quoted above is followed by the following sentence: "I will keep them from harm and injustice." Though mentioned secondarily, this principle is probably even more pivotal, as is expressed in the ancient rule: *Primum non nocere* – first and foremost, do no harm!

The historical reasons for such a drastic warning are evident. Much of ancient, much of medieval, and indeed much of pre-19th century medicine was quite risky to the patient. One's chances of being healed by a physician were not much greater than one's chances of being healed by nature. Moreover, one's chances of being harmed by the physician's interventions were considerable. No wonder physicians were taught to back off if they were not sure: *In dubio (dubiis), abstine!* – when in doubt(s), abstain!

With the advent of modern, scientific medicine, patients' chances have improved tremendously, and most healthcare providers have more or less forgotten the warning to do no harm first and foremost. However, this warning continues to be very important, as expressed in the contemporary bioethical principle of nonmaleficence. It would obviously be a violation of the principle of nonmaleficence to kiss a sedated patient or intentionally infect one's patient with HIV. However, less egregious practices, such as overtreatment of patients or performing dental interventions requested by the patient yet known to be ineffective or harmful, would violate this principle as well.

Even well-intentioned dentists who carefully guard against overtreating patients are likely to harm their patients occasionally. There is ample evidence that dentists make mistakes, or treatments have unexpected harmful outcomes, including death. Almost every dental intervention, whether diagnostic, preventive, therapeutic, or experimental, poses certain risks to the patient and involves some harm. We tend to call those risks *side effects*, but they are no less real. Whenever we risk inflicting more harm than good on the patient, we must abstain. At the very least, we should pause to re-examine the situation and the proposed interventions and discuss these matters with the patient. After all, it is the patient who will be the one to enjoy the benefits, as well as undergo the harms.

Scarce resources and the inevitability of choices between patients

There is a final aspect of professional dental practice that we briefly review here because it is another source of the contemporary interest in the discipline of dental ethics. The trust of patients in dentists is not vested first and foremost in individual dentists, but in the profession of dentistry as a whole. Because of this, the profession must assure that all dentists meet basic levels of knowledge and skills and abide by state-of-the-art practice guidelines. But knowing that all dentists are competent is unlikely to make patients trust dentists if patients cannot gain access to the dental services they urgently need.

Lack of access to oral healthcare is, of course, not a new problem in human history. It is precisely because people lacked access to competent dentists that barbers and even quacks were able to sell their dental services to desperate clients. In some countries, large numbers of patients still have to rely on untrained practitioners to obtain urgently needed oral healthcare services because they cannot afford the services of a licensed professional or have no access to such an expert. The reality of staggering oral health disparities is widely acknowledged today as a major ethical challenge for the dental profession. Solving this problem is going to require close cooperation among dentists, patient advocacy groups, insurance companies, policymakers, public health experts, and many other stakeholders.

However, even in their own private practices, dentists are inevitably faced with challenges about balancing the interests of different patients and making choices among them. The quarter of an hour devoted to informing a patient about the patient's right to refuse treatment no longer can be spent double-checking the radiographs of another patient. A fee discount awarded to one poor patient in need of care must be balanced out by securing a small profit in the treatment of another patient.

Note that even in an ideal world in which there is no financial scarcity, the problem of balancing different patients' interests would not be fully solved. The clearest example of such a balancing problem occurs when maintaining the confidentiality of one patient may result in harm to other patients. Such a conflict may arise when a patient is suffering from a highly contagious disease, such that the patient poses a threat to the health of others. Yet protecting those others may necessitate violating the patient's confidentiality. Breaching confidentiality in turn may lead the contagious patient to become distrustful of dentists and shun them altogether, resulting in a lack of treatment and an ever-worsening condition.

Simple, everyday routines involve such conflicts and demand choices by the dentist. Dentists must manage their time commitments to different patients; they have to decide who will get the free drug samples and who will not; they must assess when a patient's need is so urgent that other patients may be left waiting; they must choose how many indigent patients the practice can accommodate. Conflicts, small and large, between one patient's interests and those of another, are inevitable in day-to-day dental care. We will discuss these challenges in greater detail in subsequent chapters.

These are not the only conflicts of interests that routinely surface in the practice of everyday dentistry. Dentists bear responsibilities not only to patients but also to the people working for and with the dentist, be they employees, fellow dentists, or other health professionals. Dentists must accept responsibility for these inevitable balancing acts. Elsewhere in this manual we will discuss the specific *moral* challenges that arise out of a dentist's membership in a healthcare team and, at an even greater scale, the profession of dentistry.

This chapter was written by Jos V. M. Welie

Further reading

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Chapter 2:
Introduction to dental ethics

Summary

This chapter provides a basic introduction in the scholarly discipline of ethics. Dental ethics is defined as the critical examination of the values, rights, norms, and so on that guide the practice of dentistry. After distinguishing ethics from etiquette and law, the important role of reasons (versus opinions) in dental ethics is stressed. In the final section, three basic strategies for assuring a fair debate are reviewed: questions, explanations, and arguments.

The many meanings of the term ethics

In everyday life, the word *ethics* is used in many different ways. An entrepreneurial dentist aggressively marketing his practice with huge billboards all across town may be charged by his colleagues with an ethics violation. An ethics committee of the dental board may investigate the complaint. The committee may praise the dentist's work ethic, but consider his advertising campaign unethical nevertheless. The board may next decide to hire an ethicist to consult in the process of drafting an ethics code on dental advertising. This consultant's formal qualifications may include various past courses in ethics. In order to prepare for the ethical advice, the consultant may peruse a dental ethics textbook, which can be found in the ethics section of the university library.

The previous paragraph contains as many as 10 diverging meanings of the noun *ethics* and its derivative adjective *ethical*. The issue could be further complicated by adding a dozen uses of the words *morality* and *moral*. In fact, in the foregoing example the word *ethical* could have often been replaced by the term *moral*, and *ethics* by *morality*, which makes perfect sense because the words *ethics* (derived from ancient Greek) and *morality* (derived from Latin) literally mean the same, as do the adjectives *ethical* and *moral*.

Yet on closer inspection there are some significant differences between those meanings. If we question a dentist's ethics or charge the dentist with an ethics violation, we contend that the dentist has behaved in ways that are unjust, wrong, unfair, blameworthy, or irresponsible. But if we call in an ethicist who has completed various ethics courses and reads books on ethics, we are examining a behaviour. In this chapter, the term *ethics* is reserved for the scholarly discipline that studies behaviours.

Exactly what kind of behaviours does the discipline of ethics study? We do not expect a dental ethics committee or dental ethics consultant to deal with the technical aspects of dental practice, nor with the scientific, administrative, economic, or legal aspects. Ethics is concerned with the moral aspect of human behaviours. An ethical study of human behaviour is always e-valu(e)-ative. An ethicist looks at the values that are expressed by certain behaviours, the values that affect human behaviour, or those that are affected by human behaviour. Members of healthcare ethics committees will ask such questions as: "Was it justifiable what Dr. Smith did?" "Is our clinic treating patients fairly, and are we respecting their rights?" "Would it be wrong to breach confidentiality in this particular case?" In this chapter, the term *morality* is reserved for all these phenomena taken together: values, justice, fairness, rights, and so on – in short, the normative structure of certain practices and of human life in general. Ethics studies morality.

Let's further clarify this distinction by drawing some analogies. Pathology is the study of diseases, disorders, handicaps, and symptoms (which we may collectively call maladies). Unfortunately, we quite commonly say that Mr. A suffers from this or that pathology, when we actually mean this or that disease. After all, it is clear that a pathologist is not diseased (at least not necessarily so). Whereas a pathologist studies disease (and tissues taken from diseased patients), a hygienist studies health (or does things to make people more healthy). To be a good dental hygienist, one must know a lot about dental health and about cleaning people's teeth. But it is not at all necessary to have healthy and clean teeth oneself to be a competent dental hygienist. Likewise, an ethicist studies morality, but an ethicist is not necessarily a moral person.

A pathology manual helps readers understand diseases; fortunately, it does not make the readers diseased. A dental hygiene textbook teaches students how to improve the dental health of their patients; but it will not make students' own dentition any healthier unless they decide to act in accordance with their newly gained knowledge and apply it to their own teeth. The same is true for dental ethics. Thus, we the authors hope this manual increases readers' understanding of the moral aspects of dental practice. Indeed, increased ethical understanding may be of help in making morally good decisions. However, it should be noted that it will be up to each reader to make the right decisions. It is the readers' choice and responsibility to act in accordance with their newly gained knowledge of dental ethics.

Ethics involves a critical examination

Dental ethics critically examines the values, principles, and norms shaping the practice of dentistry. This examination differs from the empirical research with which dentists are familiar. That is because values, principles, and norms are not facts; hence, ethical questions generally cannot be answered by collecting more facts. For example, it would be important to know that most dentists are willing to treat AIDS patients. But that empirical fact does not prove that dentists are morally obligated to treat AIDS patients. Most issues in dental ethics cannot be analyzed unless empirical data are available, but having those data available does not suffice to settle the ethical quandaries.

The difference between an empirical study and an ethical study can also be summarized as the difference between a descriptive and a prescriptive approach. Whenever a scholar adopts a descriptive approach, the aim is to adequately describe the state of affairs at any given place and any given moment in history. The descriptive scholar wants to know how things were, are, or will be. On the other hand, a scholar adopting a prescriptive approach wants to know how things ought to be.

If we cannot find out how things ought to be by collecting more data on how things are, how can we find out? One answer is to turn to customs: we ought to treat patients this way and not that way because that is how we have always done it. This answer is reasonable. There is usually wisdom in established traditions. Both the ancient Greek original of the word *ethical* and the Latin original of the word *moral* refer to customary or appropriate behaviour in society. Many behavioural rules that guide the behaviour of dentists are a matter of custom. Dress codes are a good example.

Another answer is to turn to law. That too makes sense, for the very purpose of laws is to tell people what they ought to do and not do. And again, each country today has issued a variety of laws instructing dentists on how they ought to practice.

So, what is different about customs and law on the one hand, and ethics on the other? In this chapter, the difference is explained in terms of reasonableness. Customs and laws are binding, even if the reasons for the specific obligations are not (or are no longer) evident. Whether we walk on the left side of the sidewalk or on the right doesn't really matter, as long as we all abide by the same custom.

If, on the other hand, the reasons for a moral obligation are not clear, the moral obligation itself ceases. Adultery is morally wrong, not because tradition, parliament, God, or some other authority prohibited it. Rather, it is morally wrong because a solemn promise is breached. Conversely, since we can no longer justify the longstanding prohibition against informing patients of their diagnosis, that moral prohibition has ceased to exist. The examples given here show that the process of critical reasoning is essential to the discipline of dental ethics.

Personal opinion or reasoned argument?

Before we can continue our discussion of strategies to reach reasonable and justified ethical guidelines for the practice of dentistry, we need to tackle a challenging objection. It is extremely common nowadays to hear people say that morality is ultimately a matter of personal and hence subjective opinion, not unlike taste. In the same way that different people have different tastes, so different people have different values. There is no point in arguing about matters of taste, and, likewise, there is no point in arguing about matters of value – or so the objection goes.

So let us compare a statement about taste with a statement about values:

1. I think dark chocolate is better than white chocolate …
2. I think you should not attempt repositioning this patient's lower jaw …

Both are statements of opinion. It makes perfect sense to continue the first statement by saying:

1. … but feel free to take a bite of the white chocolate, if you prefer.

However, it is clearly problematic to continue the second statement in a similar vein by saying:

2. … but feel free to undertake the operation anyway, if you prefer.

Where patients' interests, their life, and well-being are concerned, it is no longer a matter of personal opinion, taste, or style. If a dentist is convinced that the surgery proposed by a colleague will harm the patient, the dentist should not simply brush off their disagreement as a mere difference of personal opinion. Instead, the dentist should enter into a critical dialog with the colleague to determine what is really in the best interest of the patient. Even if the patient wants the surgery, that still does not establish persuasively that the surgery is objectively in the patient's best interest. Patients, too, can be mistaken about what is truly of value to them.

Note that in an ethical dialog, the question is not who is right, but what is right and why. It is the ideas and arguments that count, not the people voicing them. The advocate of repositioning the patient's lower jaw must explain why it is in the patient's best interest to undertake the surgery. The opponent must challenge that view, providing arguments against the surgery. Out of that confluence of different explanations and arguments, hopefully a well-founded viewpoint arises about this particular patient's interests, as well as a decision about the best clinical course of action in view of those interests. It is irrelevant whether this final proposal turns out to be exactly what one dentist believed from the very start of the dialog, whether it is somewhere in the middle of different starting beliefs, or whether it is surprisingly innovative.

Ethical debates are founded on the conviction that a novel, enriched, and morally sound viewpoint can arise out of the confluence of many different perspectives on the case. Such a high ideal assumes that the ethical debate is conducted with the greatest possible degree of care and rigor. The various ideas and insights must be laid out, clarified, analyzed, examined, criticized, refined, combined, re-examined, and so forth until a properly argued conclusion is reached. To be successful, this argumentative process requires that the participants to the dialog be able and willing to debate fairly.

A fair debate

Fairness in an ethical dialog first and foremost implies genuine respect for ideas, one's own as well as those of others. Genuine respect is not a matter of polite tolerance. Genuine respect entails interest and concern, a willingness to listen to new ideas, to carefully consider them, and to critically test and appraise them. Genuine respect may lead one to exchange one's opinions for new and superior insights, adjust one's own opinions, or defend them against alternative ideas that fail this critical test.

There is nothing wrong with entering an ethical dialog with strong and principled moral convictions. In fact, there is little benefit to be gained from participants to the dialog who have never seriously considered the ethical dilemmas being discussed or who merely repeat the ideas pushed in the mass media. A person who is able to provide solid arguments in favor of a particular position is much more likely to advance the ethical debate than one who is not, provided of course that this person is also able to recognize and accept superior counterarguments.

Genuine respect for the ideas of others is also reflected in the manner in which we carry out the debate. While it is imperative that we address ideas critically and argue about them, our criticism and counterarguments must be fair. It happens quite often that debaters, intentionally or not, resort to fallacious reasoning. For example, we may end up attacking our opponents instead of their ideas. When we use such statements as “we all know that X is not the case,” we hope to intimidate our opponents such that they retreat. When characterizing our opponents as “lacking expertise,” “not knowing what they are talking about,” or “pretty dumb,” when making fun of them or fueling their growing uneasiness, we are in effect terrorizing them instead of respectfully examining their views.

The opposite may happen too, when we flatter a person (without sincerely agreeing), only to lure the person into our own camp. We may play with the emotions of others by emphasizing the sorrowful elements or by singling out the bright aspects. We may grant undue authority to the dentists in our own camp by addressing them as “Dr. Smith” and “Dr. Chang,” while referring to the opposing dental hygienists as “Mary” and “John.” All of these strategies frustrate the argumentative process and reduce the likelihood of uncovering creative innovations.

There are three main strategies that participants in an ethical debate can use to move the discussion forward in a constructive and fair manner: ask questions, provide explanations, and construct arguments.

- **Questions**. The first strategy, questioning, helps to get at the truth. Unless somebody specifically asks why X is true, there is the risk that everybody simply assumes X to be true, and so the truth of X is never carefully examined. The purpose of persistent questioning is not to cast doubt on everything that is being said and create confusion and uncertainty, but to determine what exactly the truth is.
- **Explanations**. The second strategy is to explain one’s views in great detail. Without such laying out of ideas, other participants to the debate may not fully grasp the intentions of the speaker. This is even more important when participants to the debate represent different professional disciplines, cultures, national heritages, or religious denominati.ons. Explanations force the speaker to be self-critical and allow for greater understanding among the other debaters.
- **Arguments**. Arguments are the most important elements of an ethical dialog. In the English language, the word *argument* evokes associations with aggression and even fights (as in the statements: “I got into an argument with my brother” or “John is an argumentative fellow”). But “to argue” literally means to clarify. Indeed, the purpose of an argument is to make one’s idea so clear that any reasonable listener must agree. If a mathematician clarifies with a series of geometrical maneuvers that a2 + b2 = c2, the attentive observer will conclude that a2 + b2 does indeed equal c2. Likewise, if we grant the thesis that all competent patients must give explicit informed consent prior to nonemergency dental treatment and we establish that John Smith is competent, and that the proposed repositioning of the lower jaw is not an emergency treatment, then it follows logically that John Smith must explicitly consent to the repositioning. And what if John is not competent? Based on the information provided so far, we cannot logically conclude whether he must consent explicitly. So, a new question arises: What decision-making rights do incompetent patients have? This is how a fair debate in ethics proceeds.

Then again, some ethical dilemmas are so complicated that even a fair debate among open-minded participants does not yield an acceptable resolution. Indeed, humankind has been struggling with thorny ethical dilemmas for thousands of years. Philosophers have proposed different ethical theories in an attempt to make sense of the complexity of moral experiences and to help sort through vexing moral challenges. Some scholars have tried to develop an ethical theory based on mathematical principles. Others have started with human emotions. Some have argued that the morality of any action depends on its consequences. Others have denied that outcomes are relevant because outcomes can be unforeseen and completely accidental; what matters instead is intent, the free-willed decision by the acting person. Still others have insisted that it is impossible for any theory of ethics to solve particular clinical dilemmas, and that the most one should expect from such a theory is a general understanding of how to live a morally good life as a human being.

In this manual, we do not delve into ethical theory (although the reader may occasionally encounter a brief reference to a specific ethical theory). Those interested in learning more about the application of different theories of ethics to the analysis of ethical topics in dental practice should consult one of the many textbooks of dental ethics currently available.

This chapter was written by Jos V. M. Welie

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Chapter 3: The standard of care

Summary

Trust is the basis of the dentist–patient relationship. When patients have a long history with a dentist, trust is based on experience with that dentist. When a dentist starts a new practice after graduation from dental school, patients will come to the practice without any experience with that specific dentist. As a consequence, their coming to the practice is not based on trust in that dentist but on trust in the profession of dentistry. They trust people who call themselves "dentist" to have certain basic skills because they have graduated from dental school and been granted a license to practice by the health authorities.

Introduction

The recognized role of trust raises some questions:

- Who determines how a dentist should behave?
- Is the explication and elaboration of ethical norms locally determined, or should they be nationally or even globally determined?
- What about transparency in dentistry? Should a patient automatically trust that the dentist will adhere to ethical norms? How does a patient know the manner in which these norms should be applied in the daily practice?
- What is the role of guidelines and protocols?

In this chapter we will try to answer these questions.

Who determines how a dentist should behave?

The hallmark of professionalism is trustworthiness. It is the trust in the profession as a whole that warrants patients' trust in individual dentists. Conversely, it is only when each individual dentist practices in accordance with professional norms that the public's trust in the profession as a whole can be sustained. If every dentist did whatever he or she personally deemed beneficent for the patient, there would be a high probability of patients getting different treatment plans from different dentists. In fact, it only takes one journalist to compare a few dozen dentists and find that they all prescribe different treatments, to bring damage to the public's trust in the profession of dentistry.

Reader's Digest, one of the most widely read magazines in the United States, published an issue in 1997 with the damnatory title on the cover, "How Dentists Rip Us Off." The cover article showed that price estimates for treatment of a particular problem for one dental patient ranged from $500 to $30,000. To prevent such disparities in treatment plans, the profession should inform both individual dentists and the public at large of the accepted standard of care for dentistry.

In general, the standard of care in dentistry is defined as what would be done by the reasonably prudent dentist in the same circumstances. This criterion was first used in an English civil law case and is called the Bolam test.

The Bolam case

Mr. Bolam was wounded during electroconvulsive therapy, and he sued the hospital. In order to determine whether or not the hospital was negligent, the judge instructed the jury:

"I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent if he is acting in accordance with such a practice, merely because there is a

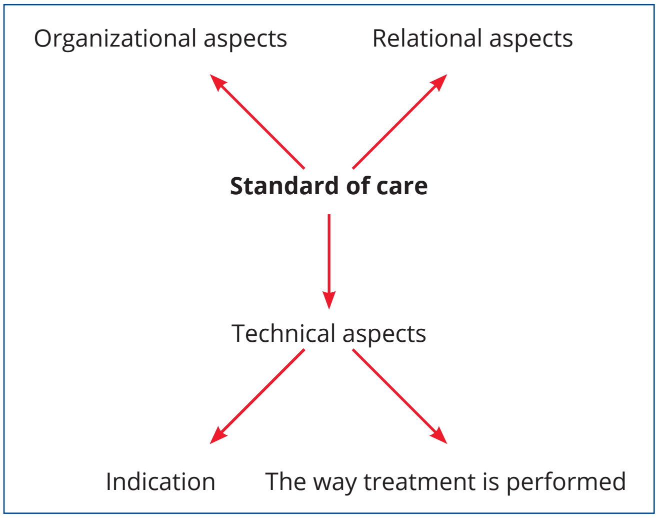

Fig 3.1 Aspects of the standard of care.

body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion." (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582)

The Bolam test was used in court to establish what a dentist should do according to his relevant peers. In many countries, a standard of care similar to the Bolam standard is adopted in law or in jurisprudence, emphasizing the importance of agreement among peers. Figure 3.1 shows the aspects of the standard. It covers technical aspects of dentistry – the indication of treatment and the way treatment is performed. It also includes organizational aspects of a practice, for instance, the practice's infection control or the duty to treat people during weekends. The third group of aspects included in the standard are the patient's rights.

From a legal point of view, there are only two options: either a particular act is in accordance with the law, or it is not. In many cases, the standard of care represents this border between legal and illegal in matters of oral healthcare. We need to remember, however, that even when an act is legal, it does not mean it is truly a good act, ethically speaking. Suppose, for example, a local dental association has issued a rule that says patients who have had an accident should be seen during a weekend. The association has issued no rule regarding any other emergency action. This implies that a dentist is not obligated to help patients with a toothache. Nevertheless, one could argue that the ethical principle of beneficence obliges a dentist also to see people with a simple toothache during the weekends.

What if a patient wants treatment that is against the standard of care?

What if a patient asks the dentist for treatment that is against the standard of care? The answer to this question firstly depends on the local law. In many countries, the law forbids the dentist to digress from the standard of care, unless following the standard is harmful to the patient. If the dentist believes it is, the dentist will have to provide scientifically and clinically sound reasons to prove that following the standard is not in the best interest of this specific patient. In most jurisdictions, the mere wish of the patient is not a valid reason for deviating from the standard.

Now, some may object that a well-informed patient knows best what is good for him, so the dentist should follow the request of the patient. But this objection is itself questionable.

Firstly, many patients do not know what is good for them in the long run, and so they have to be protected against themselves. For instance, a patient who is very afraid of the dentist and requests to have his perfect teeth removed so he does not have to face the dentist ever again, may be right in the short term, but eventually he will most likely regret his request. Another example is the patient whose front teeth hurt so much that he asks the dentist to remove them to get rid of the pain instead of agreeing to a conservative treatment.

Secondly, the patient is not the only one with interests. The dentist, for instance, cannot be forced to perform a treatment that will harm the patient. Other parties involved may be insurers. It is unreasonable to expect an insurance company to pay for treatment that will harm the patient.

And then there is the dental profession as a whole. It, too, has an interest. In the introduction we argued that trust in the profession is essential for society. In order to get dental help, patients have to trust the individual dentist as well as the profession to work in their interest and to cause no harm. If dentists, even a small minority of them, are willing to start providing treatments they themselves believe are not in the interest of the patient, the public will lose trust in the profession as a whole.

Change of the standard over time

Because the standard of care is derived from the insights of peer dentists, the standard may change over time as new graduates enter the practice of dentistry. Some hundred years ago, patients were advised to rinse with turpentine after extraction – advice no dentist will give today.

Another change in the standard of care is seen in endodontics. Decades ago, dentists used medication that contained arsenic. Today, in most countries, arsenic is not used. Such changes can actually happen within a short time span. Only a decade ago, most Dutch dental students, when presented with a case involving a cracked filling, wanted to replace the filling. Today, they do not consider immediate replacement necessary (survey research performed by W. Brands). And not only has the indication for a filling changed over time, but also the way the cavity is prepared. For a long time (since 1891), cavities were prepared according to Black's "extension for prevention" concept, with sound tooth material being removed. This concept has now been set aside for a more preservative approach, both for the use of resin fillings and for amalgam fillings (Osborne 1998). As the practice of dentistry continues to change over the years, so does the standard of care.

A local or a global standard of care?

The way in which the standard of care is interpreted differs from country to country, and even within a country. For example, some countries assess the standard as a "national standard of care," while other countries employ the "locality rule." If the locality rule is used, the dentist's interventions are evaluated according to the standards of the community. It is important to bear in mind that both of these standards focus on the dentists and their geographically determined habits. Neither standard is well-equipped to address the ever-increasing geographical movements of patients who may come to dentists with culturally motivated requests.

In several parts of Africa, for instance, it is esthetically desirable to grind the front teeth so they are pointed. In other countries, front teeth are removed altogether. At first sight, it may seem evident that extracting healthy teeth solely to meet culturally defined ideas of beauty is harmful. Then again, it is not uncommon for orthodontists in Western countries to remove sound premolars when the ultimate goal of that intervention is purely esthetic, and yet those extractions are within the standard of care in these Western countries. In short, the standard of care appears to reflect not only prevailing educational and technical levels in the region, but also the dominant values about health and beauty. We will discuss this topic in Chapter 12.

Though there are certain local elements in the standard of care, there is a tendency to move away from locally determined standards of care toward the gradual adoption of standards of care that are more global. To understand this tendency, the sources of the standard need to be examined.

Standards of care and evidence-based dentistry

Dentists are trained in different schools in different countries and in different times. They have gained different experiences treating different patients. Therefore, the odds of deriving a uniform standard of care from the personal insights of a group of individual dentists are low. What other sources are available upon which to base standards of care?

A second source for the standard of care is the existing laws and the decisions reached by local dental boards and disciplinary courts about the practices of individual dentists. As laws and

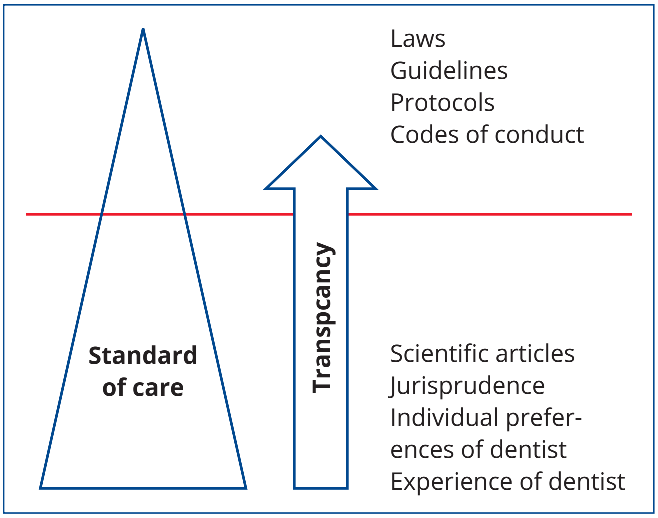

Fig 3.2 The sources of the standard of care and transparency of care.

jurisprudence are by definition limited to a certain country (or even area of a country) they will not lead to a global uniform standard of care. Moreover, such legal information is not always easy to access, and dentists are rarely interested in legal matters. Research has shown, for instance, that Dutch dentists know little about the legal rules that pertain to their dental practice.

The third and most important source of the standard of care is dental science. The indication, and the best way to perform treatment, should be based on scientific evidence. The leading opinion today is that dentistry should be evidence-based. Since scientific findings are supposed to be true anywhere in the world, in theory this could lead to a global standard of care.

However, there are some challenges. The first challenge is the accessibility of research. There are huge databases like PubMed, but researchers can only find information there if they know what they are looking for. In addition, although there is a tendency for open access, many hard-core research journals are only accessible in full text at high costs. Another challenge is the scientific articles themselves. Nowadays one must know quite a lot about statistics to evaluate published research. Another challenge when evaluating research may be ties between the researchers and suppliers, such as suppliers of a filling material. This will be discussed in detail in Chapter 9. The conclusion is that there is a tendency to embrace evidence-based dentistry, but it is very difficult for a dentist, let alone for a patient, to weigh up the evidence. The standard of care is like an iceberg: most of it is not visible for dentist, patients, or third parties.

Transparency of care, guidelines, and protocols

The standard of care is not only a standard for dentists, to help them make the best choice for a patient. It also serves as an aid for patients, to judge the treatment their dentist proposes. In this way, the standard of care is an instrument to serve the autonomy of the patient. The standard is also used as an instrument to help the dentist account for his choices and work. By applying this standard of care, third parties can judge the work of a dentist. To serve these different objectives, the standard should be transparent, easily accessible, and understandable, not only for dentists but also for patients and third parties (see Fig 3.2).

To clarify the standard and make it more transparent, relevant organizations develop guidelines and protocols. When these guidelines concern organizational or patient rights, they are usually based on local laws, local jurisprudence, and the opinion of expert dentists or members of local dental associations. When guidelines or protocols concern the indication of treatment and the way treatment is performed, they are usually based on evidence or derived from scientific articles. Besides evidence, authors of clinical guidelines consider the opinions of practicing experts. Often consumer or patient organizations are involved in the development of guidelines.

However, even when there are clear guidelines, some challenges remain. Is the organization that made the guidelines considered relevant by dentists and hence a trusted authority? Are the guidelines and protocols available to all dentists, to the public, and to third parties? Occasionally, organizations make them available only to their members. By doing so they limit the scope of their guidelines

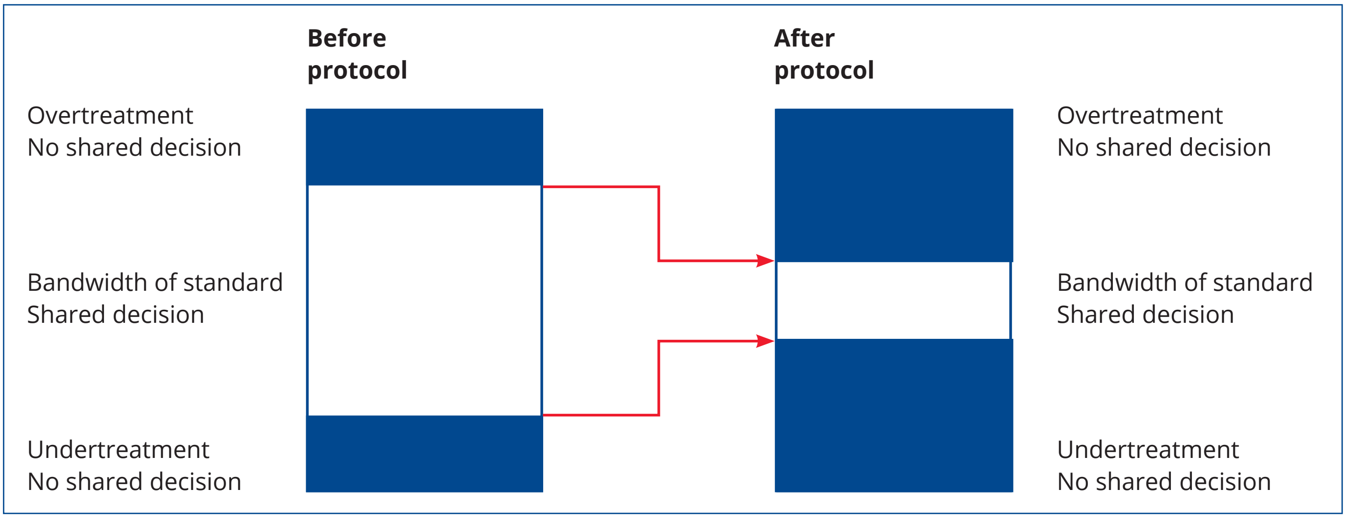

Fig 3.3 A protocol limits the bandwidth of the standard and thus shared decision-making.

to mere advice for their members. The most important question concerning guidelines and protocols is whether a clarification of the standard of care is always beneficial to dental patients and third parties.

The standard of care and circumstances

Guidelines and protocols are adapted to normal circumstances – an averagely skilled, reasonably prudent dentist in an adequately equipped practice. But what if the circumstances are not normal? In that case, we should go back to the definition of the standard: What would be done by the reasonably prudent dentist in these abnormal circumstances? It is important to keep this standard in mind when a patient cannot come to the practice because of illness. In this case, the first question that arises is: Did the patient do everything that could be expected to come to the practice? The second question is: Are there other dentists who are better equipped to perform treatment at the patient's home? Let us assume the answers to these questions show that a dentist has the choice between leaving a patient who cannot come to the practice for good reasons, or performing treatment that is of less quality than under normal circumstances. In the latter case, the standard of care is not the care a reasonably prudent dentist should deliver in his or her well-equipped practice – but what a reasonably capable dentist should do in these specific circumstances.

Shared decision-making, evidence-informed decision-making, and evidence-guided decision-making

Clarification of the standard of care can prevent some unexplained differences between dentists when it comes to the indication of treatment. Earlier we saw that these differences confuse the public, and that the press then concludes that dentists cheat their patient, thus undermining the trust of the public in the profession.

Figure 3.3 shows what happens when the standard of care concerning the replacement of a filling is clarified by a protocol. Before the implementation of the protocol, the standard has a certain validity. If dentists replace fillings too quickly, they overtreat, and if they replace fillings too late, they undertreat patients. As the standard of care is rather vague, there is a broad zone in which one dentist would replace a filling while the other would rather wait, and yet both practice within the standard of care. This may lead to confusion of the public. After implementing the protocol, the standard of care becomes clearer, so there should be less confusion.

But paradoxically, the development of protocols can also have disadvantages for patients. To explain this point, it is necessary to return to an earlier conclusion: that a dentist can only offer treatment that is within the standard of care (with the exception of treatment that, while meeting that standard, would not be beneficial to the particular patient). Consequently, a patient can only request treatments that are within the standard of care. The broader the space within the professional standard between overtreatment and undertreatment, the more room there is for dentists to meet the diverging requests of their patients while still abiding by the standard of care.

Consider, for example, a patient who wants a perfectly functional but discolored filling removed. While most of the dentist's peers might consider replacement of such a filling improper, the broad leeway in the standard of care could allow the patient's own dentist to grant the patient's wish. But if a much stricter protocol with less leeway is issued, there will be less room for negotiations between the individual dentist and his/her patient. Thus, reducing uncertainty in the standard of care may also cause limitation of choices.

There may be another solution: evidence-informed and evidence-guided decision-making. In the first concept, a dentist informs the patient about the evidence for certain treatment. But the dentist and patient may choose other treatment than the relevant evidence-based guideline or protocol prescribes, if this is what the patient requests. Gitterman and Knight proposed a similar solution: evidence-guided practice. Evidence-guided practice incorporates research findings, theoretical constructs, and a repertoire of professional competencies and skills consistent with the profession's values and ethics and the individual social worker's distinctive style (Gitterman and Knight 2013).

In many countries, dentists and patients are not allowed to deviate from the standard, and dentists will face legal problems when they and their patients choose treatment outside the standard of care, even if the patient is adequately informed, perfectly capable of judging what is good for him, and the choice is recorded in the patient's records. As a result, evidence-informed or evidence-guided decision-making is only allowed within the standard of care. As we saw earlier, the smaller the leeway in the standard of care, the less room for evidence-informed or evidence-guided decision-making.

Individualization and the standard of care based on a long-term goal for dental treatment

As noted earlier, in countries with a rigid, protocolized standard of care, shared decision-making is only possible within the strict and narrow boundaries of guidelines and protocols. Perhaps there is, even in countries with a binding and strict standard of care, a possibility to have more space for shared decision-making. To understand why such space actually exists, we need to revisit the very foundations of the standard of care, that is, the obligation to benefit the patient.

Though guidelines or protocols do not mention their goal explicitly, most of the time the goal of the guideline is to reach an optimal condition of health. In medicine, this goal is evident and enjoys widespread support, since good health is valued highly by the vast majority of people, and in order to attain good health, patients are often willing to undergo burdensome and extremely costly treatments.

However, in the field of dentistry it is not nearly as evident that most people subscribe to optimal oral health and are willing to submit to burdensome and costly treatments. If they choose to spend their money on alternative objectives, such as a family vacation or a new car, or if they lack dental insurance and simply cannot afford treatment, they will perhaps lose their teeth, but they will not die, and they can have a fairly normal life. Now, if a patient's overarching goal regarding his dentition is not optimal health, but maybe a much more limited goal of freedom from pain, it does not make sense to force this patient and his dentist to abide by protocols and guidelines that assume optimal dental health is the goal.

In other words, in this concept, dentist and patient agree about a long-term goal of the treatment. This can vary from pain-freeness with the acceptance of a denture within a period of 10 years to the long-term preservation of natural teeth at all costs. As a consequence, a guideline or a protocol is, in this concept, only applicable when it has the same long-term goal as the dentist and the patient (Brands and van der Ven 2015). In theory this concept can be used in countries with strict and binding standards of care when several conditions are met. The applicable guideline should mention what treatment is advised, given a certain goal. The dentist should adequately inform the patient. The patient should be able to weigh his interest in the long term. There must be agreement between dentist and patient about the long-term goal of treatment (this goal should be evaluated after some years). And, last but not least, the goal and the evaluation should be recorded in the patient's files.

Real cases

1. A dentist extracts a maxillary molar of a colleague. The molar breaks, and the extraction causes a perforation of the antrum. The dentist and his patient (also a dentist) agree to leave things as they are and make a bridge to replace the extracted molar. After the root of the extracted molar, which was left in place, causes an inflammation, the patient brings the case before a dental board. The dentist argues that he is not to blame as the patient, who was a dentist himself, agreed to the treatment plan.

How should the board respond to this complaint?

2. A patient visits a dentist for a check-up. The dentist finds periodontic problems. As the relevant guideline prescribes, he advises the patient to consult a periodontologist. The patient refuses and asks the dentist to remove the calculus.

What should the dentist do?
Would it make any difference if the dentist found a carcinoma and advised the patient to visit an oro-maxillary facial surgeon?

This chapter was written by Wolter Brands

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Chapter 4:
The duty to treat

Summary

One of the main interests of patients is to get help when they feel they need it. When patients seek help, two factors decide whether they will be treated: accessibility and availability.

Decreasing availability, which forces the dentist to refuse further treatment is, in most cases, a conscious choice of the dentist. Limiting accessibility is, in many cases, not a conscious action. It is merely a question of practice management and thus affects all patients.

In this chapter we will discuss the question of whether or not the dentist has a duty to treat, and if so, what factors decide the extent of this duty.

Introduction

It should be made clear that dentists do not have a duty to treat, but a duty to offer treatment. Actual treatment is only possible after the consent of the patient (for consent, see Chapter 5). As the term *duty to treat* is more commonly used, we will use this term in this chapter.

The duty to treat may depend on several factors; for instance, the condition of the patient who asks for help. Conditions can vary from a patient who does not need or does not want urgent help, to a patient who has had a small accident or who is in pain. Contrary to medical patients, dental patients are rarely in a life-threatening situation. In case of a serious accident, patients will be brought to a hospital to visit a maxillofacial surgeon. A second factor may be the type of treatment that is requested. Treatment can be limited to an oral exam, to preventive treatment, to first aid, or it can include extensive treatment, such as crowns and bridges. A third factor may be the relationship between the dentist and the patient prior to the request for help. For instance, did they have an assistance contract, and if so, what were the conditions? In this chapter we will use the term *patient of record* for patients who have indicated that they wish to have a long-term professional relationship with that specific dentist or dental practice, and the dentist or the practice accepted them. These patients do not come to a dental office for a single visit (such as emergency treatment), but they are expected to undergo regular dental care at this particular office. In some countries these patients are called *patients of record*, while in others they are known as *patients of the practice* or *regular patients*.

The previous chapter discussed another important factor in the duties of a dentist – the local rules. Many countries have rules that incorporate a certain duty to treat. These rules vary, and sometimes they are incomprehensible. It is hard to explain why a dentist in a specific region is not allowed to refuse help to a HIV-positive patient, although it is perfectly acceptable to refuse help to someone who cannot pay for treatment. As these rules have their own background, and this book is about worldwide ethics, we will base our thoughts on the universal principles of benevolence and *do no harm*. As dentists are obliged to follow the country's rules, they should seek information about legal duties wherever they practice.

In this chapter we will explore the duty to treat a patient, based on the principles of beneficence and nonmaleficence. We will do this while responding to some questions:

- Does the duty to treat depend on the relationship between the dentist and the patient?
- What is the relation between the condition of the patient and the duty to treat?
- What is the relation between the requested treatment and the duty to treat?
- What other factors may indicate a duty to treat?
- If there is a duty to treat, and if this duty depends on a relationship, is the dentist obliged to enter a relationship?
- What are the conditions needed to terminate this relationship?

Does the duty to treat depend on a prior relationship between dentist and patient?

The relationship between a dentist and a patient may vary from country to country. In some countries, dentists and patients do not have a relationship at all. When they feel the need to seek treatment, patients go to whatever dentist they want. In other countries, dentists and patients have a relationship that can last for years. This relationship is based on the agreement that the patient will seek treatment from the dentist, and the dentist will deliver treatment on time and according to the standard of care discussed in Chapter 3. These patients are called patients of record. In some cases, the relationship may be with a practice or clinic rather than an individual dentist, and the patient becomes a patient of record for the practice and may be treated by different dentists.

This dentist–patient relationship is beneficial for both the dentist and the patient. Dentists can assess their workload and their income, while patients are assured of help from a dentist or a dental practice they have chosen. Besides getting help from a dentist one trusts, there are more advantages with a stable dentist–patient relationship. Only with a stable relationship can dentist and patient agree about a long-term goal for the dental condition of the patient. If a patient visits Dentist A for a single crown, Dentist B for an extraction, and Dentist C for a filling, there is a chance that all consistency in treatment is lost.

Another advantage is that all relevant information is kept in one record. For the relevance of good record-keeping, see Chapter 7. Previously, we saw that the duty to treat a patient of record is not only based on general factors but on an agreement to deliver treatment within the standard of care and within the abilities of the dentist. The duties of dentists when treatment exceeds their abilities is discussed in Chapter 8.

The duty to treat: Patients of record versus prior unknown patients

Previously, we concluded that dentists have a rather extensive duty to treat their patients of record. This duty is based on an agreement between dentist and patient. In some countries, the duty to treat is limited to patients of record. The system in which dentists have only a legal duty towards their own patients has some advantages for the dentist, as they can plan their work and perhaps, even more or less, select their patients.

When discussing this issue from an ethical point of view, it is tempting to consider the question concerning the duty to treat primarily from the point of view of the patient who seeks treatment. From this standpoint, dentists should, based on the principle of beneficence, offer any patient the same treatment as their patients of record. On closer inspection, this solution is not as ideal as it may seem. It undermines the system of patients of record and, if dentists spend all their time treating other patients, the treatment of patients of record may be compromised.

On a national level, there may be another disadvantage to the unlimited duty to treat. In a system in which dentists as a profession have the duty to care for the whole community, each dentist takes on the burden of a problem that is only partly his or hers. If the dentist resolves the problem, it will not encourage the other stakeholders, the insurers, and the government to become involved, such as by adjusting the care that can be insured or by raising the number of caregivers. On the other hand, if dentists as a profession do not participate in the solution to the problem, they force the stakeholders to seek their own solutions, for instance, by educating more dental hygienists and by licensing them to treat patients even without supervision.

Dentists' primary obligations are towards their own patients of record. If a dentist has started to treat a patient, that patient may not be abandoned so that the dentist can treat a new patient, even if the latter patient is in greater need or would benefit more. Such abandonment would undermine the relationship of trust between the patient and dentist.

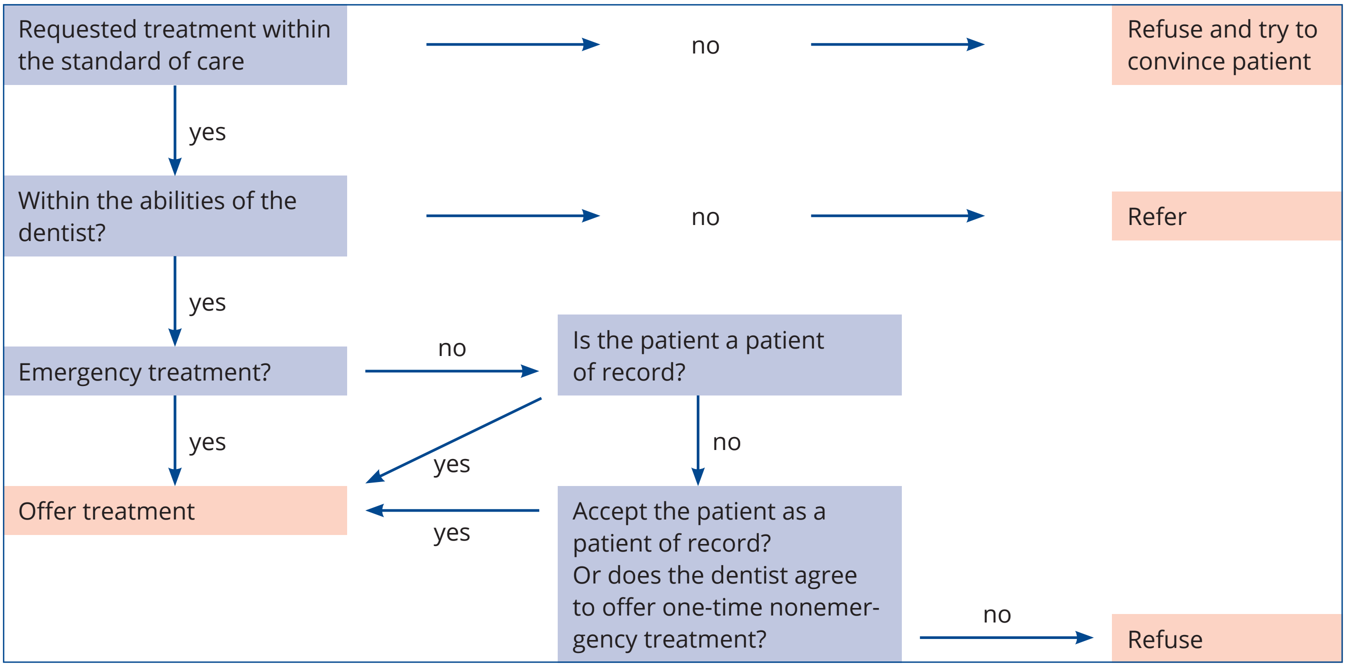

Fig 4.1 Questions and answers when a patient asks for a specific treatment. The questions concerning standard, ability, and patient of record are placed into a certain order in this diagram. Depending on the circumstances, the dentist may consider changing the order of the questions.

On the other hand, dentists may not devote all their time and resources to their own patients and completely disregard the dental interests of other patients. If an all-out investment in a select number of patients leaves others without even basic dental care, the dentist has failed to properly balance their obligations to all those in need. The duty to treat becomes a weighting of interests – the interests of the patient of record and of the dentist himself, against the interests of patients in need of basic treatment. Depending on the outcome of this process, basic dental need may vary from normal dental treatment to emergency treatment only. Often the treatment of patients who are not patients of record is limited to treatment that stops pain, bleeding, or swelling, or the results of an accident.

Requested treatment and the duty to treat

Earlier we examined several limitations of the duty to treat. The dentist's duty will depend on the kind of treatment and the patient who seeks treatment. In Chapter 3 we concluded that dentists are not allowed to offer treatment that is not in line with the standard of care. Consequently, dentists should refuse when patients ask for treatment that is outside the standard of care, and they can refuse such treatment without violating the autonomy of the patient. The principle of autonomy is discussed further in Chapter 5. The same is true in the case where the patient seeks treatment that is beyond the abilities of a dentist. This situation will be discussed in Chapter 8.

Earlier we discussed that dentists may limit the treatment offered to patients who are not patients of record and only provide emergency treatment. Consequently, if such a patient requests treatment other than emergency care, a dentist is not obliged to treat. Figure 4.1 illustrates the questions a dentist might consider when a patient seeks a specific treatment. Once again, it is emphasized that these are ethical questions. Legal questions and answers can differ from one country to another.

Duty to treat and the characteristics of the patient who seeks help

Patients who cannot or do not want to pay

Many patients are unable to afford adequate dental care. The United States spends a large part of its Gross National Product on healthcare, yet does not make healthcare available to the total population. In the United States the percentage of people without health insurance coverage for the entire calendar year 2016 was 8.8 %, or 28.1 million people (Barnett 2017). Even more people lack dental insurance, and yet dental insurance is a significant predictor of access to oral healthcare. The problem of the distribution of care, whether worldwide or within a country, is addressed in Chapter 9. In this chapter we will discuss the question of whether or not a dentist has a duty to care for a patient who does not pay the bill.

Patients who do not pay the dentist's bill can have many reasons. They may be dissatisfied with the service rendered by the dentist, or they may choose to spend their money elsewhere and hope to get away with it. A third group may simply lack the money to pay their bills. Contrary to the practice of many big companies or government agencies, it is highly unusual for a dentist to assess the reason why a patient does not pay his or her bill.

Let us assume the dentist manages to find the reason that a patient is not paying. If the patient is not satisfied, the dentist should talk with him and come to an agreement. This can prevent a claim or a visit to the dental board. If the patient prefers to spend his money elsewhere, a dentist can sue the patient. The dentist can also consider to decline to treat in the future, particularly when a patient makes a habit of refusing to pay. Whether or not he is allowed to do so depends on local laws. But what if the patient cannot pay? No dentist is morally obligated to deliver full treatment to every needy patient knocking on the door. To do so may harm the practice financially, and other patients may be encouraged not to pay. On the other hand, if some dentists turn away every patient who does not have insurance or a credit card, those dentists with a more generous heart would soon be overburdened. However, one could argue that if every dentist were to be generous and to give at least emergency treatment, indigent patients would get help, and the burden would be evenly distributed over the profession.

Noncompliant patients

A peculiar problem arises for the dentist when the patient intervenes in the therapeutic process. Can a dentist refuse to treat a patient if the latter is not compliant with the treatment plan or refuses the indicated therapy outright? A patient has a right to refuse certain treatment options, as well as the right to select an option that is not the best alternative in the dentist's mind.

Take the example of a patient who needs a prosthesis. Because of his propensity to vomit, he hates the process of making impressions and insists on doing one impression only, instead of the usual two. The dentist's ability to create a perfectly fitting prosthesis is now undermined, and hence his obligation to seek that perfect outcome is lessened. However, the consequences of the patient's request are relatively minor, and so the dentist should proceed, although it would be important to clearly inform the patient of the consequences of making only one impression and to make specific note in the record of the patient's insistence.

If, on the other hand, the consequences of granting a patient's request are serious, the situation changes. Consider the patient whose first mandibular molar is fractured. The dentist recommends an endodontic treatment with a crown, but the patient does not want to pay for either the treatment or the crown and requests an amalgam. Concerned that the tooth will soon fracture, possibly resulting in aspiration, the dentist proposes an extraction instead, but the patient is adamant. Here, the patient's wishes push the dentist into a near-unprofessional corner. Therefore, the dentist has no duty to grant this wish, because reasonable alternatives are certainly available. On the other hand, the health risks are remote (e.g., the chance of aspiration is extremely small), the dentist may still grant the wish upon ample warnings.

In other cases, however, the health risks may be severe and exceed the medical benefits that can be gained. Consider a patient who has impacted wisdom teeth. These need to be extracted in order to prevent future pericoronitis. However, let's assume the patient has a compromised cardiac condition, and prophylactic antibiotics are required to prevent an endocarditis. If the patient wants the extraction but refuses the antibiotics, the dentist ethically and legally must refuse the extraction, because the potential oral health benefits are outweighed by the risk of a life-threatening endocarditis.

The following vignette, a real Dutch Dental Board case, shows that there may be rare circumstances in which a patient is in such need of specific treatment that a dentist is obliged to refuse alternative treatments. One could argue that a well-informed patient should be able to decide whether or not she wants treatment. However, just as one cannot ask a doctor to assist with a suicide, one cannot ask a dentist for a treatment option that harms the patient

Case study

A dental assistant asked the dentist, her employer, to inspect a sore spot on her tongue. The dentist inspected the spot and advised her to visit an oral surgeon. The assistant refused to visit the surgeon, and she continued to request an inspection, and the dentist kept on inspecting the spot and urging her visit an oral surgeon. In the end the assistant died because of a carcinoma on her tongue. The widower filed a complaint against the dentist. The dental board decided that timely treating of the carcinoma was so important that the dentist should have put more pressure on his assistant in order to get her to visit an oral surgeon. The board decided that the dentist should have refused further inspection of the lesion.

Neither the patient nor the dentist may blackmail the other into a particular treatment regimen. The dentist's obligation to treat is mirrored by the patient's obligation to cooperate in his or her own treatment. The dentist must offer the patient a reasonable selection of treatment options and respect the patient's choices. However, if the patient rejects all of these options, s/he can no longer claim the right to dental treatment.

Patients who pose a health risk to the dentist

Every now and then a patient who poses a health risk will visit the dentist. Such illnesses include HIV infection, hepatitis, and tuberculosis. The question is: Do dentists have to treat these patients?

Dentists carry responsibility for their own well-being, but here again, a difficult balance must be struck. The first question is whether or not there is an emergency. If a patient has a curable disease, for instance tuberculosis, one can postpone dental treatment until the patient is no longer contagious. Another consideration might be: Is there a treatment that is less dangerous for the dentist, even if the cure is less effective? What if all options have been considered and rejected and the patient continues to be a threat to the dentist? It is clear that dentists are not obliged to sacrifice their lives for the good of their patients. May a dentist refuse to treat patients suffering from the plague, Ebola, or some other highly infectious disease? The *heroes* in the history of healthcare surely were the care providers who continued to care for their patients even when such care implied a high risk to their own health. But never in history has such exquisite altruism been encoded in oaths and other such documents as a standard duty for every care provider.

On the other hand, in case of less infectious diseases, or if one can prevent contamination, such as with hepatitis C or HIV, one could argue that dentists are morally obliged to treat patients suffering from those diseases and accept the minimal risks such treatment poses to their own health. These patients will have to accept that their attending dentists may approach them with much more caution, slowing down procedures or even increasing treatment costs if their medical condition so demands.

The duty to treat is an obligation shared by all dentists, except when such treatment poses a severe risk to their own health and life. Dentists are jointly responsible for the oral health of patients, and so they must each assume an equal burden. If some dentists begin refusing to treat infectious patients, their colleagues end up with a disproportionate risk.

Aggressive patients

In healthcare, aggression can be shown in several ways: verbal, physical, and legal. When considering the duty to care, a dentist must weigh his or her own interests against those of the patients. Basically, the relationship between a dentist and a patient is based on trust. Trust and aggression do not go together. Two important factors may be the gravity and the cause of the aggression. Some people are frightened, and frightened people may act aggressively. One could argue that dentists are professionals, and as such they should be able to cope with mild forms of aggression. If the aggression is a character flaw of the patient, or if the aggression causes harm to the dentist, a dentist could refuse treatment.

Patients who cannot come to the dental office

Figure 4.1 shows the ethical considerations of a dentist when a patient seeks specific treatment. A dentist could consider the same questions when patients ask for normal treatment but under unusual circumstances, for instance, because they cannot visit the dental office. In Chapter 3 we discussed the challenges a dentist has to meet when a patient cannot come to the dental office. We concluded that the standard of care is dependent on the circumstances. So when a dentist visits patients in their homes, the standard of care might differ from the standard that can be achieved in a dental office. This leads to the conclusion that the standard of care is not a valid ethical reason to refuse a home visit, unless the patient can come to the office or another dentist can visit the patient and will perform more adequate treatment under these circumstances. An additional question a dentist might ask is whether or not the distance between the home of the patient and the dental office is reasonable.

Is a dentist obliged to accept a patient as a patient of record?

Earlier we saw that dentists are obliged to offer their patients of record all treatment that is within the standard of care and within their abilities. On the other hand, duties toward patients who are not patients of record are limited. Therefore, it can be very important for a patient to be registered as a patient of record. Along this line, two questions arise: Is a dentist obliged to accept a patient as a patient of record? Also, is a dentist allowed to terminate such a relationship? In the following two paragraphs we will discuss these questions.

Legally, the relationship between a dentist and a patient is a contractual one. In most jurisdictions, parties are free to enter such a relationship. In some countries there are exceptions to this rule, and these exceptions may play an important role in ethical discussions about entering into a dentist–patient relationship:

- When refusal would be discrimination, based on race, sex, or religion;
- When a dentist had treated a patient in a way this patient was inclined to think he was a patient of record;
- When accepting the patient is a duty based on a contract between, for instance, the dentist and the insurer of the patient.

Some refusals are less obvious. Is, for instance, a dentist obliged to accept a patient when he is the only dentist in town? Based on his monopoly, one could argue that the dentist has an obligation to accept all patients. On the other hand, accepting too many patients would mean the dentist might become overworked, which would not only harm the dentist but also the other patients of record.

Terminating the relationship with a patient of record

The answer to the question of whether or not a dentist can terminate a relation with a patient of record depends on the reason for the termination and perhaps whether or not the termination meets certain conditions.

A dentist may want to terminate the relationship with a patient of record for two categories of reasons:

- Because of the behaviour of the patient (e.g., the patient acted in a manner that was so stressful for the dentist that the dentist could not continue the relationship).
- Earlier we discussed the duty of the dentist to terminate the relationship if a patient refuses certain life-saving treatment because the dentist planned to limit, or even to stop, the practice.

Terminating the dentist–patient relationship because of the patient's conduct

One could argue that unreasonable behaviour should always be a reason for terminating a relationship, because it is a breach of the mutual trust that is the very basis of the relationship. In this view, a breach of trust is enough for an unconditional termination of the relationship. On the other hand, dentists have a monopoly on dental treatment, and thus the patient is dependent on their services. In this view, the dentist can only terminate the relationship because of compelling reasons, and only if he meets certain conditions.

Some reasons for termination could be: aggressive behaviour, refusal to pay, or refusal to cooperate with the treatment. Depending on the gravity of the reason for termination, and based on the monopoly of the dentist, it could be argued that in situations in which a patient behaves badly but not aggressively, a dentist might have a right to terminate the relationship, but only under certain conditions. The worse the behaviour of the patient, the fewer the conditions. Some of these conditions are: a duty to warn; a duty to give the patient a certain time to search for another dentist; a duty to help the patient find another dentist; and a duty to make sure the patient receives emergency treatment in time. In these cases, dentists must find a balance between their own interests, the interests of their coworkers, and the interests of the patient. As the monopoly of the dentist plays an important role, this balance can be highly influenced by the availability of dental help in the region. If one assumes that dentists should assist patients to find another dentist, the question arises of whether or not it is fair to refer an aggressive or nonpaying patient to a colleague.

Terminating the dentist–patient relationship because the dentist plans to limit his practice

It seems to be reasonable, because dentists decide themselves the size of their practice, that limiting a practice could be an acceptable reason to terminate a dentist–patient relationship. However, when a dentist plans to limit his practice, one could argue that, when possible, he should warn patients, give them enough time to find another practice and, if possible, to help to find a successor.

Whatever the reason for termination, dentists are obliged to send, at the request of a patient (a copy of) his patient records to the subsequent dentist. Questions about record-keeping are addressed in Chapter 7.

Questions

1. One could argue that a dentist should help a patient to find a successor when the patient wants to terminate the relationship. On the other hand, this might not be fair toward the colleague if the patient presents certain behaviour problems. How should these arguments be weighed?
2. A dentist wonders whether he can refuse to enter into a relationship with two patients, one who is infected with HIV and the other who is a homeless person. How would you advise him?
3. A dentist is asked after working hours to help a patient who is in pain. The patient has been in pain for several days, but he could not go to

the dentist because of his busy job. Should the dentist help him immediately or offer to help him only during office hours?

This chapter was written by Wolter Brands

Further reading

Barnett JC, Berchick ER (2016). Health Insurance Coverage in the United States: 2016. US Census Bureau Report Number: P60–260.

Chapter 5: Principle of respect for patient autonomy

Summary

The bioethical principle of respect for patient autonomy is widely accepted as one of the most important principles guiding the practice of healthcare. It is among the 13 principles included in the International Principles of Ethics for the Dental Profession adopted by the FDI Council in 2016. This chapter briefly describes the origins of this principle and explains how it has been operationalized most clearly in the patient's right to consent. This right states that the dentist may not start treatment unless and until the patient has authorized the dentist to do so, by agreeing to the recommended treatment. In other words, the patient is free to refuse any and all dental treatments, even those that are objectively in the patient's best interest. The processes for obtaining consent are outlined next, including for specific patient categories, such as children, and adults who are unable to make autonomous healthcare decisions. Particular attention is paid to the dentist's duty to adequately inform patients prior to obtaining their consent.

Introduction

The science of dentistry is necessarily generic. It is founded on certain presumptions thought to hold true for large categories of patients. For example, the science of dentistry presumes that the pain of toothache is unbearable, that the maintenance of functional teeth is a benefit, and that aligned and white teeth are desirable. It presumes that early loss of teeth is pathological (even though such loss has been common for centuries and is still common in parts of the world), and that irregularly positioned teeth are abnormal (even though, again, statistically, abnormal teeth are the norm).

Without these generic presumptions, scientific research is impossible. However, individual patients may not agree that white teeth are desirable, or they may not want to submit themselves to the presumed norm that teeth should be aligned. When providing care to individual patients, the clinical dentist hence must find a way to adjust the generic benefits presumed by dental science to the particular and sometimes unique needs and interests of individual patients.

Prior to the 20th century, healthcare providers had been in the habit of determining patients' individual needs and interests independently from actual patients. The Hippocratic Oath can be interpreted to justify such action: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment." There were probably a variety of reasons for this paternalistic attitude that the doctor always knows best. Maybe the author of the Oath was thinking of the power of politics, demanding from clinicians that they reject such influences in making treatment decisions. Maybe he was thinking of the difference between a medical intervention based on sound knowledge and clinical skills, and one based on quackery or magic. Perhaps the author was indeed advocating paternalism, that is, making decisions for patients without involving them (soft paternalism), and sometimes even against patients' objections (hard paternalism).

However, even if the latter is the case, we must not lose sight of the changes that have occurred in medicine and dentistry. For thousands of years, most healthcare providers had little to offer their patients, who were surely even more in the dark than their care providers about their own conditions, the prognoses, and the therapeutic options. Conversely, the multitude of effective options presently available to modern dentists and their patients demand choices, which cannot be made by the dentist alone. Secondly, the remedies to which the author of the Oath refers (dietetic measures) were unlikely to be harmful, nor was harm likely to result if the patient decided to be noncompliant by disregarding the dietetic advice of the ancient physician. But the remedies of 21st-century dentistry entail quite serious side effects and hence necessitate a careful benefit–burden balance by dentist and patient jointly. Finally, patients are often at the mercy of their dentist once the latter has begun treatment. The anesthetized patient is simply unable to be noncompliant.

Because of the individuality of every human being and the uniqueness of each person's life, needs, and specific interests, we owe one another respect. This obligation is even more true for those who are called to intervene directly into another person's body and life through medical or dental interventions. The dentist who sends away the patient in serious pain is guilty of the moral wrong of negligence. The dentist who pulls all of a patient's healthy teeth merely because the patient asked him or her to do so, is guilty of harming the patient and commits a moral wrong. But then so does the dentist who competently and skillfully embarks on a complicated treatment without first informing the patient, involving the patient in the decision-making process, and obtaining the patient's consent for the proposed intervention. That dentist has failed to respect the patient's autonomy.

Respect for autonomy: Consent

The word *autonomy* literally means *self-law*. An autonomous people freely chooses its own laws and is not subjected to laws imposed by others. Autonomous individuals are free and able to determine the course of their own lives, rather than being paternalistically directed by others. In the area of healthcare, the ethical principle of respect for patient autonomy has been operationalized most clearly in the patient's right to informed consent. This right has two parts: information and consent. We will return to the issue of information in the second half of this chapter.

In a nutshell, the patient's right to consent means that s/he can be treated if, and only if, the patient agrees to proposed interventions. Such a right to consent to, and hence also to refuse, all healthcare interventions should not be interpreted as a state-sanctioned right to self-destruction. Rather, it reflects the belief that even important goods, such as life-extension and health, do not justify paternalistic coercion by healthcare providers. Patients cannot demand certain treatments from their dentists (for, in that instance, the autonomy of the dentist would be violated). But the patient can refuse any and all dental interventions. And to make sure that patients can execute their right to refuse, dentists must actually obtain the patient's explicit consent before they can commence diagnostic or therapeutic interventions.

Explicit consent can be obtained both verbally and in writing. However, so-called consent forms are not a substitute for a patient's active consent. If the patient is provided with written information, in addition to a personal conversation, such forms can help the patient become better informed. But if the consent form is simply presented to the patient as one of many other forms to sign, sometimes even before the patient sees the dentist, signing the form will do little to respect and protect the patient's autonomy.

Explicit versus implied consent

There are practical limits to the dentist's obligation to obtain a patient's explicit consent (also called *expressed consent*) for proposed dental interventions. For example, when a patient comes to a dentist's office, this patient choice implies a consent to the dentist's taking a basic history and oral examination. It is not necessary for the dentist to obtain explicit consent first. But when a more drastic diagnostic examination is required, and certainly when a therapeutic plan is proposed, the dentist cannot rely on such an implied consent. The dentist now must obtain the patient's explicit consent. However, once the patient has explicitly consented to a particular therapeutic plan, such consent can once again be understood to imply consent for the various separate actions that must be undertaken in the realization of that plan. For example, if a patient consents to an operation, implied in that consent is also the consent to suture the wound.

It is not always clear when a dentist can act on the basis of an implied consent. Even though the patient's consent to surgery implies consent to suture the wound, it may not imply consent to a hematological exam in preparation of the operation of a cardio-compromised patient. In some countries, a blood draw is considered a separate invasive intervention that hence requires a separate explicit consent by the patient. To determine whether consent must be obtained explicitly will often require knowledge of the particular sociocultural and legal contexts and sensitivity to each patient's situation. But patients also carry part of the responsibility and must be proactive and voice their specific concerns and expectations.

Explicit consent versus presumed consent

There are also situations in which explicit consent simply cannot be obtained. This is the case when patients are unconscious or otherwise unable to make their wishes known and authorize the dentist to initiate treatment. For example, a patient may suffer a cardiac arrest while in the dental chair. Typically, emergency treatment of an unconscious patient without explicit consent is justified on the basis of a presumed consent: in true emergencies, the dentist may presume that the now unconscious patient wants the emergency treatment and would have consented to it had the patient been competent to do so.

Of course, once the patient is stabilized and regains consciousness, the consent can no longer be presumed but must be explicitly obtained. It may be that at that time the patient voices anger over the imposed emergency treatment and refuses continuation of dental interventions. Such anger and refusal do not invalidate the presumed consent on the basis of which the treatment was begun. Most patients want to be treated in such circumstances, and so the dentist could have reasonably presumed this patient wanted the treatment as well. However, the present refusal does necessitate the termination of whatever treatment was begun but is now refused by the patient.

Except for oral surgeons on-call in a hospital's emergency room, most private practice dentists may not ever be faced with an unconscious patient needing emergency treatment. But they may be faced with emergencies involving a different category of decision-making incompetent patients: children. Suppose a 10-year-old boy is hit in the mouth by a baseball during a practice game coached by a dentist. The child's parents are not present. Here again, the dentist could justify providing emergency care on the basis of a presumed consent: the dentist can justifiably presume that had the parents been present, they would have consented to the emergency intervention.

Patient decision-making incompetence

Dental emergencies are exceptional situations, and emergencies in which the patient is also incompetent to consent are even rarer. Indeed, patients must always be assumed competent to make decisions regarding their own healthcare, unless and until they have been proven incompetent. Unfortunately, it is not clear what exactly the competence to make decisions regarding one's own healthcare entails, and how it can be assessed.

What is clear, firstly, is that patient decision-making competence is a very specific type of competence. A patient may be unable to administer his finances, but such incompetence does not entail incompetence in healthcare-related matters.

Secondly, the competence to make healthcare-related decisions is independent from the actual wish or decision made by the patient. In reality, that distinction is often overlooked. As long as patients agree with the dentist's recommendations, their competence is rarely questioned. But once patients voice wishes that are strange in the dentist's view (e.g., refusing antibiotics for a serious abscess), the patient runs the risk of being deemed incompetent simply because of that unusual wish. It should be remembered, however, that a patient's agreement does not prove the patient's competence: the patient may agree simply due to feeling intimidated by the dentist. Conversely, a patient's refusal does not itself prove the patient's incompetence. For as we have seen, the whole point of the patient's right to consent is to enable the patient to freely refuse recommended treatments.

In determining a patient's decision-making competence, the dentist must consider whether the patient can demonstrate specific capacities:

1. The ability to understand and memorize information
2. The ability to manipulate information and balance the pros and cons of various treatment options, both short term and long term
3. The ability to freely choose in accordance with the patient's own rational considerations
4. The ability to communicate decisions made

The first capacity is likely to be diminished when, for example, the patient suffers from late-stage dementia or severe pain and anxiety. The second capacity is diminished by decreased consciousness, intoxication, or mental disabilities. The third capacity is diminished by certain psychiatric conditions, such as depression or phobia. The fourth capacity is absent in such rare and unfortunate conditions as locked-in syndrome, but it may also be hampered significantly by severe communicative disorders, such as aphasia. Naturally, the inability of a patient to speak the dentist's language does not prove the patient is unable to communicate. Likewise, being mute does not prove the patient is incompetent to consent. The dentist will have to establish other lines of communication. Similar facilitative strategies must be instituted as necessary in reference to the other three criteria.

A final note: If a patient has become incompetent to make decisions, that does not mean the patient has lost all rights. In fact, the patient has lost only one right: the right to consent to treatment. The patient retains other important patient rights, such as the right to information and the right to confidentiality.

Decision-making for children and incompetent adult patients

If a patient is incompetent, treatment decisions cannot (or can no longer) be based on the patient's own consent. As mentioned, dentists can rely on presumed consent only in emergency situations. In nonemergency situations, a person close to the patient, called a proxy or surrogate, may consent on behalf of the patient. There are various mechanisms by which such a surrogate can be identified.

Children and their parents

Minor children are by law incompetent, although dentists need to remember that the legal age of adulthood differs in different countries and even in different provinces/states. Furthermore, the legal age of adulthood regarding healthcare decisions may differ from the age at which a youngster can vote, sign a contract, or marry. The minor's parents are generally considered the legal surrogates. More complicated surrogacy arrangements can arise following parental divorce and second marriages, in which a court may have issued specific rules about parental authority for healthcare decisions, as well as when child protective services are involved.

Familial consent

In some jurisdictions, the law also prescribes who can make decisions on behalf of incompetent adults. So-called familial consent statutes typically provide a ranked list of surrogates, including the spouse/significant other, parents, adult children, siblings, and so on.

Surrogate appointed by the patient

In many jurisdictions, patients can, while still competent, select a surrogate themselves and assign that person legally binding decision-making power. Such an authorization is often called an *advance directive* because this directive to the healthcare provider is written in advance of the patient's becoming incompetent. It will only take effect once – and remain in effect only as long as – the patient is incompetent.

Court-appointed surrogate

Finally, a court can step in and award some individual the authority to make healthcare decisions for an incompetent patient, a so-called guardian.

It should be emphasized that many jurisdictions do not provide comprehensive surrogate decision-making rules. For example, many jurisdictions lack familial consent statutes. This should not be a source of immediate concern to the practicing dentist. Rather, we need to remember that laws are created only when there is a serious need for them, that is, when volatile conflicts continue to arise in certain circumstances. If common rules of social behaviour provide adequate guidance, there is no need for legally enforced rules. Thus, when an adult son brings his dementia-suffering father to the dentist for treatment, the dentist working in a country without a familial consent statute does not need to first call the judge to have the son appointed as the patient's guardian.

Decision-making on behalf of an incompetent patient

Once a surrogate has been identified to make healthcare decisions on behalf of an incompetent patient, that surrogate is now faced with the difficult task of making such decisions. Two decision-making modes are available.

The first, which is generally considered the ethically best mode, is a so-called substituted judgment. That is to say, the surrogate will try to step into the patient's shoes and reconstruct what the patient would have decided had the patient been competent to do so. The surrogate will take into account all of the patient's previous statements on the matter while still competent and, as necessary, supplement these data with (corroborated) intuitions about the patient's probable wishes.

If the patient has never before been competent (as in the case of a minor child or an adult patient who has been developmentally disabled from birth), the surrogate cannot make a substituted judgment. Instead, the surrogate will have to reach a so-called best interest judgment. Such a judgment takes all the available information into consideration, that is, both the dental information as well as relevant social and personal information on the patient.

In many instances, a *substituted judgment* and a *best interest judgment* will yield very similar results. But sometimes significant differences can occur. Consider, for example, a lady who always put herself last, opting for the cheapest instead of the best dental care, so that she would have more money left to spend on her children, even after her children had grown up. The patient now is suffering from late-stage Alzheimer's dementia and hence is accompanied by one of her sons when she comes to the dentist's office. The dentist advises that in view of the patient's loose dentures, a new set is recommended. But keeping the existing set is evidently cheaper. To which of these alternatives should her son consent? If he decides on the basis of a *substituted judgment*, he will opt to keep the existing set, for that is what mother would surely have decided had she been competent. But if he makes a *best interest judgment*, he will consent to a new set, in accordance with the dentist's recommendation.

The former example also makes clear that there are situations in which complete adherence to the principle of respect of patient autonomy may result in harm to the patient. Hence the son, notwithstanding his deep respect for his mother, is likely to authorize the new dentures. In fact, if he were to opt against the new dentures and keep the money saved himself, the dentist would probably deem the son very selfish and maybe even immoral – even though that's exactly what his mother would have done had she been competent: have the extraction and give her son the rest of the money.

In all of this, it is important to remember that it is the patient who should be able to appreciate the results of the dental interventions – not the dentist or the patient's family. The latter may be equally excited about the new and perfectly fitting dentures for an older patient suffering from advanced

Alzheimer's dementia. However, if the patient is thoroughly confused by these unfamiliar looking and feeling dentures and does not want to use them, the prosthodontic interventions cannot possibly be considered in the patient's best interest. The parents of a developmentally disabled daughter may want her to look as attractive as possible, but if the orthodontic treatment, the regular visits to the dentist, and the braces themselves only annoy and irritate her, even the expected outcome of perfectly spaced teeth does not justify years of orthodontic interventions.

Informed consent

In principle, then, patients may not be forced to undergo dental treatment, not even treatment that is objectively in the patient's best interest. Patients must authorize the dentist to initiate treatment. This process of authorization is called *informed consent*. As has been shown, there are two parts to this: the right to consent, that is, to grant permission to a proposed treatment or to refuse that treatment, and the right to be informed before (not) consenting.

These two rights are actually very different. The right to consent or refuse is a so-called negative right, or liberty right. The patient has the right not to be coerced into treatment. The patient should remain free from dental treatment if the patient does not desire to undergo it. In short, if invoked, this right forces dentists not to act. However, the right to information is a positive right or entitlement. If invoked, it forces dentists to do something, namely to provide information to patients.

In fact, even if patients do not have to consent to a treatment, for example, because they are children or because there is no treatment available for their particular condition, they still need to be informed about their condition by their dentist. Information is itself a healthcare benefit. Information is of importance and value to patients, and they usually want it.

If there is one thing that truly distinguishes the dental patient from the medical patient, it is that the dental patient cannot talk as soon as the dentist begins treatment. Whereas the dentist can continue to talk, the patient is made mute by the apparatus in their mouth, the pooling saliva, and the local anesthesia. This is a very disconcerting position to be in, even more so since the dentist often is (or in the patient's mind appears to be) oblivious to the patient's predicament.

Many patients are already hesitant to solicit information; being virtually muted does not make it any easier. Since the patient is unable to ask questions and solicit further information during treatment, dentists – even more so than physicians – must be proactive when it comes to the provision of information. All important discussions must be completed prior to treatment. If it becomes clear during treatment that the patient is concerned and in need of additional conversation, treatment must be interrupted so that the patient can do more than gargle and nod.

Patients have the right to learn about their diagnosis, the various treatment interventions possible, the prognoses with and without those interventions, the side effects and risks of these interventions, financial costs, and other burdens. They also have the right to know the qualifications of the person treating them (e.g., dental student, general dentist, specialist, dental hygienist, and so on). They should be informed of any financial investments on the dentist's part in the recommended products. In short, patients should be informed about any and all aspects of their oral health and the dental care offered.

In this regard, patients differ from consumers. If we enter a restaurant and the waiter describes the various dishes served that day, the waiter may not lie or otherwise coerce us into buying the most expensive dish. In this limited sense, the dentist is like the waiter who must respect the customers' culinary autonomy. The waiter is under no obligation to make sure that the patron makes a good choice, one that is truly in his own best interest. If a diner makes a poor, foolish, or even a bad choice, for example, by choosing a dish that it is too hot and spicy for him, the waiter is not in the least accountable. Nor does the waiter have to volunteer that the cheapest dish is really the most delicious or that the cook at the restaurant around the corner is a real expert in preparing vegetarian meals. But a dentist is obliged to facilitate a decision that is truly in the best interest of the patient. The dentist has to offer all reasonable options, explain these options in an understandable manner and, if necessary, counsel and advise the patient. The dentist cannot coerce the patient, but if the latter is about to make a bad decision, the dentist is morally obliged to strongly caution the patient. And the dentist must refer the patient to a specialist as needed, notwithstanding the risk of losing a client to the other dentist altogether.

Information is never value-neutral and can be harmful

Some ethicists argue that healthcare providers should always be value-neutral and nondirective when informing patients. But this is not possible. While explaining, advising, counseling, and cautioning the patient, the dentist is necessarily making a best-interest judgment. The dentist must decide what is probably in the best interest of the patient and, hence, what the patient should be informed about. And even if the dentist were to refrain from specific advice and counsel, it is impossible to provide information in a value-neutral manner.

For example, dentists cannot share all of their dental knowledge with the patient. Hence, dentists must pick and select what information to share. And that selection always entails value judgments about the bits of information that are probably most valuable to the patient and hence in that patient's best interest. Moreover, dentists generally must translate their dental knowledge into layperson's terms. And that translation again entails value judgments. Even the order in which things are said, the intonations, the emphasis: it all colors the message and entails direction.

Unfortunately, information can also harm. It can depress people and rob them of hope. It can anger them or instill fear. More generally, information can be burdensome, because knowledge often comes with responsibilities. Hence, it would be wrong for a dentist to force information onto a patient. In other words, patients also have the right not to know. For example, a patient may tell the dentist: "Doctor, I appreciate your attempts to explain the procedure to me and all the risks; but I prefer not to know those details; they just scare me and make me nervous." Such a refusal of information should be respected by the dentist. Patients have a right to informed consent; they do not have a duty to informed consent. If a patient consents to treatment based on very limited information, and it is the patient himself who does not want more detailed information. Such a situation qualifies as legally valid informed consent.

Sometimes a patient's refusal of information may put the dentist into a real dilemma. When a dental intervention is invasive, complex, or rather risky, the dentist may feel very uncomfortable operating on a noninformed patient. If this happens, the dentist may have to explain that sense of discomfort and negotiate some middle ground. In the event that the patient remains adamant, refusing any and all information about the proposed intervention, the dentist may be justified in refusing to proceed with the treatment.

The right not to know should not be confused with the so-called therapeutic privilege or therapeutic exception. In the past, healthcare providers often attempted to escape from the difficult task of informing patients honestly about bleak prognoses. Not being trained to discuss these issues with patients, many tried to justify their silence by invoking therapeutic privilege, that is, the privilege not to inform patients if the dentist assumes that the information will end up harming the patient.

While informing the patient, the dentist must be acutely sensitive to subtle signs of the patient's distress over the information provided. But it is virtually impossible to predict, prior to informing the patient, that the information will be more harmful than beneficial. The therapeutic privilege can be invoked only if there is clear and convincing evidence that the information to be provided will cause serious harm for the patient. Consider a patient with advanced dementia. If every time the dentist starts providing information, the patient immediately becomes thoroughly confused and anxious, the dentist may have to invoke therapeutic privilege and abstain from further informing the patient about the proposed treatment.

How much information is enough?

In the previous section we considered two rare situations: the patient who refuses to be informed, and withholding information based on therapeutic privilege. In all other situations, patients should be informed. But how much information should they be given? It is obvious that the dentist cannot share with the patient all of the knowledge possessed by the dentist.

Earlier in this chapter we saw that a dentist does not have to obtain explicit informed consent for every single intervention. In the patient's explicit consent to a root canal, consent is implied for preparing the tooth and surrounding oral tissues, drilling into the tooth, removing the root, and any other steps necessary to complete the procedure. It would be practically impossible to explicitly discuss with the patient every single step, and it would probably annoy patients more than it would benefit them. At the other extreme, dentists should not simply dump as much information as possible onto patients. This, too, will do more harm than good. Many patients will not understand what is said, and they certainly will not remember all that was said, further adding to the confusion. Rather than being involved and active partners in the therapeutic process, most patients would end up feeling lost and disrespected when bombarded with scientific and technical information.

If the goal of informing patients is to improve their understanding of the care to be provided, it is imperative that information be not merely dumped but truly communicated. Genuine communication requires an interpersonal dialog between dentist and patient. The dentist must monitor whether the patient is comprehending the information offered, whether terms used need further explanation, whether the patient understands the logic of the proposed treatment, whether the patient is following along or growing confused and anxious. If necessary, the dentist may have to seek the assistance of a translator, postpone informing the patient until the anesthesia has relieved the worst pain, or tell the whole story in a series of consecutive meetings spread over a week or so rather than during one very long information session.

But the question remains how much information should be shared in this communicative dialog. In part, it is the patient's responsibility to ask questions. But given the unavoidable power difference between dentist and patient, the dentist is morally required to volunteer information. How can the dentist determine the amount of information to be volunteered? Or to rephrase the question from a different perspective: If a patient were to complain to the dental board that the dentist had insufficiently informed the patient, how is the board going to evaluate this complaint? What is the standard to which the dentist can be held accountable? How much information is enough?

Two different standards have been developed to answer this question: (1) the *competent professional* standard, and (2) the *reasonable patient* standard. If the dental board were to follow the competent professional standard, the dental board will assess whether the average competent colleague of the dentist would have given the same amount of information, less, or more. In other words, the board will not look at the best dentist in town, let alone the best dentist in the country, but assess what an average competent colleague in this dentist's community would do under similar circumstances.

This standard has been criticized by patient advocates as being overly protective of the dental profession. Given medicine's 2,500-year history of paternalistic silence, it does not seem a good idea to only look at what other dentists tend to do. Indeed, too many physicians and dentists still fail to adequately inform patients. This criticism has led to the development of the second standard, the reasonable patient standard. Under this standard, it does not so much matter what the average dentist would have told a patient under similar circumstances, but how much the average, reasonable patient would have wanted to hear.

It should be clear that the second standard is considerably more difficult to implement than the former. It is certainly feasible for a dental board to find out what the average competent dentist in town would have told by inviting a dozen local dentists as expert witnesses. It is much more difficult to find out what the average, yet reasonable patient would have wanted to hear. But then, the primary objective of the reasonable patient standard is to force dentists to step into their patients' shoes. Rather than thinking as all dentists tend to think about patient information, this standard forces dentists to overcome their own professional biases and think like their patients.

Recently, a third standard has emerged in certain jurisdictions, which tightens the informed consent standard even further. Under this third standard, it no longer suffices if the dentist tells the patient what most reasonable patients would want to hear. Rather, the dentist should strive to provide the particular information that the particular patient needs to hear in order to make an informed decision. This third standard is, of course, what the ethical ideal of informed consent has always sought to achieve. Dentists do not treat average patients – they treat specific individuals with life histories, future goals, and preferences that are specific to these patients and who now face oral healthcare needs that are specific to them.

Limits to the right to information

Patients should be provided with all information that is of immediate relevance to their own health status and healthcare. Thus, dentists must share diagnostic and prognostic information with the patient and detailed information about the effects and side effects of various treatment alternatives. But as mentioned earlier, the patient also has the right to learn about any nonscientific aspects of the dental treatment that could impact their decision-making. For example, the patient should be informed about the cost of each of the available treatment alternatives. If the dentist has a financial interest in the diagnostic clinic to which the dentist is referring the patient, or in the manufacturer that produces the special materials the dentist proposes to use, this too should be revealed to the patient. The question now arises whether there is any limit to the patient's right to information.

For example, does the patient have the right to information about the dentist's grades while in dental school, or the number of malpractice suits filed against the dentist? In recent years, consumer organizations in some countries have been pushing hard to develop publicly accessible electronic databanks on dental practitioners, listing each dentist's academic training and specialization, level of expertise, malpractice suits, and any disciplinary actions taken. All of this information is believed to be helpful for the assertive patient seeking the best possible dentist.

It is evident that a patient who accidentally discovers after treatment that the operation was performed by a dental student instead of a licensed dentist, without being informed of this fact in advance, is quite likely going to be upset and will be very mistrusting of dentists in the future. Likewise, if the patient were to find out that the advice of the dentist was skewed by the dentist's own financial interests in the recommended product, the patient is likely to become very mistrusting of this dentist and indeed of all dentists. Hence, if dentists readily share that kind of information with patients as part of the informed consent process, it will strengthen the fiduciary relation between patient and dentist. But it is not nearly as evident that patients' trust in their dentists will increase by finding out which dentists have been sued or disciplined, what their grades were, and how often they have (or not) performed certain complicated interventions. In fact, such information is likely to instill distrust in dentists more generally. It is becoming apparent that graduation from an accredited dental school and a state license to practice dentistry is no longer sufficient grounds to trust dentists. Instead of increasing trust, such databases can backfire and reinforce a *buyer beware* attitude toward dentistry among the public.

Recapitulation: Toward a respectful relationship

The dentist may not treat the patient unless being authorized to do so by the patient in a process known as *informed consent*. But this patient's right to consent or refuse proposed dental treatments, important as it is from both an ethical and legal perspective, is only one aspect of the principle of respect for patient autonomy. Respect literally means *looking after* the patient; genuine respect for the autonomy of the patient is always more than leaving the patient alone if the patient ultimately decides against the proposed dental treatment. Indeed, one could argue that if the patient ends up withholding consent for a proposed treatment, something went wrong much earlier in the treatment planning process that led the dentist to propose a treatment that is not mutually agreeable. So how can dentist and patient reach a mutually agreeable treatment plan?

In order for this to happen, the dentist must first determine what is truly in the patient's best interest. This determination cannot be made without the scientific knowledge of the dentist. If patients could solve their dental problems by themselves, they would have no need to visit a dentist. However, dentists cannot reach a best interest judgment on their own either. Dentists are trained in science, and their expertise hence is generic. Scientific expertise concerns classes of patients and disease categories. The dentist only knows what will benefit this patient, statistically speaking. Science cannot tell the dentist what is truly in the best interest of this particular patient, who is a unique person leading a unique life that no one else lives. In order for the dentist to reach a best interest judgment, the dentist must be willing to learn about the patient as a unique person. The dentist must try to understand where this patient is coming from and where the patient is going. And that in turn requires conversation and a willingness to listen to the patient.

Conversely, the patient must be introduced to the strange world of dental science and technology. It is only if the patient comprehends the scientific interpretation of the patient's condition (i.e., the differential diagnosis), the scientific interpretation of the patient's future (i.e., the prognosis), the scientific and technological options, and likely (side) effects of treatment – it is only when the patient comprehends all of this that the patient's consent is truly a *con-sent*, a *coming-together* with the dentist in a reasonable, feasible, and mutually agreeable treatment plan.

This chapter was written by Jos V. M. Welie

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Chapter 6: Confidentiality and privacy

Summary

Being part of the dental profession brings with it many privileges, and one important privilege is the right to ask patients often very personal questions of a confidential nature and to expect truthful answers in return. However, this privilege and trust cannot be taken for granted, as it imposes an ethical and legal obligation to treat any such information obtained in the dental practice setting as completely confidential.

Introduction

The principle of autonomy has been discussed in Chapter 5. It refers to the right of every individual to make decisions for him or herself. In dentistry, this means allowing the patient to make the final decision regarding his or her treatment, after having been given all the necessary and relevant information. Respect for autonomy creates the obligations on the part of the dentist of informed consent, confidentiality, truth-telling, and effective communication. Confidentiality is another way of respecting the patient's autonomy.

Confidentiality is related to keeping things secret – specifically, patient information and documentation. Protecting the confidentiality of patients' identifiable health information that is acquired, used, disclosed, or stored during the course of treatment is essential to respecting their dignity and privacy. Theories of confidentiality and privacy of identifiable health data are featured in the earliest origins of medical ethics. However, this privilege imposes an ethical (and legal) obligation to treat any information so obtained as completely confidential. Dentists explicitly or implicitly promise their patients that they will keep confidential the information confided in them. These protections are not only theoretically, legally, and ethically grounded, but are critically important for practical reasons – in the absence of such promises of confidentiality, patients are unlikely to divulge the highly private and sensitive information that is needed for their optimal care. Unwarranted disclosures of identifiable health information can cause direct or indirect harm to patients.

Why is confidentiality important?

What does it really mean to respect the confidentiality of a patient? Protecting confidentiality is easy in theory, but in practice it is complex and fraught with trade-offs. The obligation of confidentiality appears as early as the Hippocratic Oath and forms a fundamental aspect of codes of medical ethics that has been passed down through the ages. The Oath of Hippocrates vows that, "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding shameful to be spoken about" and the World Medical Association in 1983 reiterated in the Declaration of Geneva, "I will respect the secrets which are confided in me, even after the patient has died."

Confidentiality is central to the relationship of trust between the dentist and patient, but it also applies to members of the dental team and pertains to any information about the patient obtained in a professional role. The relationship between dentist and patient is based on the understanding that any information revealed by the patient to the dentist will not be divulged without the patient's consent. The information provided should only be used for the purposes for which it is given (e.g., cell phone numbers and email addresses are useful when communicating with the patient, but they should not be passed on to other parties). Patients have the right to privacy, and it is vital that they give the dentist full information on their state of health to ensure that treatment is carried out safely. The intensely personal nature of health information means that many patients would be reluctant to provide the dentist with information if they were not sure that it would not be passed on. If confidentiality is breached, the dentist/dental hygienist/dental therapist/dental nurse may face investigation by their statutory body and possible erasure from the register, and may also face legal action by the patient for damages and, for dentists, possible prosecution for breach of the Data Protection Act.

But should patients always expect this duty of confidence? The expectation of confidentiality must be balanced with communal or other needs for disclosure. Governments may need routine access to identifiable health data to promote public health, prevent emergencies, investigate crime, or protect individuals from harm. However, disclosure could cause harm, and patients must be protected from the distress, embarrassment, potential stigmatization and discrimination that may consequently impact their health and interfere with the practitioner's ability to render effective care. For ethical and practical reasons, the duty to maintain confidentiality must be absolute, although there are a few exceptions, which are described later in the chapter. It is, however, complicated to categorize what is confidential information and what is not.

What is confidential and what is not?

During the course of a dental consultation, a dentist is told many things by his or her patients. While some information (such as a medical history) is clearly confidential, the sensitivity of other information may not be as easy to discern. A patient's eye color or height may be plain for all to see, but is a patient's address confidential? Should the time that a patient spends in surgery be confidential? Is it reasonable to tell a wife, who rings to ask if her husband is having dental treatment at the office, that, yes, he is there, or should you say that the information is confidential? While the information seems harmless enough, the reason it is being requested may not be. Other situations are more complicated still. Should you give information to a school teacher or principal who phones to check on the whereabouts of a pupil on a particular day?

There could be a genuine concern for public safety. Should a dentist give information to law enforcement officials if they enquire whether a person they suspect of a crime was having treatment on a particular date at his or her office? Should a dentist inform a patient's spouse that his or her partner is HIV positive when he or she does not know, and the patient specifically requests that you do not tell the spouse? Do dentists have a responsibility for the partner's health as well as observing the spouse's request? One can see from these examples that it is not so easy to decide what we need to keep secret because it is confidential, and what is safe to disclose because it is self-evident or has been published elsewhere.

Any information obtained in the context of the professional relationship with a patient is bound by the ethical duty of confidentiality, even if other people could obtain this same information about the patient by other means. Confidentiality is maintained almost always, except in circumstances that require a breach of confidentiality in favor of a higher good. The law often enshrines some of the ethical concepts and provides general answers as to what constitutes confidential information and what would be a breach of confidentiality if it were disclosed. What therefore is the legal duty of confidence?

Duty of confidence

While the principles of confidentiality are well established, there are general conditions that establish a duty of confidentiality and what constitutes a breach of that duty:

- The information has an inherent quality of confidentiality, for example, a medical history.
- The information is disclosed in circumstances implying an obligation of confidence. When a patient provides information in a dental practice, and certainly within the treatment area, then those circumstances would almost always imply the obligation of confidence.

- Unauthorized disclosure of the information would cause harm to the patient. This harm is often psychological rather than physical.

Within the dental practice, any information provided by the patient in relation to the patient's own treatment must be regarded as confidential. Unauthorized disclosure of this information would be a breach of the obligation of confidentiality, as harm would almost certainly occur either immediately or in the future. The decision to disclose or withhold information can be an awkward one, especially with patients who have been attending the practice for many years. How ever, despite friendly relationships with patients and possibly even sharing the same social circles, dentists are bound by the ethical code of the profession. It may sometimes be awkward or embarrassing when one is unable to disclose seemingly innocuous information, but one can say that the code of professional ethics prevents the dentist from answering those questions. The refusal does not therefore come from the dentist as an individual but rather as part of the professional ethical obligations of dentists.

Justified disclosure with patient permission

When considering disclosure of any patient information, patient autonomy is paramount. Information about the patient belongs to the patient, not to the dentist. Therefore, if the patient permits disclosure of their clinical information to a third party, then this would be permissible. In many instances, the third party is a professional colleague, but can include any person authorized by the patient or, in the case of children and adults without the capacity to consent, by a parent or other responsible adult. Patient records belong to the clinician and are not physically the patient's property; however, access to records is often assured for the patient by data protection legislation.

Justified disclosure without patient permission

Disclosure of confidential patient information without the patient's consent is rare in dentistry but may be justified in exceptional circumstances. The dilemma of what is confidential and what is not obviously requires an assessment of the facts and is unique for each situation. In some countries, a distinction is drawn between the *primary purpose* for which the personal information about the patient was gathered and stored (e.g., their dental care) and any *secondary purpose*. Apart from the legal guidelines, it is helpful to remember that personal health information obtained in the course of consultation and treatment is both confidential and indivisible. No part of the information should therefore, in normal circumstances, be disclosed to any third party without the patient's permission. Furthermore, selective parts of the record that may not be considered confidential also cannot be disclosed. The rule for disclosure must be that there is either an individual justification, based on the circumstances of the situation, or a legal justification or obligation. In some instances, a patient's treatment may be funded by a third party (e.g., the state, a private insurance scheme, or a healthcare fund), and the patient may have agreed that this third party may have access to information about his or her treatment.

In the context of the dentist–patient relationship, confidentiality is always maintained, except where there is a legal or statutory requirement for disclosure, or when disclosure is ordered by a court of law. The following situations may permit disclosure without consent by the patient, parent, carer, or other responsible adult:

- When the life of a third party is at risk.
- When the dentist is ordered to divulge information in a court of law. This requires an order from the court or a judge, not just a request from a lawyer.
- When one is compelled to breach confidentiality by legal or statutory requirement, such as in cases of child abuse or an infectious disease under public health legislation.
- When a dentist is a defendant or an accused. Confidentiality may be breached only with information that is material to the case against the dentist.

Data protection

Patients need to be informed about limits, legal or other, of the dentist's ability to safeguard confidentiality and the possible consequences of breaches of confidentiality. The increasing practice of longitudinal electronic records and their prospective linkage to national electronic health information systems have heightened individual concerns about potential widespread data sharing and unwarranted uses.

Anonymization

Anonymized data means data from which the patient cannot be identified by the recipient of the information. The name, address, and full postal code are removed, together with any other information which, in conjunction with other data held by or disclosed to the recipient, could identify the patient. Patient reference numbers or other unique numbers may be included only if recipients of the data do not have access to the *key* to trace the identity of the patient using that number.

In general, all healthcare establishments that process personal data need to protect that data from inappropriate use or disclosure. However, the same establishments may want, or be required, to publish information derived from the personal data they collect. In some instances, while being required to protect the identities of individual patients, it may also be required that statistics about patient outcomes be published. Anonymization may help the establishment to be compliant with data protection obligations while making information available to the public. Any organization processing personal data must comply with the data protection principles of relevant countries or jurisdictions.

The anonymization of personal data is possible and can help service society's information needs in a privacy-friendly way. In principle, anonymized data can be provided to third parties, such as, for example, hospitals that want to get a better understanding of patient requirements. However, there is always a risk that, despite the care taken to protect details, a user of the information can still piece together a picture of individuals' private lives. With ever-increasing amounts of personal information in the public domain, it is important that every dental practice has a structured and methodical approach to assessing the risks. If the risks are properly assessed, anonymization can allow for the information derived from personal data to be made available in a form that is rich and usable, while still protecting individual data subjects.

Privacy, confidentiality, and security

As an ethical and legal obligation, confidentiality is often bundled with the concepts of privacy and security. They are, however, ethically and legally distinct. Privacy refers to an individual's right to control identifiable health information and decide what other people will know about them. Individuals have a right to inspect, copy, and amend health data, to limit the acquisition and use of health data, and to demand reasons for disclosures.

While privacy represents an individual right, confidentiality is the corresponding duty to protect this right. Confidentiality comprises those legal and ethical duties that arise in specific relationships, such as dentist-patient. Confidentiality is an implicit expectation that privacy will be protected by those entrusted with the information. The level of protection should be commensurate with the level of risk, and in some instances the risk of a breach of confidentiality may be high, with serious implications. A dentist's duty to maintain confidentiality, which invokes the *secrecy* aspect of privacy, is one mechanism to protect the individual's broader privacy interests, which also include the individual's right to access or correct his or her own information. Security refers to technological or administrative safeguards or tools to protect identifiable health information from unwarranted access or disclosure. Although the dental team may work hard to protect the data they acquire, privacy breaches can occur if adequate security protections are not maintained. These three terms – privacy, confidentiality, and security – may be clarified further in this statement: “If the security safeguards in a system fail or are compromised, a breach of confidentiality can occur and the privacy of patients' data can be invaded."

These days, many practices are designed in an open-plan manner, such that patient consulting areas or rooms are within earshot of the reception or waiting area. This set-up may lead to breaches of privacy. While patients expect privacy from the dentist and dental team when they enter the consulting room, patient privacy is already limited, even within the confines of a single consultation room, since a dental assistant is often present during the consultations. Nonetheless, the patient must be protected from distress and from any potential stigmatization and discrimination that may be caused if his or her privacy is in some respects betrayed.

Concluding remarks

The expectation of confidentiality and privacy is central to a patient's trust in the dentist and dental team. Patients expect that their identifiable health data will be kept confidential and that their use or disclosure will be limited to management of the data and the patient's care. Theories of confidentiality and privacy are pervasive throughout the history of medical ethics, human rights, and law. Modern notions of privacy support a strong respect for individual autonomy, offering significant protections for identifiable health data use. These protections continue to evolve and necessitate secure information practices to prevent breaches of confidentiality.

Where there is any doubt in the dentist's mind regarding disclosure of confidential information, careful thought should be given, and specialist advice and guidance should be sought. In addition, the dentist must remember that the principle of confidentiality extends to other members of the dental team, who should not disclose confidential information either inside or outside the practice. Dentists may have a vicarious liability for the actions of their staff who divulge confidential patient information to a third party. It is therefore essential that staff are trained in this area. Breaches of confidentiality by staff, after they have been made fully aware of their duties, can result in serious disciplinary action, even though confidentiality ultimately remains the dentist's responsibility.

This chapter has shown that the need to maintain the confidentiality of any patient information provided to dentists in their professional capacity is paramount. The trust that this care elicits is essential to the success of a professional relationship with patients. The ethical principle of patient autonomy and the accompanying value of confidentiality must be ensured in all but the most exceptional circumstances. Patients have the ethical and legal right to expect this confidentiality from the entire dental team, together with the expectation that the information provided is kept safe at all times. In some circumstances, there may be a need to disclose information, but this can only be done with the patient's consent or if there is an overwhelming public interest, prescribed by law, in disclosure.

Some practical rules to ensure confidentiality and privacy include:

- All records (paper or electronic) must be kept secure and in a location where it is not possible for others to see them (see Chapter 7).
- Identifiable patient information should not be discussed with anyone outside of the practice, including family, relatives, or friends.
- Requests from schools about whether a child attended for an appointment on a particular day should not be divulged. Instead, it should be suggested that the child obtains the dentist's signature on his or her appointment card to confirm attendance.
- Training and demonstrations of the practice's administrative and computer systems should not involve actual patient information.
- When communicating with a patient on the telephone or in person in a public waiting or reception area, care should be taken that sensitive information is not overheard by other patients.
- Information about a patient's appointment record should not be given to a patient's employer.
- Messages about a patient's care should be given directly to the patient and not to third parties or

left on answering machines. If the patient is unavailable, leave a message to ask the patient to call the practice back.
- Recall cards, reports, and other personal information must be sent in a sealed envelope.
- Only upon the instructions of the dentist can disclosure of appointment books, record cards, or other information be made to police officers or other officials.
- Patients should not have access to or be able to see information contained in appointment books, day sheets, or computer screens.
- Discussions about patients should not take place in public areas of the practice.

Case study

Following uncomplicated root canal treatment (RCT) on a mandibular molar in a 20-year-old female patient, the woman returned a few weeks later, together with her husband, complaining about an ulcer on her palate that her husband assumed was related to the earlier RCT. On examination, the dentist concluded that the ulcer on the palate appeared to be a syphilitic chancre. The patient was informed that the lesion was not related to the recent RCT but rather looked very much like a sexually transmitted lesion. She was then carefully asked if she had recently had oral sex, and she said, "Yes, but please do not tell my husband!"

While the dentist's diagnosis was presumptive, the dentist was placed in a difficult position by the patient's request for nondisclosure. The dentist had to choose between respecting the patient's autonomy (maintaining the confidentiality of her diagnosis) and nonmaleficence (protecting the patient from harm by disclosure to her husband).

The dentist had to consider the follow options:

- Maintain confidentiality and discharge her.
- Maintain confidentiality and refer her to her general medical practitioner for a definitive diagnosis, advice, and treatment.
- Encourage her to allow the dentist to inform her husband, and if she agrees, to inform him that in the dentist's opinion, the lesion on her palate is not related to the RCT and that the diagnosis and treatment of the ulcer is outside of general dentistry and that she requires a referral to the family general practitioner for a definitive diagnosis and appropriate care.
- If she does not agree to let the dentist inform her husband and refuses to be referred to her general medical practitioner, maintain confidentiality, but consider a referral to a community clinic or one that specializes in sexually transmitted infections (STIs).

This chapter was written by Sudeshni Naidoo

Further reading

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Chapter 7: Record-keeping

Summary

Together with the obligation of confidentiality (see Chapter 6) comes a second ethical obligation to store confidential patient information safely. The keeping of dental records is essential to patient management and is considered an ethical and legal obligation of the dentist. It is ethical, as it satisfies the duty of care that the dentist has toward the patient, and legal, as it protects against medico-legal problems. Furthermore, dental records can provide critical information to forensic examiners to assist in the identification of victims and perpetrators of crime or victims of natural and human-made disasters. In this chapter, we examine the importance of good record-keeping and discuss its uses, essential components, retention, ownership, accessibility, and relevance to forensic dentistry.

Introduction

Daily dental practice requires efficient, detailed record-keeping and is an important aspect of patient care. A dental record is defined as any record made by a dental practitioner at the time of – or subsequent to – a consultation with, an examination of, or the application of a dental procedure for the patient and which is relevant thereto. Since the relationship of a dentist and patient is based on trust, every dental record is compiled under the premise that the health information of the patient will be kept confidential, not only by the dentist but by the entire dental team. This information should be protected from unauthorized use or disclosure even to family members, except when required by law or where the patient has given their express consent, ideally in writing.

Practitioners are obliged to establish and maintain adequate records of dental history, clinical findings, diagnosis, treatment and costs, consent, and patient-related communications, including instructions for home care. Dental records are therefore legal documents owned by the dentist and contain both subjective and objective information about the patient. There can be only ONE patient record. The quality of the patient dental records is a reflection of the quality of the practice and the professional services rendered. Bad record-keeping can compromise a practitioner's professional reputation and defense if a patient lodges a complaint. This is especially important today, when patients' records can be viewed, and are increasingly being used, by third parties.

What are dental records used for?

There are many uses for a well-maintained patient record. Apart from administrative purposes, dental records can provide vital evidence that a practitioner has treated the patient appropriately, with the requisite degree of skill, attention, and continuity of care. A dental record may be used (i) as a basis for planning and maintaining continued patient care; (ii) for documentary evidence of the evaluation and diagnosis of the patient's condition, the treatment plan and informed consent, the treatment actually rendered, recalls and referrals made, and the follow-up care provided; (iii) not only to monitor the success or failure of treatment carried out, but also to monitor the patient's oral health and assist with oral health promotion and preventive practice; (iv) to document all communications with the patient, whether written, verbal, electronic, or telephonic; (v) as a record of communication regarding the patient and other healthcare providers, as well as interested third parties; (vi) to protect the legal interests of all parties involved; (vii) to provide data for continuing dental education, training, and research; and (viii) for billing, quality assurance, and other administrative functions.

Detailed and accurate records can be used for communication with other practitioners or specialists for second opinions and for conducting clinical audits, healthcare research, and the production of healthcare statistics. Dental records are indispensable as direct evidence against litigation or complaints lodged by patients in the event of malpractice lawsuits and investigation by medical schemes for utilization and clinical audits. A person's dental record can provide vital evidence to forensic investigators in the identification and detection of a crime, or in natural or human-made disasters. In addition, records may also be used variously for historical, teaching, research, and case review purposes.

What constitutes a dental record?

A complete dental record should contain all information related to the dental management of the patient. It includes subjective data (reasons for visiting the dentist, chief complaint, and symptoms), objective findings (obtained from clinical examination and diagnostic tests), assessments (diagnostic and therapeutic judgments based on the subjective data and objective findings), and treatment plans (various options and their costs, risks and benefits, time considerations, and so on).

A dental record usually comprises three sections: patient information (see next); business information (billing details with date and amount, copies of claim forms submitted, information related to laboratory services used and their charges, scheduling of appointments); and drug record (condition being treated, dates and method of prescription, administration and dispensing of the drug including its name, strength, quantity, form, and directions of use).

All records should be chronologically dated, objective, and contain only facts and professional opinions and not subjective interpretations or derogatory remarks regarding the patient. No information or entry may be removed from a dental record. An error may be corrected with a single line drawn through the incorrect information and corrected with black ink. The date of change must be entered, and the corrected information must be signed in full. The original record must remain intact and fully legible. Any additional entries added at a later date must be dated and signed in full, and the reason for an amendment and/or error must also be specified on the report. The signing of all official documents relating to the patient's care (prescriptions, certificates, patient records, or other reports) must have a signature plus initials and surname in block capital letters.

The following minimum patient information should be recorded:

- Time, date, and place of every consultation;
- Personal particulars of the patient (gender, age, date of birth, employment, telephone and address contact details, referral information);
- Bio-psychosocial history of the patient (including drug histories, allergies, and idiosyncrasies);
- The assessment of the patient's condition (chief complaint, past dental, medical, family history, immunization status, pregnancy, and lactation);
- A picture of the patient's mouth. There should be charting of existing restorations, together with the patient's current needs;
- A dental and periodontal profile, together with details of important signs, such as gingival inflammation or swelling, along with a soft tissue examination for evidence of any oral pathology;
- Clinical radiographic tests, scans, or imaging findings, diagnosis, and the proposed treatment and prognosis;
- Copies of test results, instructions for home care, patient follow-up and recall examinations, fees charged, and details of referrals to specialists;
- The medication and dosage prescribed;
- Information on the times the patient missed work and the relevant reasons;
- Written proof of informed consent and the signature of the patient. These are also necessary for informed refusal, for example, if the patient refuses to undergo treatment, even though the dentist feels it is essential to the patient's management.

Together with the above information, all communications with the patient, including emergency telephonic or electronic consultations, should be recorded. If a patient has a complaint, it should be recorded with the information on how the problem was dealt with and if a solution was found or an agreement reached. If a patient wishes to discontinue treatment, the reasons should be documented.

Ownership of records

Where records are created as part of the functioning of a private practice, including the original radiographs or ultrasound or scanned images, the dentist is the legal owner of such records and they remain solely the property of the dentist. They may be retained by the dentist and are never released, unless by the express wish of the patient. A copy of the records, radiographs, study models, and so on can be provided to the patient or transferred to a new practitioner on request. The patient may be charged an appropriate fee for such copies, provided that the patient is made aware of the charges.

As the ownership of records in a multidisciplinary practice depends on the legal structure of the practice, the governing body of such a multidisciplinary practice should ensure that the guidelines relating to records are being adhered to. If a dentist leaves or sells a practice, patients should ideally be given written notice of the change of ownership. If the dentist is unable to do so, then the incoming dentist should notify patients that he or she is the new owner of the practice and is now in possession of their dental records.

If a dentist in private practice (both in solo practice and in partnership) dies, then his or her estate, which includes the dental records, would be administered by the executor of the estate. Should the practice be taken over by another practitioner, the executor shall pass the records to the new practitioner. The new practitioner is obliged to inform all patients in writing regarding the change of ownership, and the patient can remain with the new practitioner or request that the patient's records be transferred to a practitioner of the patient's choice. Should the practice not be taken over, the executor should inform all the patients in writing and transfer those records to other practitioners designated by the individual patients. The remaining files shall be kept in safe-keeping by the executor for at least 12 months with full authority to further deal with the files as deemed appropriate, provided the provisions of the rules on professional confidentiality are observed.

In the event that a dentist in private practice decides to close or sell his or her practice for any reason, the practitioner shall inform in writing and in a timely manner all the dentist's patients as follows:

- That the practice is being closed from a specified date;
- That requests can be made for records to be transferred to other practitioners of the patient's choice;
- That after the date specified, the records shall be in safe-keeping for a specific period with an identified person or institution with full authority to deal with the files as deemed appropriate, provided the provisions of the rules on professional confidentiality are observed.

Access to records

Patients do not have the right to possess their original record, but they may request access to, or have a copy of, their dental records for various reasons that may include an underlying dissatisfaction, the desire to resolve a problem, or the need to share the record with another practitioner or their lawyer. Occasionally patients relocate and may wish to provide their new dentist with their previous records to give them an understanding of previous treatment or problems. Dentists are obligated to provide such copies despite any disagreements or nonpayment of fees. The right of access of the patient to their records varies from one country to another. It has evolved, and continues to evolve, in response to a greater expectation by the public that they are entitled to know what is recorded on their behalf and to have access to that information. Furthermore, patients are usually given the right to alter or edit information if they consider it incorrect or inaccurate. Again, this expectation, and legal right, varies around the world, but the trend is toward greater access. It is also important to prevent information from being accidentally released by keeping the information securely stored at all times.

Disclosure of information varies, but in general, no dentist shall make information available to any third party without the written authorization of the patient or his or her legal representative. A dentist may make information available to a third party without the written authorization of the patient or his or her legal representative in cases where, for example:

- It is demanded by the court in medico-legal cases, for example, when the dentist is a witness in a trial between a patient and another party, or where the patient has instigated action in court against the dentist, and the dentist is ordered to testify on the patient's dental condition or to produce his or her dental record.
- A professional body has instituted disciplinary hearings, and the dentist must answer the charge to defend him or herself.
- The dentist is under a statutory obligation to disclose certain facts (e.g., in the case of suspected or known child abuse).

Electronic patient records

Digital technology, networked computing, digitization of information, and the use of electronic records have revolutionized the practice of dentistry – from clinical uses to continuing education, and from practice management transactions, such as appointments, payments, and marketing, to e-commerce. Patient records with audio, text, images, and clinical photographs may be transmitted to specialists anywhere in the world for second opinions. Having paperless records does not imply that they are safe and problem-free, and no matter what precautions are taken, there is still a risk that someone may gain access to stored electronic information. Furthermore, data can be lost through computer viruses and hardware and software malfunctions. Backup of all records should be performed on a removable medium that will enable data recovery in the event of a systems failure or malfunction.

Practitioners must be satisfied that there are appropriate arrangements for the security of personal information when it is stored, sent, or received by fax, computer, email, or other electronic means. As a basic requirement, there should be login and password protections. If necessary, appropriate authoritative professional advice should be sought on how to keep information secure before connecting to a network. It should be recorded that such advice has been taken. Fax machines, computer terminals, and other electronic devices should be in secure areas. If data is sent by electronic means, practitioners should satisfy themselves, as far as is practicable, that the data cannot be intercepted or seen by anyone other than the intended recipient. When deciding whether and in what form to transmit personal information, dentists should note that information sent by email through the internet may be intercepted.

During the transition to paperless records, manual filing and record-keeping continue to be extremely important. Dentists need to not only educate themselves of the ethical, legal, and technological issues that are related to the use of electronic mediums, but also to regularly consult and keep up to date with the laws related to electronic record-keeping as this area undergoes constant change.

Communicating with patients via email

Communicating with patients via email can save time and money for the dentist and may help the patient to communicate easily with his or her dentist regarding queries, scheduling of appointments, and requesting or refilling a prescription. However, it does raise significant considerations. It is difficult to ensure confidentiality and to confirm the identity of the person when communicating via unsecured email. Emails could be sent to the wrong patient in error or forwarded to unknown third parties. Patients should be informed about the possible risks and agree to accept them before using electronic communication. Apart from the patient's acceptance to use email correspondence, there are other considerations for the practice, such as how the email correspondence will be incorporated into the dental record, and how one can minimize exposure/risk or lessen the liability for business conducted online?

Retention of records

Patient records are usually classified as active or inactive. Active files contain the dental records of patients who are currently having dental treatment at the practice. Inactive patients are usually considered to be those who have not returned to the practice for two years.

Why should records be retained?

Dental records are retained for the recall of treatment proposed or to further the diagnosis or ongoing clinical management of the patient. They can also be used for second opinions, clinical audits, as direct evidence in litigation or complaints lodged by patients with the statutory council, or for investigation by medical schemes in the case of fraud.

For how long should records be retained?

Retention of records is a common concern, especially when there is a shortage of storage space in the practitioner's office. Different countries and jurisdictions have different guidelines regarding the duration of time dental records need to be retained. Records must be stored in a safe place, and if they are in electronic format, they should be safeguarded by passwords. Practitioners should satisfy themselves that they are informed of the relevant guidelines with regard to the retention of patient records in whatever format. At the end of the retention period, records may be disposed of in a manner that protects patient confidentiality and maintains the security of the information contained within them.

New technology has made it possible to store enormous amounts of data electronically. In the case of minors and patients who are *non compos mentis*, or not of sound mind, dentists should use their own discretion as to whether the records should be kept for a longer period, since action can be initiated long after the treatment is rendered. Records kept in a public hospital or clinic can only be destroyed if authorized by the person concerned. A balance must be reached between the costs of (indefinite) retention of records and the occasional case where the practitioner's defense of a case of negligence is hampered by the absence of records. Where there are statutory obligations that prescribe the period for which patient records should be kept, a practitioner should comply with those obligations.

Retention of electronic records

Storage of electronic clinical records must include the following protective measures:

- All electronic clinical records, including those stored on CD and copies thereof, must be encrypted and protected by passwords in order to prevent unauthorized persons from gaining access to such information.
- Copies of CDs used in practitioners' offices must be in read-only format, and a back-up copy must be kept and stored in a physically different site so that the two discs can be compared in case of any suspicion with tampering.
- Effective safeguards against unauthorized use or retransmission of confidential patient information is to be assured before such information is entered on the computer. The right to patient privacy, security, and confidentiality should be protected at all times.

Disposal of records

At the end of the retention obligations, dental records must be securely disposed of in a manner that is consistent with not only maintaining the confidentiality of the patient, but also the physical security of the actual recorded information. This can be done in a variety of ways, including:

- Physical destruction of records by shredding, incineration, or another method;
- Returning the records to the patient or disposing them in accordance with the patient's instructions;
- Confidential transfer to a company/agency that specializes in the destruction of records;
- All identifying information on casts and models must be removed prior to disposal;
- Ensuring that the process used to destroy electronic records renders them unreadable in a manner that will not make it possible to reconstruct the records in whole or in part.

Use of dental records for forensic investigations

Well-maintained dental records are invaluable as an easily available and accessible resource for forensic investigations with regard to the identification of perpetrators of biting injuries, child abuse, and human remains from fatalities or disasters. Apart from the clinical, oral, perioral, and hard and soft tissue descriptions, radiographs, photographs, casts, impressions, and dentures could all be part of a dental record. Radiographs and photographs can be used for facial reconstruction when identifying victims whose facial features have been obliterated or are unidentifiable. Forensic investigators may be able to use dental records to determine the identity of bite marks, palatine rugae patterns, and the chronological age of, particularly, young children. People can also be identified using dental prostheses or orthodontic appliances. Dentists should routinely advise their dental laboratories to place markers, labels, barcoding, microchips, etc. on prostheses or appliances for identification of the user.

It may not be so easy to determine when it is appropriate to release clinical records to a family member for identification purposes, as such disclosures may need to be limited to directly relevant information. The most prudent option might be that the dentist, in consultation with his or her attorney, limits a disclosure to only those records or data necessary for victim identification. As mentioned earlier, while dentists are the owners of the dental patient records in their possession (physical or electronic), a patient generally has a legal right of access to the information contained in his or her own dental record or in that of a dependent family member. Patients may have a further legal right to restrict disclosures or release of the record. Consequently, dentists need to become familiar with their national, state, and local requirements and formulate record release policies and procedures specific to their practice. Such written record release and disclosure policy in an emergency could allow access to the dental records by family members of missing or unidentified persons, or by members of law enforcement, while simultaneously protecting dental record privacy.

In most cases, photocopies of written records are acceptable to a recipient, unless originals are specifically required, or authenticity is in dispute. If investigators agree to accept photocopies of written dental records, clear copies should be provided. If a single document contains multiple pages, they should be consistently numbered. Prior to releasing copies, one needs to ensure that each page identifies both the patient in question and the dentist providing the record. Whenever possible, a dentist should release original records and radiographs in person.

Checklist for dental record-keeping

- Patients should have a single dental record.
- Records should be updated, accurate, complete, but concise.
- Records should be consistent.
- Use a standardized format: notes should contain the patient history, clinical findings, investigations, diagnosis, treatment plan, outcomes, and follow-up instructions.
- Medical status information should be updated at each visit.
- Ensure that if initials or shorthand terms are used, they are universally recognizable.
- Avoid self-serving, disapproving, or derogatory comments in records.

- Describe the facts, and only those conclusions that are essential for patient care
- If the record needs alteration in the interest of patient care, score out items with a single line, then sign in full and date the changes without altering the initial entry. In this way, the dentist shows that there is no intent to conceal information.
- Make sure signed informed consent or refusal forms are appended to the dental record.
- Release a copy of the records only after receiving proper authorization.
- Keep billing records separate from patient care records.
- Randomly select a few patient records and ask a colleague to check that they are legible and comprehensible.
- Always label attached documents (photographs, models, lab results, and so on), so that the patient can be identified.
- Request for a transfer of dental records in the event of a change of dental care provider in order to maintain continuity and completeness of the record.
- Remind staff about confidentiality of all patient records.

This chapter was written by Sudeshni Naidoo

Chapter 8:
Professional behaviour

Summary

This chapter discusses the duties and responsibilities of dentists to individuals – patients and others – as well as to the broader communities in which they live and work. It outlines the elements of being a professional that cause tension and create problems both for dentists and for the profession of dentistry. Some of the elements discussed include professional standards, understanding personal limitations, fitness to practice, and the role of individuals and associations in maintaining professional standards of collaboration, referral, delegation, and dealing with people who are not regular patients.

Introduction

Most dentists are conscious of, and try to uphold, their professional responsibilities, but there are also some dentists who inadvertently or deliberately violate the codes of practice. This chapter examines the role of a professional dealing with individuals and the wider community, mainly in situations where clinical standards of care (covered in Chapter 3) do not apply. Due to the differences between countries (and sometimes within countries), readers are advised to refer to their local laws and codes of ethics when seeking specific information.

The ethical dilemmas that dentists may encounter are encapsulated in the following questions:

- Why are the standards for professional relationships different from those for other relationships?
- Must dentists notify patients of errors, disclose details of personal limitations, or give personal information?
- How do dentists handle their own temporary or permanent disabilities?
- Fitness to practice requires dentists to be aware of impairments to their ability and modify their practice accordingly. What is the duty of colleagues and others who know of an impaired dentist?
- How should individual dentists and professional groups manage dentists who misbehave or violate ethical principles?
- How should dentists deal with other dentists and other health professionals?
- When patients are referred to specialists, what ethical problems may the dentist and/or the specialist encounter?
- What duties do dentists have to people who are not their patients?

Professional standards in relationships

Dentists take pride in being respected as members of a health profession. This status is based on trust, including a belief that high standards (both clinical and personal) will be maintained. Clinical standards are usually based on evidence, and treatment options are selected after balancing benefits and risks. On the other hand, professional behaviour reflects the acceptable, but often variable and more subjective, standards of society at a particular time and within a particular community or culture. Patients may not be able to tell if a dentist is a good clinician, but they can, and usually do, judge the dentist using behavioural indicators such as whether they are kind or rude, interested or arrogant, generous or mercenary. Many formal complaints about dentists are concerned with or include behavioural issues. Even complaints about technical aspects of treatment are often precipitated by poor behaviour.

Usually the standards of behaviour demanded of a professional are higher than those of the general public. The basis for this higher standard rests with the social contract or a public promise that is made between society and the profession of dentistry and is one based on trust.

What is the essence of the social contract?

Dentists have specific skills and knowledge that society values and needs, and so society often contributes to the education required to become a dentist through public subsidy. Even where the cost of tuition is unsubsidized, volunteers are needed for students to gain clinical practice and for research projects. The dental profession enjoys legal protection both to perform invasive procedures and from unregistered competition. Dentists have autonomy, individually and as a profession, to manage clinical standards. Both the protection and autonomy are privileges that society provides and are not a right. They may be forfeited or constrained. In addition, most dentists enjoy social and economic privileges and a status in society.

In return for these benefits, dentists accept the responsibility and duty of placing their patients' well-being first, of sharing knowledge for the advantage of everyone, of having a relationship with patients and colleagues that is collaborative, not competitive, and based on trust. Ethical codes of practice guide dentists and remind them of their obligations to individuals and, collectively, to society.

Patient vulnerability and susceptibility

Consider the approach taken by a person buying a mobile phone. The phone is moderately expensive and the user must commit to a plan. Information is gathered from many sources, competing providers are consulted, questions are asked, ratings are searched on the web, answers are mulled over with friends and experts, and prices are compared. Yet when it comes to dentistry, patients get most (if not all) of their information about treatment from one person – the dentist. They ask few questions, seldom seek a second opinion, and trust the dentist to put their interests first. This level of trust is a source of pride for most dentists, but it increases a patient's vulnerability to anyone who misuses their professional position.

To deliberately abuse this trust for personal gain is unethical and unacceptable.

Faced with such a level of trust, a dentist must be sensitive to the risk of inadvertent or unintentional influence. Mere suggestions can be interpreted as recommendations, and patients may suppress their personal preferences in accepting decisions. Dentists should not make assumptions about what is important to the patient in terms of cost, esthetics, or function. If there are several acceptable alternatives of treatment available for a patient, the dentist should give unbiased comparisons based on the clinical evidence. If the dentist tries to predict the preference of the patient based on cost, time, or outcome, the prediction may be wrong. An example may be a dentist who knows that a patient has a limited income and continues to treat a condition rather than referring the patient to a specialist. Without asking, the dentist cannot predict the value the patient may place on the outcome, and the patient is unlikely to question the dentist until it is too late.

Such soft paternalism is based on concern for the patient, and although it can be misguided, it is well meaning. There is no excuse, however, for information to be given based on the interest of the dentist. If a dentist can make a larger profit from one form of treatment, if a student needs to fill a quota of procedures, or if a research project is recruiting specific cases, the information about treatment options should be delivered accurately and without bias of content, style, or delivery. The patient may provide consent, but gaining consent using manipulation – deliberate or well intentioned – is invalid, dishonest, and unethical.

Interpersonal relations

Treating patients who have become well known to the dentist over a long time is a rewarding aspect of dentistry and helps in providing appropriate care. However, there are some risks in having such warm relationships. One risk is that the dentist or the patient may misinterpret a professional relationship as a personal friendship. If there is an inequality based on education, money, or societal status, the patient may feel flattered or under an obligation to *repay* the attention in personal, financial, or other ways. In addition, it is more difficult for a dentist to resist helpful – but fraudulent – actions, such as falsifying certificates for sick leave or manipulating dates or items on insurance claims for a friend who is also a patient.

Registration authorities, professional associations, and laws prohibit a dentist from establishing a sexual relationship with a current or recent patient, or the immediate family of a patient. A dentist should not initiate the relationship and should deflect any advances from a patient. Dentists and dental students are urged to check the guidelines that are provided by these bodies. The reason for this prohibition is that a patient is always considered to be in an unequal position of power to a health professional, and for a dentist to pursue or enter a relationship is taking advantage of the dentist's position.

Dentists should take particular care in deciding to treat a family member, intimate partner, or close personal friend, especially for complex treatments. Wherever possible, another colleague should be asked to treat this person so that patient autonomy is not compromised, so that in difficult treatment procedures the dentist is not placed under additional stress, and thus there is no constraint on free discussion when dentist–patient opinions differ.

Separation of personal and professional life can also be difficult in relation to religion, politics, culture, and business. Overt canvassing of personal beliefs can cause a patient to feel under pressure, and in some circumstances a patient may feel (rightly or wrongly) that treatment could be withheld or compromised. Others may feel obliged to attend a particular practice because of a mutual involvement in one of these activities.

Deliberate exploitation or pressure is always unethical. However, there is no clear-cut line between what is unacceptable and what is an expression of personality. Care must be taken in the public spaces of dental clinics to ensure that community and professional standards are observed. Collection boxes for charities in conspicuous positions are difficult to avoid and may place pressure on people to donate for fear of embarrassment. Religious icons, political posters and flyers, inappropriate printed material (cartoons, calendars, or magazines), business advertisements, and so on, may seem trivial, but they could cause offense or breach the boundary of professional conduct. Solutions vary from having no personal items displayed, to having a notice board for everyone to contribute to.

Personal relations with patients in any of the interactions previously mentioned become more complex when the dentist is located in a small town or a closely knit suburb or community. Here the dentist is likely to mix with patients in a variety of social settings. There can be a conflict between a dentist being an active part of a small community and maintaining a professional distance. For isolated dentists (especially newly graduated dentists) it is even more important to have a solid network of professional colleagues with whom to discuss such situations.

Understanding personal limitations

Everyone experiences challenges that limit one's ability. Some of these challenges are temporary, such as fatigue, illness, stress, performing a new procedure, or treating a difficult patient. Other limitations last longer or even become permanent disabilities. Understanding the requirement to adjust procedures, techniques, or the scope of practice is the duty of each dentist.

Burn-out in dentists is often related to striving for clinical perfection yet having to accept compromise. Young dentists particularly can become stressed by having to determine the difference between a reasonable compromise and substandard work. Older dentists need to remain aware that trusted techniques may become superseded or even contraindicated.

It is often difficult to recognize if one's own behaviour is substandard or becoming out of date. There are few continuing professional development courses that address this issue, and less open discussion about them between colleagues. Social norms, language, and interaction with groups of people such as minority groups evolve with time, and it is essential that dentists remain aware of how they may offend patients or colleagues. Moving from one country to another – and even within countries – can introduce different cultural norms.

As is mentioned frequently in this and other chapters, the best way of preventing or solving professional dilemmas is to nurture self-awareness and seek advice and guidance from colleagues.

Disclosure of personal information

Patient autonomy is one of the most important principles of dental ethics. Integral to this is the right to information (often quantified as sufficient and appropriate) that is essential for valid consent. Chapter 5 examines autonomy in clinical situations in detail, while this chapter focuses on personal information.

As discussed in Chapter 5, receiving information is a positive right, and the dentist should give it voluntarily. The decision of what to disclose, and in what depth, can be determined using one of three standards based on (i) the competent dentist, (ii) the reasonable or average patient, or (iii) the particular or specific individual (i.e., the patient).

What must be disclosed to the patient?

Based on these guidelines, there are certain details that should always be available to the patient and volunteered by the dentist, not merely given as a response to a question.

The first of these is the name and qualification of the person treating the patient – the dentist, student, dental hygienist, dental prosthetist, or specialist. Many dentists provide information related to qualifications, registration, membership of professional associations, university affiliations, and so forth on their reception walls, in pamphlets, or on websites. Should there be any possibility for confusion (multiple dentists, dentist/student, dentist/hygienist), clarification must be provided. The second set of necessary information pertains to the involvement of the patient in any research, or testing of new techniques or materials. Thirdly, the dentist should disclose any financial incentives or interests that he or she has that may be relevant to the treatment to be provided.

A dentist who suffers from any condition that interferes with delivering sound dental care should not proceed with the treatment. Disclosing the condition to the patient and gaining consent will not excuse any later mistake.

How much personal information should be disclosed to a patient?

Once all information that is necessary to the patient concerning treatment has been given, what about other, less publicly available information known to the dentist but not requested by the patient? Should lack of experience be volunteered? Many dentists (and students) find that telling a patient that "this is my first … ," "I am using a new … ," can be calming for the dentist. Patients tend to respect such an admission if coupled with reassurances, and they can choose whether to proceed or not.

Answering patients' questions

Patients have the right to ask any question that may influence their decision to be treated by a particular dentist. However, must the dentist provide an answer? What may be viewed in other circumstances as discrimination (such as preferences of gender, race, religion) does not apply to the patient in the relationship with a health professional. For cultural reasons, a patient may prefer a female dentist, or a person who speaks a particular language. A patient may request information about the health of a dentist or any past infringements on his or her registration. If the dentist or dental clinic is unwilling to disclose this information, they may indicate this to the patient and offer the option for the patient to transfer to another dentist or clinic. A patient may leave the practice if the response is not acceptable. This is the patient's decision. However, for the dentist to lie is not an option.

If other personal information is considered by the patient to be relevant in deciding whether to be treated by a particular dentist, a response should be given honestly, without exaggeration, and without manipulation to benefit the dentist.

Social conversation

Some dentists are happy to chat with their patients about family, holidays, hobbies, but others prefer to be more distant. The decision to engage in conversation is a personal one, and direct questions from patients about private matters can be diverted sensitively.

Dentists should remember that even though conversation may be two-way, some patients may feel unable to politely deflect personal questions that they find intrusive, or to respond with "none of your business." Polite social conversation to create a comfortable experience is fine, but it may be an invasion of privacy for a dentist to ask a patient for personal information that is not required directly for treatment.

It is unprofessional to discuss other patients or dentists – especially in a negative way – with the patient. Remember that any conversation with the dental assistant is also a conversation with the patient, even if the patient is not in a position to contribute.

Disclosure of errors

Almost every source of advice to dentists recommends that when a mistake, complication, or error occurs, the patient should be informed about it. Regardless of whether the patient is angry or resigned, finding out immediately from the dentist is much better, both for the patient and for the dentist, than being told later by someone else.

Patients are the ones who suffer the consequences of adverse events and have the right to know about them. The dentist has an obligation to tell the truth, and remaining silent is not ethically justified. In the past, some insurance companies encouraged a dentist not to admit fault, and dentists became defensive when faced with a mistake. However, it has been found that trying to find the correct words to tell the truth but not admit responsibility can be interpreted as evasiveness by the patient, who is better served by transparency, empathy, and an apology, followed by genuine guidance on what to do next.

Justice for the patient is served by restitution, which may take many forms, such as not charging for the treatment, replacing the dental appliance, or repairing the mistake. If the patient sues the dentist, compensation may be negotiated, or the court may impose a financial settlement. The difference between a complication in the course of treatment and an error (negligence/malpractice) on the part of the dentist involves legal interpretation, and laws differ. Dentists should be familiar with their local legislation.

Fitness to practice

Responsibility of a dentist

It is the duty of dentists to ensure that physical or mental illness does not impair their ability to provide their patients with a high standard of care. Impairment can be wide-ranging, from temporary to permanent, from specific to comprehensive, and from minor to total incapacity.

In instances of temporary, minor, or specific impairments, it is often possible to continue to practice dentistry with self-imposed exclusions or limitations. Short-term absences from the practice may be necessary in the case of illnesses or injuries. A readjustment of working conditions may be needed to cope with some chronic conditions (e.g., back pain can be managed by special seating, posture, exercises, and work breaks), and delegation or referral for some procedures may become the norm.

Some ongoing conditions that increase in severity over time may progress so slowly that the dentist is unaware of the increasing impact on clinical standards until there is the potential for serious concern. Some of these are related to age and others start with lower levels of a chronic condition, for example, reduction in visual acuity, loss of hearing, loss of dexterity, arthritis, depression, or burn-out.

Some impairments are more serious than others even though they may be less common. These include addictions and infections. Dentists who are intoxicated by alcohol or drugs (prescription or illicit) can put their patients at risk, especially since intoxication is frequently accompanied by impaired judgment, an inability to assess one's capacity, a denial of the problem, and an inclination toward antisocial or unprofessional actions.

Dentists are at risk of contracting infectious diseases as well as transmitting them, and some diseases remain on the notification lists of registration authorities. In the 1980–90s, human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) infections were often in the headlines. Infected dentists and other health professionals were excluded from practice in many countries. Over the decades, more became known about the transmission, treatment, and preventive practices, and universal infection control became mandatory. The professional future for HIV-positive dentists has improved. This history may be repeated with other new diseases. Some other infections that receive less media attention, such as TB and pertussis, influenza, rubella, and hepatitis, can be transmitted to and from dentists. It is important for dentists and staff to be immunized against known infections to protect patients and themselves – in some countries such immunization is mandatory. It may be argued that this violates the autonomy of the dentist and that universal infection control will be sufficient protection. However, this overlooks the duty of care to protect patients in the close and sustained contact of the dental practice. Dentists and staff have the freedom to seek alternative employment, but patients do not have the luxury of alternative care.

Dentists should be cautious of self-diagnosis and self-treatment and avoid self-prescribing. Maintaining a safe work–life balance and a network of colleagues will enable dentists to better manage their professional lives.

The reason that authorities regulate dentists is to keep patients and the community safe. Most registration authorities have guidelines to explain their legislation. Many authorities have moved from excluding an impaired dentist, to assisting the dentist to remain in practice under managed supervision and/or with restrictions, so that the dentist can return to full practice safely.

Peer responsibility, self-regulation, peer review

If a dentist is afflicted by an impairment (physical or psychological) that is impacting the quality of care, and it comes to the attention of a colleague, what should be done? Part of the response depends upon the relationship between the two dentists and the severity of the problem. The closer the relationship, the earlier an intervention can (and should) occur. Early stages of impairment can be easier to disguise from strangers, yet they are more readily treated if identified by friends or close colleagues.

Colleagues are reluctant to approach someone with personal problems and even more reluctant to report that person to the authorities. If a dentist is confident that the impairment is serious and not temporary, and is placing patients or others (including the impaired dentist) at risk, he or she has an ethical responsibility to act. The evidence, however, must extend beyond mere suspicion.

The best outcome is for the impaired dentist to be encouraged to self-report or to voluntarily seek treatment, but this is not always achievable. The reporting dentist should be aware of the laws covering such events. Some regulatory authorities have rules of mandatory reporting. If dentists knowingly permit patients to be endangered by not reporting an impaired registrant, they can themselves be subject to penalty. Some dental associations and authorities have facilities for voluntary and/or anonymous reporting of impaired dentists. They may also have a system of retraining or rehabilitation for the dentist in need. In some countries, defamation laws can be severe and may deter early reporting or the seeking of confirmation from other colleagues. There is also the social risk of the reporting dentist being ostracized. Nonetheless, it is a duty for dentists to protect patients from harm. In relation to behavioural misconduct: if you ignore it, it becomes the standard you are willing to accept.

Peer review

Peer review is a term in dentistry that can have several interpretations. In research and publication, it indicates a control that ensures reliability of the findings. In clinical dentistry, it may perform a proactive role in maintaining quality through regular and routine audits of skills and management of cases. This can be a way of ensuring individual and institutional improvements as well as early detection of problems. Clinical audits built into professional development activities will serve a similar purpose. Peer review can also be used to deal with an active problem, complaint, or dispute. A retrospective review can be one way of assessing the level of a problem or the type of intervention needed to prevent its recurrence. In a dispute between patient and dentist, peer review may include a mediation process.

Ethical codes of dental associations or societies

National associations, study groups, special interest groups, and specialist colleges offer dentists the opportunity to learn about and reflect on the norms of the profession. Many have a code of ethics developed to guide their members in appropriate behaviour. The criticism from outside dentistry (and sometimes from within) is that a code is only as effective as its governance and can be used to shield miscreants or the profession, rather than protect the patients.

How should dental associations manage violations of their codes of ethics/conduct?

There are opposing views on the way an organization can maintain the ethical standards of its members and manage those who violate its standards. The first method relates to the admission of members. Most associations have an open membership policy, where potential members apply and are generally accepted with the understanding (and commitment) that they will comply with the code of ethics. The alternative model is that members are invited to join and are vetted for suitability prior to the invitation. In dealing with unethical behaviour, open membership has the potential of having members who do not understand or conform to the accepted codes. The selected membership model risks overlooking unethical behaviour rather than admitting a failure of scrutiny or judgment. Neither model is inherently free from dentists who bend or break ethical principles.

If a member is guilty of serious ethical misconduct, there are two views about how an organization should act. One is that such members should be expelled. This works on the assumption that expulsion indicates to both the membership and to society at large that the code is upheld and that patients can trust members of the organization. However, this could be seen as a protection of the organization rather than the community, as it frees the violator from oversight or peer pressure.

The alternative view is that expulsion is a last resort and used only in the most extreme cases. Even in serious cases of misconduct, there is a view that an individual should be given the opportunity to learn and reform, and that most miscreants can be rehabilitated more effectively with the support of a professional network than on their own.

It is frequently found that those dentists who suffer incapacity due to drugs, alcohol, or mental illness are those who isolate themselves from colleagues. In handing down decisions in negligence (malpractice) cases, judges have directed health professionals to join a professional association for support and guidance. If the aim of a professional code is to protect the public, this aim could be best served by encouraging dentists to be part of a network of dentists where prevention or early intervention may be possible.

Teamwork and collaboration

As defined by the World Health Organization, collaborative practice occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings.

While this definition is broad, it serves as a reminder of the resources needed to ensure sound healthcare where people with diverse skills come together as a team. This discussion will focus on dentistry and oral health.

Collaboration

Dentists have long found that the support of a dental assistant (four-handed dentistry) and a dental technician are essential, and they have adopted teamwork as the norm. The stimulus for increasing the size and diversity of the team was a combination of increased disease and a shortage of dentists. Dental hygienists gained registration during the 19th century and have expanded their scope throughout the world. In the 1920s, New Zealand introduced a position called the School Dental Nurse. Since then, allied health professionals who treat patients directly have become widespread in dentistry and now include dental hygienists, dental therapists, denturists/prosthetists, and expanded-duty chairside assistants. Training, registration, and scope of practice vary across countries, but the dental team in most countries consists of a range of members with different but complementary skills.

Collaborative clinical practice extends beyond the dental team to include other health professionals, and also the nonclinical but essential support network of technicians, management, communication professionals, and community workers, as well as patients with their families, supporters, and friends.

Collaboration means a pooling of ideas, resources, and research and is based on an acknowledgment that everyone has specific expertise to contribute, and everyone has respect for others' contributions. The primary goal is to improve the outcome for individual patients, and the wider aim is to improve dentistry overall. Over the past century, measurable improvements have been made.

Collusion

One common theme across this manual is the effort to point out where unethical practices and unprofessional behaviour can damage or destroy an otherwise valuable activity.

Collusion occurs where two or more players, who are natural competitors, join forces to gain advantage over others. It usually involves an arrangement to defraud or deceive the marketplace and to distort profit or prices to the advantage of a select group. In most countries there are laws against collusion (also called anticompetitive practice).

Dental associations, dental schools, dental insurance providers, and dentists as a whole are sometimes accused of "collusive practices." One view is that the profession keeps prices and profits high by restricting competition. This is achieved, the charge claims, through strict registration requirements, by ensuring low student numbers (through limited places at, and high entry standards for dental schools), or by limiting the scope of practice for each category of health worker. These charges seldom reach the courts but are debated in the more public arena of politics and the media. Advertising is the exception. In various countries, the right of dental associations or regulatory authorities to place restrictions on advertising by dentists has been challenged in courts on the basis of restricting competition and free markets.

Some criticisms of collusion relate to the handling of dental complaints by indemnity providers, who are accused of colluding with dentists and dental associations to settle claims out of court to save money, restrict payouts, and limit damaging publicity.

When a dentist is ordered to be part of activities such as torture (either by direct action or indirectly by treating a victim), he or she is confronted with a serious moral dilemma. By not withdrawing, reporting, or criticizing such activities, the dentist may stand accused of condoning such acts. Dentists (with other health professionals) have been accused of colluding with authorities when they are involved in treating patients under duress, such as those in prisons, detention centers, or refugee camps.

Referral, delegation, and substitution: Why refer?

When a dentist lacks the skill or ability to meet an acceptable standard for a procedure, there is a duty to refer the patient. The person to whom the patient is referred may be another general practitioner, a specialist, or another health professional. The reason for a referral is to enable patients to receive dental treatment that is of an acceptable and appropriate standard for their needs. The duty to refer does not mean that a dentist must refer every extraction, periodontal or endodontic patient because the dentist is slower or less skilled than a specialist. If the standard is acceptable, a referral is not needed.

The difference between an acceptable standard of care and the best available standard is a decision that is made on an individual basis with an understanding of each patient's need. For example, a dentist may regularly restore anterior teeth that are fractured in accidents but may need a higher level of skill if the victim is a photographic model or an opera singer whose mouth or voice is essential in a career. If in doubt, the dentist should get a second opinion.

Rural areas and public health clinics commonly have limited access to specialists. If a dentist thinks that a patient should see a specialist, but access is not available, the dentist is not obliged to perform treatment beyond his or her capacity when it imposes a risk to the patient. Any decision to proceed should be made only after serious consideration and open discussion with the patient.

Choosing a specialist

How is a specialist chosen? Most dentists have a group of specialists whose skills they trust, based in part on evidence of successful treatment with previous patients. The dentist may have attended courses given by the specialist or may follow a colleague's recommendations. Many dentists will select a specialist who is located nearby. However, before referring a patient, the dentist should have some understanding of the specialist's ability.

Not all choices are without conflict. Pressure (subtle and overt) can be placed on general dentists to select a particular specialist. Loyalty to personal friends or to members of mutual groups (cultural or religious) or associations (professional, sporting, political) can place social pressure on the dentist. In some cases, the fear of reprisals, loss of reciprocal referrals, or ostracism can influence the decision. These fears should not take precedence over an honest assessment of the quality or skill of the specialist. Specialists may try to attract referrals by using gifts, splitting fees, or offering monetary inducements. Whatever the influence or inducement, the ethical duty of the dentist is to select the most appropriate specialist for the patient.

Third parties such as insurance companies, group practices, and corporate practices may dictate the choice of a specialist. In these cases, the dentist may have no alternative to offer the patient. However, if the dentist determines that a specialist is inappropriate, the patient should not be referred, and an alternative should be found.

Role of the specialist

The general dental practitioner is the primary caregiver for the patient. A specialist has a responsibility to return the patient to the dentist and inform the dentist of what has been done and of any further requirements. Professional conflicts may arise between the referring dentist and the specialist. Specialists complain when the referring dentist does not explain anything to the patient, or when the dentist tells the patient in too much detail what the specialist will do. Both these options place the specialist and the patient in a situation where differences in opinion are likely.

Quality of prior treatment

One complaint from specialists is that some dentists deceive patients about their own skill levels, and when problems arise, they delay seeking help from a specialist. Ethical problems arise when the specialist (or any other dentist) encounters substandard work, supervised neglect, or overservicing by a referring dentist. What should the specialist tell the patient? What should the specialist tell the dentist? Should the patient be returned to the dentist? What if the poor-quality work is not correctable by the specialty? Can a specialist refer the patient to another specialist, or must the patient first be sent back to the dentist? What problems require authorities to be notified? Each of these questions raises a possible debate.

Patients should be told of conditions that present an oral health risk. Any direct questions should be answered truthfully. This is an ethical requirement under the fiduciary duty of a health professional. Problems arise in responding to questions that call on the dentist or specialist to speculate on reasons, causes, or responsibility. Without understanding the circumstances or restrictions under which treatment was provided, or the compromises that were considered and accepted after discussion with the patient, it is impossible to be factual. On the other hand, not being transparent can appear as protection of the profession. If malpractice is established with certainty, the dentist or specialist has a duty to act ethically and legally to ensure that patient safety is maintained.

Patients and referrals: Follow-up

When a patient is referred to a specialist, the dentist has an ethical duty to follow up on the referral to see that the patient followed through, even if the patient does not return to the practice. This particularly applies in the case of referrals to medical practitioners and oral pathologists, where the failure of the patient to keep an appointment may have serious consequences. In some countries, follow-up is also a legal duty. It is important when discussing with the patient the reasons for a referral to include a discussion of the consequences of failure to attend.

Inappropriate referral requests

Some patients will ask for referrals based on their exposure to advertising, TV programs, and the internet. When the request is not necessary or appropriate, the dentist should explain why, but if the patient persists, should the dentist refuse? There are two situations that may influence the dentist's decision. The first is where the patient is paying directly for the specialist visits, and the second is where the patient is not paying.

If the patient is bearing the cost of a second opinion by a specialist, and the dentist has explained that it is not necessary, there is no justification for withholding the request. Where children are involved, such as requests for referral to pedodontists and orthodontists, some parents are not reassured by a general dentist and are happier paying for an early referral, even if it is unnecessary.

In a public health clinic, dentists have a dual responsibility to treat the individual patient and to serve as a gatekeeper to manage expenses. Inappropriate referrals within the system may result in a wasteful use of limited resources and a shortage of funds for necessary patient care, or they may extend the waiting list for specialists to an unreasonable extent. The patient can be told of the policy and be given the opportunity to receive a referral outside the system should they wish. (Ethical decisions in public health are covered in other chapters.)

If a referral is required for reimbursement of specialist fees for patients with dental insurance, and the general dentist believes that the referral is inappropriate, what should be done? To provide a referral may place the dentist in a difficult position should the insurance fund mount a challenge to the need for specialist care, but to deny a referral risks violating the patient's wishes. The dentist's prime responsibility is to the patient.

When a patient requests a specialist who is not known to the dentist, the dentist has a responsibility to find out more about the specialist before completing the referral. In the situation where a patient requests a specialist whom the dentist knows to be a poor choice, the dentist should not criticize the specialist but find a way of deflecting the patient from this choice. If there is a strong reason for not referring the patient to this specialist, the dentist should not do so.

Patient responsibility

Patients also have responsibilities in the referral system, and both referring dentists and specialists complain that they are placed under pressure by some patients to defraud the health system by exaggerating the need for specialist care, by asking for backdating or padding of accounts for insurance companies, or by being asked to falsify medical certificates. The correct response is to refrain from participating in these activities. In some clinics, this problem is frequent and often upsetting in nature. Some practitioners have found a solution by placing a sign in the reception area stating that such requests will be denied.

Delegation

Delegation differs from referral in that responsibility rests with or is shared by the original dentist. When a referral is to a specialist, the responsibility for the standard of that specific treatment is transferred. Delegation to another dentist is similar to referral to a specialist, except that the dentists are equally qualified. Delegation is frequently to dental hygienists, but can also be to other oral health auxiliaries or students. The original dentist must oversee the quality of the treatment and in many instances is liable for errors – individually or jointly – depending on legislation.

Substitution

Role substitution involves a member of the dental team undertaking a task that is usually done by the dentist. This is done under the direction and with the approval of a dentist and is subject to local laws. The reason is usually cost and efficiency. A dental hygienist may undertake a routine examination and report to the dentist, a dental assistant may remove orthodontic wires, or take impressions. It has been found that patients do not often understand the specific role of each team member, but trust the dentist with the overall responsibility for their treatment. This does not mean that they should not be informed of who is providing clinical procedures. This responsibility places an added duty on the dentist to be aware of the nature and quality of the work done.

Leadership

The number and variety of individuals who are routinely involved in the dental treatment of a patient is growing. With referrals and delegation, patients and oral health operatives can lose track of who is coordinating the treatment. It is imperative that one person is responsible for knowing what is happening with the patient overall and for gathering all the details into one file. This person should keep the patient informed of the various results and make sure nothing is overlooked. In most cases, this is the general dentist. The mobility of patients geographically places additional responsibility on dentists. Coordination and mobility are two issues that will become increasingly problematic in the future. While patients must take some responsibility for keeping track, dentists should find ways to facilitate continuity of care, such as written reports and summaries for the patient.

Emergency dental responsibilities

A dentist has an obligation to care for regular patients and to respond to their emergency situations, either personally or through a roster of cooperating dentists. Postoperative incidents can often be anticipated, but beyond that, dentists do not have many unanticipated after-hours emergency calls from their regular patients. Indeed, regular patients are often reluctant to disturb their dentist and choose to wait until working hours, if at all possible (see Chapter 4).

In this section, the discussion will be limited to interactions with strangers or people to whom the dentist is not professionally committed.

How do you deal with people who are not your regular patients but need help outside normal working hours or when your practice is unable to accommodate them? Is there a point at which a dentist may deny emergency care for personal reasons? There is a professional obligation (discussed earlier as a social contract) to go beyond the individual relationship where you are available for those who need help. Given that few dental emergencies are life-threatening or need immediate attention (as opposed to medical emergencies), a roster of dentists or practices can deal with most cases, or the patient can be directed to a hospital or public clinic for after-hours palliative care or treatment.

Neither of these options may be practical in small towns with only one or two dentists, and the dentist needs to be careful not to become overloaded with after-hours work.

After-hours emergencies

There are times when a person who is not a regular patient but is in pain contacts a dentist. While the initial reaction is to offer help, this may not be in the best interests of the patient or the dentist. With experience, a dentist can ask questions over the phone to triage the type and severity of need and sort out those who need immediate attention from those who can wait until the next day.

If dental equipment is needed to provide temporary treatment, the dentist should pause before agreeing to treat the person. Is a chairside assistant necessary to ensure safe treatment of the patient, to be a chaperone or witness, or to provide additional security for the dentist? If so, is an assistant or substitute available? Is there any barrier to providing acceptable treatment, such as using untrained assistance or having none at all, having consumed a small amount of alcohol, extreme fatigue, and so on? Disclosure of such issues should be made to the patient, consent obtained to proceed, and then documented in the records. The treatment undertaken should only be that which is needed to maintain the patient in comfort for the short term. It is important that if the risk to the patient or the dentist is greater than the risk of recommending palliative care, the dentist should not proceed.

A dentist needs to maintain a healthy life–work balance, and this is especially so if there is no other dentist to share the load, as happens in small towns. Opening a clinic, whether for one patient or a whole day, takes time, both for setting up and for shutting down. A simple half hour of treatment can be extended by an hour or more with setting up equipment, turning on compressors and computers, following infection control protocol, and then closing down. While it may be a difficult decision to deny treatment to one patient, excessive fatigue or stress due to overwork will not be in anyone's interest in the long term.

Dentists who are being frequently called out after hours should examine why, and modify their work pattern to ensure only genuine emergencies are treated. Are other dentists refusing to see the patients? Have you got a reputation for being available to patients as the first call? Do local pharmacists or doctors recommend you because others make a fuss and you don't? Do you screen patients adequately over the phone? Are you using your ready availability to build a practice or increase your income? Offering unlimited hours of treatment for nonurgent cases may lead to compromising the treatment of others.

Good Samaritan emergencies

Is a dentist obliged to act as a Good Samaritan when accidents happen in public areas or at social events?

Suppose a person suffers an avulsed or mobile tooth due to an accident, and a dentist is nearby. In most countries there is no law requiring a *duty to rescue* on the part of the dentist. However, to identify oneself as a dentist and to offer assistance is the humanitarian response, and society needs people to help others in times of accidents, sudden illness, or in natural or human-made disasters.

In recognition of the technical problems of first aid in compromised conditions, most jurisdictions have some type of Good Samaritan legislation to cover the actions of those who offer aid. Most provide legal protection for mistakes that may happen, and the dentists will not be sued. Others take into account the conditions when determining the standard of care in negligence litigation.

The two ethical principles of beneficence and nonmaleficence (do good and do no harm) are relevant here. Every effort should be made to gain consent consistent with the situation and provide only limited essential help until full consent is obtained. If the dentist has been drinking alcohol, is fatigued, or is otherwise impaired, the dentist has an ethical responsibility to realistically assess his or her physical or mental state. Consent, even with disclosure, does not dismiss professional responsibility.

Concluding remarks

As can be seen in this chapter, it is not always easy for a health professional to strike the right balance between supportive, empathetic, and patient-centered care, and maintaining a professional distance that supports objectivity. However, by acting professionally and ethically at all times, this elusive balance can be found and can lead to a practice that is rewarding and professionally satisfying.

This chapter was written by Suzette Porter

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Chapter 9:
The impact of business on dentistry

Summary

Most dentists work in what could be defined as small businesses. The patients pay for their services, and the dentist has to make an income after paying for the overhead expenses. A dentist also has the ethical duties and obligations of a professional, in particular the duty to place the interests of the patient first. While this is a simplistic summary, these dual roles – as a professional and as a businessperson – can introduce potential ethical conflicts.

Introduction

This chapter introduces some of the complexities in managing the business/professional relationship and presents some of the concepts that are challenging the profession in defining what it is to be a dentist who both upholds ethical principles and whose practice remains profitable. Some of these questions include the following:

- Dentists face multiple conflicts of interest. How can they identify what will present a conflict, and how can they deal with the issue?
- Both professions and businesses can function ethically, but they may still differ in the manner they approach key values. What are the differences?
- Dentists need to place the interests of their patients first, but third parties are increasingly making this difficult to achieve. How do dentists deal with both patients and third parties?
- Dentists are turning to business advisors to help keep their practices financially viable. Some of the suggestions presented to improve the commercial side of the practice cause dilemmas for dentists in ensuring that professional behaviour is not breached.
- Regulators define the scope of dentistry broadly to ensure innovation is not stifled. In a desire to offer a wider range of services, dentists look beyond traditional dental treatments. Is this ethical or acceptable?

Conflict of interest

Conflict of interest (COI) is having a dual loyalty, responsibility, or accountability in which unbiased or independent decisions are compromised because of overlapping pressures.

Having a COI is not unethical per se, but it opens the potential for unethical behaviour. The reputational damage caused by a perception of misbehaviour due to a COI can be as severe as for actual misbehaviour.

The expectation of society is that such conflicts will be removed or disclosed, but this is not always possible or practical. While patients may not be aware of some conflicts, dentists should be sensitive to the possibility of being compromised. When roles overlap so that a dentist can no longer make an independent or unbiased decision with regard to the patient, he or she must step back and relinquish one of the roles, either that of treating dentist or the other role that presents the conflict.

COI is mentioned throughout this manual, so this section will concentrate more closely on those conflicts that arise through commercialization of dentistry and the interaction between dentistry and business.

Personal interest versus patient interest

Self-interest can take many forms. As one example, a dentist may bring personal interests to bear in considering the available options for a particular treatment. In other examples, students may be tempted to bias their advice toward procedures that meet quotas, and clinical supervisors may recommend that a student replace a procedure with a quicker one to finish the clinic session on time. Dentists experience both predictable and unexpected events that require choosing between personal and clinical priorities. If the events are likely to be regular, the dentist should make suitable plans (not making appointments for complex work at the end of a day if children need to be collected from preschool, or factoring in a buffer time to accommodate phone calls for committee work). If the unexpected occurs, rescheduling or rearranging the sequence of the treatment plan is preferable to selecting a quicker but poorer treatment option.

Public versus patient interest

- **Rationing:** Balancing the needs of a community or group of patients against an individual patient is more challenging. Most public health clinics would collapse both financially and under the weight of waiting lists if all patients were given equal access to limited resources. Dentists involved in designing the guidelines for the distribution of certain options have trouble deciding what is appropriate to include and who should receive what. Dentists treating individuals are torn between the real person in the dental chair and the group of people on the waiting list. The final outcome rests with the judgment of a dentist in striving for a just distribution.
- **Reporting:** Should a dentist be required to report incidents that become known in the course of confidential discussions such as child abuse, domestic abuse, infectious diseases, child pregnancy, drug abuse, or other such problems? Whether there is mandatory or voluntary reporting of these problems, a tension between confidentiality and disclosure is created. (This has been discussed in Chapter 6). Dentists may not report suspected, or even confirmed cases for fear of making a mistake or for fear of social or financial repercussions to themselves. A sobering check in each case could be to ask oneself the question, “If I do not report this suspicion, can I accept some responsibility for an adverse future event?”

Third-party interests

Ethically, and under most laws, the dentist treating a patient holds the primary responsibility for that patient’s care. However, third parties have an increasing influence on clinical decisions or, at least, have the potential to place pressure on dentists. The two most frequently encountered third parties that intervene between a dentist and a patient are employers (public or private) and insurance companies or health funds. A third category, institutional interests, includes those patients who are under the direct control or protection of a facility, such as prisons or other institutions.

Employment

For an employed dentist to enjoy full autonomy in dealing with patients is becoming rare. Restrictions or demands placed on the employed dentist (including self-imposed loyalty) can mean that the dentist may have to decide between the best interests of a patient or the employer. A practice manager or owner may outline what treatments or materials are precluded, limited, or preferred. Many materials have acceptable alternatives, but to compromise quality, such as by using products with expired dates or from dubious sources, is unacceptable. Any universal directives for treatment are not based on knowledge of a particular patient. When the treatment is unsuitable, the appropriate action is to explain the situation to the patient and offer a referral to a practice that can handle the patient’s needs. If this is forbidden by the rules of a clinic or other facility, the ethical decision becomes a serious one that goes to the core of the dentist–patient relationship.

Most practices have specialists, hygienists, and technicians either as staff or on a preferred list. This does not necessarily cause a problem, as those chosen may have been selected based on their proven expertise (and confirmed by the dentist making the referral). Conflict with the practice can arise if there is a financial incentive to select such a person from the list or if either the dentist or the patient has a strong desire to choose an alternative to the person on the preferred list.

Chapter 8 discusses the referral or delegation of patients to other dentists in greater detail, but the final decision is the responsibility of the referring dentist in discussion with the patient.

The methods of paying employed dentists can exert subtle or overt pressure on the way these dentists treat patients. Receiving a percentage of fees may tempt dentists to offer more expensive or more profitable procedures, or may tempt the dentist's employer to retain these procedures and give the dentist the less lucrative ones. The employees may find themselves with blocks of unfilled time and be tempted to overservice those patients whom they do see. Fixed salaries or hourly rates may reduce the stress of variable income, but employers then complain of lower productivity.

Insurance

Scarcity in the public sector and money in the private sector are considerations in many treatment plans. When necessary, compromises can be reached, and arrangements such as extended payments or staged treatment implemented. Involvement of insurance and third-party payment schemes introduce a greater risk of COI. Ideally, these schemes should be arrangements entirely between the patient and the third party. There should be no clinical restraints on the patient or the dentist, and the dentist should clearly explain that payment rates are based on actuarial or commercial principles and not on clinical costs. Clinical decisions would remain a discussion between dentist and patient. However, the ideal is rarely the reality, and dentists say that the pervasiveness of third-party payment methods means that they cannot be ignored. To overcome third-party constraints (perceived or real), some dentists resort to unethical behaviour and make the situation worse for other dentists. There are several issues that may cause conflict or confusion.

- **Choice:** If the amount reimbursed by insurance and other third-party payment schemes is linked to a preferred provider, members of the scheme accept that their free choice of dentist is removed. Dentists may have to decide between joining a scheme and losing autonomy by restrictions placed by a third party, or losing patients who are members of a scheme.
- **Reimbursement:** Regardless of any small print, patients will often assume that the rate of reimbursement is indicative of the clinical costs and that dentists are overcharging if there is a gap between the reimbursement and what the dentist has charged. Patients, and sometimes dentists, have difficulty understanding how the reimbursement amounts are calculated.
- **Restrictions:** The contract may define frequency of visits, total reimbursements per year, need for permission to undertake a procedure, and family inclusions or limits, resulting in restricted flexibility of both patient and dentist. In response to these restrictions, dentists sometimes deliver treatment (or patients demand treatment) based on insurance payment timing for procedures such as recalls, frequency of radiographs, or periodontal visits, without considering clinical requirements. The result can be overtreatment or undertreatment. Patients may also be misled into thinking that the insurance-determined timing constitutes standards for best practice.
- **Ethical challenges:** There is pressure to maximize the returns from such schemes. Patients want a dentist to provide details that will recoup the maximum refund possible. Dentists know this and are sometimes tempted in *worthy* cases to satisfy the patient by selecting code numbers to inflate the invoice and give maximum return, adding extra item numbers but not doing the treatment or falsifying dates or names on invoices. Whether requested by the patient or not, and whether written up by the dentist or receptionist, these actions are unethical and amount to fraud.

Institutional influence

Prisoners, people in detention, vulnerable people with mental health problems and others can have their access to health and dental care controlled and monitored by a designated authority in a secure facility. Whether the dentist is employed directly by the authority or not, there are rules and restrictions placed on them that may seem to impose unnecessary restrictions (especially on autonomy and confidentiality) but are based on experience within the facility and designed to protect the inmate, the dentist, and the other staff. It is recommended that dentists working within such facilities get advice in order to understand any specific ethical requirements.

Research

Chapter 11 provides a detailed review of the ethics of research. Practicing dentists can also encounter ethical problems that arise from research.

Companies that fund research or purchase patents following successful research need to make a profit. They will target dentists with marketing activities devised to enhance product recognition and to sell their products. Some promotion tools include gifts, conference trips, samples, lectures, and payment to give lectures or payments to support the product by recommendations. When any monetary value of the promotion exceeds what is moderate, warning bells should ring. Dentists should remember that these activities have a commercial purpose, and they should always seek independent information about claims, suitability, and effectiveness before using or prescribing products. Reputable scientific journals require disclosure of a potential COI, but this is not always required by other publications. The lay press, the company's website, or general internet searches are not reliable sources of independent advice about dental materials, pharmaceutical products, or procedures.

Education

Dental schools are always in need of more funds. Seeking grants from companies that have an interest in selling products, materials, and equipment to dentists or their patients is routine and mutually beneficial. Companies know the impact of implied endorsement that is tied to seeing their name or their product in a dental school. It is also well known that dentists, particularly recent graduates, favor using what is familiar to them from school.

Administration and financial departments may be provided with personal gifts or inspection visits to overseas factories. Faculty and teachers may be targeted with funds for research support, paid lectures, attendance at conferences, publication opportunities, gifts, samples, and so on. This promotion is only an ethical problem if it is excessive or is not disclosed openly, if it consciously or subliminally hinders independent decisions or if it requires payback.

Students are frequently the target group for promotion, and they actively seek sponsorship for their activities. Supporting their sporting or social activities, providing guest speakers and lectures, assisting with educational materials and handouts, providing gifts, samples, products such as electric toothbrushes, and awards are rich opportunities for promotional activities. Students are familiar with commercial advertising techniques but are less experienced in professional ethics. They are more inclined to want to reciprocate or show gratitude toward these sponsors. It is the responsibility of educators to guide their understanding of COI and how to maintain a balanced ethical approach.

Dealing with COI

COI is contained most effectively with honest and open disclosure (to oneself and to others). As already mentioned, it is not easy or even practical to remove all COI situations. Indeed, it is often difficult to separate what amounts to COI from the normal and varied interactions of people. Being aware of mixed obligations, even potential ones, is a start. Understanding and awareness that influences may impede the relationship with patients is essential. If a potential or actual COI exists, such as using a product and being sponsored to present a paper by the distributor of that product, a clear and transparent disclosure should be made. When a deal is offered that is 'too good to be true,' it should be rejected. And finally, when the COI is such that an objective and unbiased relationship with the patient is not possible, a dentist must decide whether to sever the relationship with one or the other party.

Professional versus business ethics

Dental practices are usually owned and operated by dentists. However, it is becoming more common for dentists to be employed in practices owned and operated by corporations or individuals who are not dentists. When small practices are sold, the buyers are often not dentists, or are dentists in combination with nondentists. Tension can occur for dentists in negotiating between the management styles of commercially oriented business managers and those used by health professionals. As with many conflicts, the reason is not so much the differences per se, but the lack of understanding of those differences and how to reconcile them.

Common ground

Businesses and professions both seek to be seen as ethical participants in society, and one of the distinguishing features of ethical participants is integrity.

Many businesses function and thrive as commercial enterprises while at the same time displaying integrity and altruism. Indeed, much ethical behaviour – honesty, sound dealing, unbiased advice, integrity, responsibility for actions – is consistent across both businesses and professions.

Integrity is being honest, accepting accountability, and having a moral compass that directs one's actions. Integrity is the foundation of ethical businesses and is consistent with professional behaviour. It includes:

- Veracity – being truthful, not withholding information, sharing important information, and not using knowledge as a means of control over others;
- Making commitments and fulfilling the stated or implied promises;
- Not taking advantage of others or seeking to profit at their expense;
- Refusing to be involved in corrupt activities;
- Refusing to succumb to inappropriate pressure or influence.

Two people can hold different opinions and subscribe to different philosophies, such as private versus social healthcare, but can acknowledge that each is acting with sound intentions.

Differences

The differences between professional ethics and business ethics are best illustrated by the way that each approaches three concepts: obligation, training/skills, and relationships.

Obligations

In both professional and commercial enterprises, there is a need to remain profitable. Neither group has a requirement to do so at the expense of others. Dentists as professionals have obligations both individually and collectively that extend toward patients and the wider community. Two of these obligations may differ from business – putting the interests of others before self, and having responsibility and authority for the overall standard of the profession. Commercial interests do not have the same ethical obligation to act in others' interest but have an ethical obligation to refrain from harming others by coercion, cheating, or fraud. Altruistic activity is optional for commercial enterprises, but is considered to be part of professional obligations.

Training and skills

Dentists may see their training and skills as being facilitated and supported by the community to benefit patients, which means that there is a duty to maintain and improve those skills. Patients trust dentists to maintain acceptable standards. In business, any skill or expertise is seen as a commodity to be used by the provider in competition with other providers. The consumer has an interest in selecting the best quality or getting the best deal so that superior skill or expertise is promoted to gain the competitive advantage over other businesses.

Relationships

The relationship between dentists and patients is an open commitment based on trust that a dentist will help the patient to place his or her interests first, and be unbiased and honest. In the collaboration between the two, the patient trusts that the dentist will not take advantage of an unequal situation.

Businesses rely on defined contracts, where the rights of the consumer exist only as outlined. It is the responsibility of the consumer to understand the details of the contract, as both the business and the consumer have open self-interest in the negotiation. The consumer is advised (including by ethical businesses) to seek a second opinion on any important contract.

Dentistry as a business

Dentists run small businesses. Patients pay for treatment (with or without subsidy), and the dentist pays for the expenses of managing and improving the practice. The remaining profit becomes the dentist's income or return on investment. There is always a risk that a dentist with a weak sense of integrity may resort to unprofessional behaviour to make a larger profit or even just to remain solvent. While a dentist needs to adopt sound business principles to stay viable, this should be done with attention to ethical and professional rules.

The need to make a profit has supported a rise of management consultants focusing on dentistry. Frequently they preach the methods of business by substituting *dentist* for *widget seller* without examining how business practices should be modified to incorporate professional behaviour. They measure their success by the increased financial gain of the dental practice. One of the errors most frequently made by these consultants is to overlook any social responsibility that professionals have and emphasize the responsibility to the shareholder. The social duties are not seen as essential elements in the professional business mix, but as a *luxury* or publicity tool. They also ignore the importance of professional collaboration and emphasize competition between practices. As few dental schools incorporate business ethics or business principles in their curricula, graduating dentists are often naïve buyers of management consulting services. They are vulnerable to adopting activities that are unprofessional without critical appraisal.

Marketing

Marketing combines advertising and promotion, where advertising gives information and promotion uses techniques to encourage the choice of one practice over another. For the purpose of this section, they will be used synonymously. An entry in the local phone book stating name, qualifications, address, phone number, and opening hours, with a similar sign in the clinic, is advertising at its most basic level and is necessary for both current and potential patients. This is the only advertising allowed for dentists in some countries.

Critics of marketing activities say that they are deceptive, they create unnecessary demand for products or services with subsequent waste, and they manipulate consumer needs to suit profits. The following are some potential pitfalls in maintaining professional standards of behaviour in marketing activities:

- **Deception:** Outright untruths in advertising are unethical and often illegal, but it is possible to mislead without actually lying. An advertisement that uses creative narratives, digitally enhanced photos, or exaggerated claims can be misleading and therefore unprofessional. Providing oral health information to promote health education or explain treatments is acceptable and encouraged. Oral health pamphlets for use by dentists are often available from health departments or dental associations. These are useful for information and as an aid to communication. Unprofessional advertising, on the other hand, includes information that is biased or presented in a way that states or implies that the dentist is superior to other dentists.
- **Expectations:** Neither the patient nor the dentist can decide what is appropriate treatment

without an individualized discussion, including an examination. Advertising is good at outlining what is available by giving information about alternatives, comparing and contrasting, and introducing new concepts and ideas. However, advertising can also create a desire for something inappropriate or stimulate dissatisfaction with something that is perfectly normal. In the case of a susceptible personality and a persuasive advertisement, a patient may expect an outcome that is not possible.

- **Inducements:** Publicizing discounts, promising gifts, inducements, or rewards in return for becoming a patient or for referring a new patient have the potential to interfere with the rational approach to choosing a dentist. It also introduces a potential COI in paying existing patients to solicit for clients. An honest recommendation from a satisfied patient will stimulate confidence, but doubts are generated when the recommendation is not seen as freely given.
- **Social marketing:** Dentists are usually respected, educated, and affluent members of the community, and social obligations are part of being a professional. Dentists are approached to join or support many organizations, such as the local school, sporting clubs, scouts, the opera society, and charities. Their generosity is acknowledged in newsletters, local papers, certificates, and such. These acknowledgments – within reason – are not seen as unprofessional.
- **Tastelessness:** One complaint against advertising is that it is tasteless. Although ethics and professional behaviour are not identical, they both relate to morals and values. The value in professional behaviour is that it upholds the serious nature of the contract between professions and individuals within the community. Anything that subjects the profession to ridicule or scorn is to be avoided. This may mean that extremes of humor or taste are tempered. Advertising should be free from anything that is vulgar or offensive. The content and the style, whether serious or light-hearted, should not reduce confidence in the profession. Even though manners, fashion, and style reflect cultures and age groups, advertising should aim to be universally acceptable.
- **Keeping up with others:** Advertising is pervasive, in part because business management consultants insist that one must advertise or fall behind. Advertising is expensive to design, and costs increase with the complexity of the advertising platforms. For some practices, there is little or no increase in patient numbers from advertising beyond that achieved by simple basic notices with word-of-mouth referrals. It is time-consuming but essential that the advertising content and standards are reviewed by the dentist and not left to marketing experts. There is a common view that good dental advertising should minimize any promotion of the dentists themselves and maximize the presentation of unbiased clinical or health-related information.

Social media

Emails, text messages, and the use of social media platforms have all but replaced letters and have reduced the number of telephone conversations. The speed and immediacy of current communication has benefits, but the time taken to reflect on the content of messages may become a casualty. There is also the loss of privacy and the chance for errors in distribution. Having a permanent record and an ability to reach many people can be seen as both an asset and a potential problem with electronic communication methods. Third parties are able to search for data on social media, use facial recognition, assemble a profile, and map opinions. Employers and patients can find out personal information to form opinions of current or potential dentists.

Due to the fact that social media platforms have only become mainstream in the past couple of decades, the professional implications of using digital communications are still evolving. Here are a few of these implications:

- **Privacy:** Confidentiality is breached when identifiable information about a patient is disclosed. Dentists may discuss patients in good faith for the purpose of getting advice, in teaching, and as part of referrals, as long as the exchange does not identify the patient unnecessarily or widely. Social media exchanges between professionals, however, carry the risk that patients may be identified unintentionally because of electronic media's wide and unconstrained reach.

- **Breaking rules:** Countries require dentists to register to practice, which makes them subject to the local regulations. The global reach of social media can mean that advertising, treatment advice, seeking patients, and so forth can cross jurisdictions, and it is impossible to keep this from happening. Dentists may find themselves in contravention of some rules in jurisdictions other than their own, and regulators are yet to establish satisfactory methods of handling such situations.
- **Personal versus business:** Marketing experts see a rich potential in using social media to promote a dental practice. Ethically, the same rules apply to social media as to other professional activities, with particular attention needed to be paid to issues of privacy, accuracy, transparency, and keeping public trust. When social media use is regarded as just another practice management procedure, it is easy to overlook its wider implications. If patients join the social network, material that should not be shared publicly may be circulated widely and out of the control of the dentist.

  Patients, for example, can exchange their feelings about a dentist or a clinic freely and widely and can join ratings sites to add a testimonial or a complaint. They can share information that a dentist gave them, with the risk that errors will occur in their interpretation. They may say that a dentist is a specialist with no basis for the claim. Most regulators and associations acknowledge that there is a limit to how much a dentist can control or amend information when posted by others on social media, and they warn against soliciting or paying for testimonials or resending comments, all of which could be seen as active participation and treated as an infringement of ethical codes.

  Family and friends use social media as part of everyday communication. However, when the user is a dentist (self-identified or noted by others), the profession may become implicated, especially if something is reported in the press and the dentist is accused of bringing the profession into disrepute. There are instances where individuals have been targeted, hounded, and even dismissed for expressing views (e.g., political) or actions (e.g., game hunting) that they posted on private sites. Social media sites create a blurring between the private and public worlds.

Extending the scope of practice

Continuing education is universally encouraged and often mandatory, and it ensures that the innovations undertaken by dentists are supported by science and training. Authorities that define the scope of dental practice tread carefully between having a definition that is broad enough to permit innovation, yet narrow enough to ensure public protection. They require a dentist to be competent and have sound training and experience before undertaking a new procedure. Whether an activity is not professional dentistry is sometimes difficult to determine, and the definition of professional dentistry will vary between generations and cultures.

The impetus for expanding the activities undertaken by a dentist is to be found in the cities within wealthy countries where dental disease has diminished, the number of dental graduates has increased, and dentists are reluctant to leave urban private practices. These dentists look for new ways to attract patients and fill their appointment books. Conversely, in the public sectors and rural environments, there is an increase in disease and shortage of dentists. In these areas, the current scope of dentistry provides more than enough opportunity for professional stimulation in range and variety of disease.

This section will consider innovations in dental practice that move beyond the use of new materials and techniques and consider those that introduce new concepts.

Cosmetic dentistry

Esthetic and cosmetic dentistry are terms that are sometimes misused as synonyms but have different purposes.

Every dentist who performs necessary treatment aims to restore health and function and to do so in such a way that the resulting appearance is generally acceptable by society. Orthodontics, restorations, implants and so forth are used to improve the appearance of patients that is considered outside this norm because of accidents, disease, or genetics. This application of esthetic dentistry is an integral part of the scope of dentistry.

Cosmetic dentistry, on the other hand, starts with an appearance that is acceptable (and indeed may be attractive) to many people. The dentist then changes the dentition to a preconceived sense of beauty dictated by individual taste or fashion trends. Under this definition of beauty, exaggeration of features can challenge natural function or form. The span of a fashion may be short, and its concept of beauty may be disputed. Whereas esthetic dentistry is part of the repair process (e.g., one or two veneers over teeth darkened by accident or disease and matched to the surrounding teeth), cosmetic dentistry can destroy sound structures (e.g., veneers on multiple healthy teeth to create a wider and whiter smile).

Dentists are trained to discuss oral diagnosis and treatments that are needed to repair damage. The discussions needed for cosmetic changes should be more detailed and are more complex. They include advertising, magazines, and TV makeovers supported by celebrities. These promote the current idea of beauty. If patients aspire to change their appearance, can they describe what outcome they expect, and can the dentist really translate this image into a result that meets their expectations? Can the procedure be reversed if fashion changes?

The dentist should try to determine the real stimulus for change. Is it to fulfill a personal desire for a different appearance, or does it include additional goals, such as social or career success, to satisfy a partner or friend, to achieve happiness, or because of a personality disorder? Can the dental procedures alone achieve these goals?

Dentists should resolve these questions, or refer the patient to someone who can resolve them, before agreeing to extensive cosmetic changes. Achieving technical perfection may not be enough to satisfy the patient’s expectations. Temporary satisfaction may change to subsequent disappointment or buyer’s remorse that can leave the patient worse off than before.

If someone else is paying, the dentist may need to satisfy both parties. Does the treatment conform to insurance requirements? Is a partner or parent the stimulus for the visit or just paying the fee? Are the dynamics of the relationship between the patient and the partner or parent influencing clinical decisions?

Most dental treatments carry the risk of iatrogenic damage, a risk that must be weighed against the benefit of treatment and the risks of doing nothing (discussion of which is necessary for informed consent). If there is no clinical or health benefit from a procedure, the proper balance of risk and benefit is more difficult to determine. Few would condone the extraction of a healthy tooth, but some people ask for removal of posterior teeth to give an appearance of high cheekbones. If the dentist accepts the patient’s request just because the patient might go somewhere else for treatment, the dentist is making a financial decision, not one based on health concerns.

Patient autonomy is an issue in cosmetic dentistry. On one hand, autonomy is served by allowing the patient to have the final decision. On the other hand, dentists can use their expertise to provide information and advice and help patients make decisions based on the best fit with their needs. To proceed, then, is a shared decision, and either the dentist or the patient can withdraw.

There are sensible ethical precautions that should take place when the desired cosmetic dentistry is extensive. Given that dentists are not always trained to understand personality disorders, it is wise to proceed in stages. A simple whitening process can be started before embarking on removing sound tooth structure. Tooth jewels can be attached with adhesives that can be removed later. Less permanent or less invasive options can be undertaken for many other common requests.

When it comes to treating disease, patients and dentists jointly determine what is a successful outcome and collaborate in achieving it. For cosmetic (elective) treatment, the patient acts more like a consumer in that they have a predetermined idea of what constitutes success. However, dentists should not exaggerate or let the patient form an exaggerated opinion of the expected outcome. Patients should be given time for reflection. Another precaution is to keep accurate and comprehensive records, including good photographs of all stages.

Nontraditional procedures

The dental profession has achieved success in caries prevention and early intervention. It is suggested that dental training could include routine screening for other abnormalities, particularly of the head and neck, during the regular dental examination. Examining lymph glands and the soft tissue of the mouth for early signs of abnormality is currently normal practice. Extending training to identify other abnormalities, such as skin cancer, melanoma, diabetic testing, and so on, may be a useful public health service. Dentists have also assisted in health promotion activities, such as water fluoridation, smoking cessation, reduction of sugar consumption, dietary counseling, and relaxation techniques for pain or anxiety. Such activities arguably fall within healthcare and would be under ethical conduct requirements similar to those of traditional dental practice.

Other activities may stretch the definition of what constitutes treatment of the orofacial area and would raise ethical issues. The following are examples of procedures that have been reported. Many are unethical, some are quackery or are illegal, and others are open to debate.

Unproven treatments

Dentists should always try to use techniques that have strong scientific evidence to support them and are appropriate for the patient. However, parents of young children and people in pain are often willing to try anything, especially if recommended by a dentist. There is an increasing popularity in some practices, for example, to routinely recommend a frenectomy to improve suckling in newborn infants, even if there is no proven need, and the dentist has not undergone special training in treating neonates. Advertisements for expensive but unproven treatment for temporomandibular disorders abound and target those who are in pain. Snoring devices, sleep apnea treatments, devices for clicking joints, and many others have been promoted by dentists who want to turn a skill that may be useful for some people into the latest profitable fad, recommended for all.

Unconventional treatments

People who are worried about poisons, pollution, or nonchemical cures are attracted by alternative procedures such as using urine analysis to justify removal of amalgam restorations, amalgam/mercury detoxification, allergy testing, using homeopathy to prevent or cure caries – treatments that reinforce their concerns or philosophy. Some dentists market such services as a new or alternative science. In a similar vein, some dentists and others use quasi-science to deny the effectiveness of fluoride, vaccinations, or endodontic treatment. Patients see claims in the media or on the internet that are wrong, and they approach dentists for clarification. It is unethical for a dentist to promote unscientific evidence or to capitalize on the patient's concerns. They should redirect the patient to sound advice that can be found on dental association or health department websites.

Nondental treatments

Dental practices are advertising the use of Botox and dermal fillers to smooth frown lines and enlarge lips. Dentists, or their staff, may also provide body piercing and tattoos. None of these procedures fall within the definition of dentistry or healthcare. The argument put forward for allowing such procedures to be performed by a dentist or under a dentist's supervision is that dentists have a knowledge of anatomy and infection control that is vastly superior to beauticians, tattooists, and others who usually perform these procedures, and that the patient would be safer. Also, dentists are able to offer local anesthesia. Some legislation prohibits dentists from undertaking these procedures or from using local anesthesia except for dental treatment. In addition, medico-dental indemnity insurers may not cover these procedures, should problems occur.

Commercial sales

Dental clinics normally stock products such as toothbrushes, interdental cleaners, toothpastes, and so on, as a convenience for the patient. Many ethical codes of practice preclude selling such items for profit, but they permit cost recovery.

Business consultants, however, view retail activities as a potential for improving dental practice income. The range of products is often selected on the basis of profit margins and may include items that have dubious benefit. In addition, some advisors have promoted selling nondental items on commission, such as health insurance policies. To justify this retail expansion, they point to pharmacies as an example of ethical professionals being retailers. The comparison, however, is a business one, not a professional one.

Concluding comment: Ethical work in progress

Many of the topics raised in this chapter are new or gaining in prominence and have not been debated fully, either within the dental community or within this chapter. Dentistry has moved away from being a relatively small, tight community, where senior mentors were heard (if not always followed), and where practitioners could remain somewhat separated from the heat of commerce. In developed countries, both the relative level of dental disease and shortage of dentists are reduced. There is an increasing gap between high-need communities and overserviced ones. The wide access to the internet has changed the way information about oral health and dentists is gathered and spread.

The professional and ethical values of beneficence (do good), nonmaleficence (do no harm), autonomy, justice, and trust are still valid and will continue as professional values into the future. What has increased is the breadth and scope of the gray areas between ethical/professional actions and those that are unethical. During a time when larger sections of society remain free from serious disease, even the concept of what constitutes healthcare, including dental health, is debated.

It is important for the profession of dentistry to place a priority on the discussion of ethics at every opportunity, to avoid mistakes that may prove irreversible.

This chapter was written by Suzette Porter

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Chapter 10:
Access to care

Summary

Global public oral healthcare needs are increasing in complexity, and there has been a renewed interest in the ethical dimensions of oral health decision-making and the development of health ethics in teaching and research in dentistry. Despite their reduction globally, oral diseases persist, with a distribution pattern that reflects increasing and widespread inequality in access to community oral health preventive and dental care. This inequality reflects differences in the appropriateness, availability, accessibility, and acceptability of oral health education and care. This chapter provides an overview of access to care from an ethical perspective, including the importance of equity, human rights, and social justice in providing oral healthcare to underserved and vulnerable populations. The need for a paradigm shift from the highly technical and individualistic dental training curriculums are discussed, together with the need to instill a holistic approach to ethical and social responsibility in new dental graduates.

Introduction

The changing global patterns of oral diseases continue to reflect a widespread inequality in access to preventive and dental care. The varying oral health status of populations highlights major differences in the availability, accessibility, and acceptability of education and oral healthcare. This implies that the *social contract* between the dental profession and the public is endangered, as the needs of large segments of the public are not met. It is a moral obligation to do something about this problem. Both the profession of dentistry as a whole, as well as its individual members, need to take action, to strive for better access to oral healthcare services for all in need of dental care.

However, a variety of complex questions arise: What exactly is the duty of the dental profession to address this problem? How much are individual dentists obligated to do? What is the theoretical basis for distributing scarce oral healthcare services? In this context, ethics can be used as a tool for the discussion, improvement, and consolidation of citizenship, human rights, and social justice. This chapter will offer a reflection on access to care in underserved populations from a bioethical standpoint.

It is necessary to start with an analysis of the role of bioethics in public health.

Public health bioethics

The study of bioethics expanded in the early 2000s from purely biomedical health issues to the broader public health, biotechnological, and other social issues, such as health and the environment. On a conceptual basis, the bioethical principles proposed by Beauchamp and Childress, which are based on the four essential tenets of autonomy, beneficence, nonmaleficence, and justice, are the most widespread.

Autonomy relates to the basic concern for developing public policies that avoid undue limitation of individual free will.

Justice reflects on inequalities and the allocation of scarce resources. In the conceptual framework of bioethics, questions concerning access to healthcare fall primarily under the principle of justice – fairness, along with entitlement to and equitable distribution of resources. Issues of justice in healthcare can be separated into two different but related dimensions: access and allocation. *Access* refers to whether people who are – or should be – entitled to healthcare services receive them. It includes rights to healthcare, what constitutes entitled healthcare services, and barriers to these services. *Allocation* refers to the process used to determine which resources will be distributed for healthcare within populations and for individuals, and it usually involves three levels: (i) the social level, which relates to the amount of government resources that will be used for healthcare as opposed to other budget needs, such as defense or transportation; (ii) allocation at the point of healthcare service, which involves decisions about the healthcare portion of national budgets and how, where, and for whom the funding will be spent; and (iii) the individual patient.

Public health is the societal (rather than individual) approach to protecting and promoting health and improving the well-being of communities. The population-based public health focus has often given rise to ethical dilemmas regarding the appropriate extent of its reach and whether its activities infringe on individual liberties. Bioethics has enabled health professionals and public policymakers to make decisions about their behaviour and about policy that governments, organizations, and communities must consider regarding how best to use new biomedical knowledge and innovations. Public health and bioethics have many issues in common, since both are concerned with issues of human rights, citizenship, social movements, and public policy.

Responsibility, prevention, and precaution are the key tenets of the multi-, trans-, and interdisciplinary approach of public health bioethics. Responsibility is a core value, and prevention is required to be effective and efficient with a sustainable cost–benefit ratio. Its ethical component addresses the just distribution of preventive policies. Precaution refers to decision-making in uncertainty, where future harm is avoided with suspected, but not ascertained, risk factors.

It is generally assumed that the state assumes the role of protecting all its citizens, because they do not have the means to protect themselves against certain risks and threats to their personal vulnerability. To safeguard essential needs, such protection should ensure that moral and legitimate requirements are met. From a health perspective, protection bioethics considers the right to healthcare and the equality of treatment as a necessity. To ensure access to care, there must be an ongoing discussion of the social responsibility of the state, a definition of priorities regarding the allocation and distribution of resources, allocation of appropriate human resources, organized involvement of the population throughout the process, a review and update of codes of ethics for different health professional groups, and necessary and profound changes in university curricula.

Traditional bioethical approaches are being questioned as new theoretical perspectives arise. Two important concepts reflect existing conditions: the bioethics of persistent situations and the bioethics of emerging situations. Bioethics of persistent situations is related to conditions that have persisted in human societies since ancient times and continue to do so despite socioeconomic and technological developments. These conditions include social exclusion and concentration of power, discrimination, inequity, the control and distribution of economic resources in health and human rights, and their impact on people’s health and way of life. Low- and middle-income countries fall into the emerging issues category. Emerging issues have arisen from recent biotechnological and scientific developments, including genetic engineering, the donation and transplantation of human tissues and organs, cloning, biosecurity, and scientific research that utilizes humans.

Global burden of oral diseases

Oral diseases remain a major public health burden worldwide affecting both well-being and quality of life. Poor oral health has a profound impact on general health, and several oral diseases are related to chronic diseases, such as diabetes and obesity. Dental caries is the most common of all chronic diseases in industrial and most low- to middle-income countries. “Oral conditions affected 3.9 billion people, and untreated caries in permanent teeth was the most prevalent condition evaluated for the entire Global Burden of Disease (GBD) 2010 Study with a global prevalence of 35 % for all ages combined.” In addition, the global burden of periodontal disease, oral cancer, and caries increased markedly by an average of 45.6 % from 1990 to 2010 in parallel with the major noncommunicable diseases like diabetes by 69.0 %.

In children, tooth decay not only affects the child's overall health but has other ramifications, such as school absenteeism for the children and work absenteeism for the parents. Due to the high prevalence and recurrent cumulative nature of caries and periodontal disease, the mouth is one of the most expensive parts of the body to treat in some countries, and it has been estimated that if treatment was available for all, the costs of dental caries in children alone would exceed the current total healthcare budget for children.

While the prevalence of dental caries in children has declined markedly over the past 30 years in most countries as a result of the successful implementation of many public health measures (including the effective use of fluorides, changes in living conditions and lifestyles, and improved self-care practices), disparities remain, and the disease persists in certain demographic groups. For example, many children, older adults, people with poor education or low socioeconomic status, people in racial and ethnic minority groups, and those with special health needs are defined as high-risk groups. Many health education programs and healthcare public policies have only been partially effective in reducing dental caries rates in these populations. Unfortunately, the populations most affected – the vulnerable and underserved – are those who receive the least care.

Apart from the two most common dental issues, dental caries and periodontal disease, both of which are reversible and, in most cases, can be controlled by individuals and communities using simple measures, diseases of the soft tissues of the mouth and of the jawbones are debilitating and sometimes fatal. The prevalence of cancers of the mouth and throat continues to rise at an alarming rate in often underserved and poorer communities, but with inadequate attention from the profession. Oral potentially malignant disorders (OPMDs) are those lesions and conditions that have an increased potential for malignant transformation and are risk indicators of future malignancies. They are holistically defined as "a group of disorders of varying etiologies, usually tobacco; characterized by mutagen associated, spontaneous or hereditary alterations or mutations in the genetic material of oral epithelial cells with or without clinical and histo-morphological alterations that may lead to oral squamous cell carcinoma transformation."

The impact of OPMD on an affected individual's life is multidimensional, and patients diagnosed and treated for oral malignancies have been found to experience poor quality of life. The impacts extend beyond physical impairment and functional limitations to aspects of daily living, including psychological and social well-being. The ethical considerations relating to access to care for these populations emphasize the need to consider: (i) the training of healthcare workers to diagnose and treat; (ii) provision of facilities locally or at a center where patients can receive specialist care; (iii) what to do when patients are diagnosed and there is no possibility of treatment or preventive education against social and commercial pressure toward, for example, betel nut chewing or use of tobacco, snuff, and so on; and (iv) long-term sustainable strategies for health promotion and disease prevention through effective multidisciplinary teamwork.

Ethical considerations in improving access to care: What kind of oral healthcare do we owe?

Most theories of justice affirm that there are social obligations to protect opportunity. With regard to an opportunity-based view, justice requires that we protect people's share of the normal opportunity range by treating illness when it occurs, by reducing the risk of disease and disability before they occur, and by distributing those risks equitably (Daniels, 2013). Therefore, on the fair equality of opportunity view, it is of special moral importance to protect and meet the oral health needs of all people, who are viewed as free and equal citizens. Meeting the oral health needs of a population protects the range of opportunities people can exercise, and any social obligation to protect opportunity implies an obligation to protect and promote the oral health (normal oral functioning) of all people. Extrapolating this into the dental environment means that all people must have access to a reasonable array of services that promote and restore oral function, and preventive measures must not be neglected in favor of curative ones.

Clinical interventions account for only a small proportion of health improvements, and therefore there is a need to look not only beyond clinical dental settings to traditional public health measures that profoundly affect oral disease risk levels and their distribution, but also beyond the health sector to the broader social determinants of health and their distribution. The dental profession should be in the forefront of efforts that call for a reduction in income disparities and increased access to care and resources for good oral health, as well as well-being and overall health. Industries whose products are harmful to oral health and overall health, especially producers of free sugars in foods and drinks, as well as manufacturers of foods containing refined carbohydrates, should be required to label their products as harmful. However, since all the oral health needs that arise inside or outside of dentistry cannot be met, one must be accountable for the reasonableness of the resource allocation decisions that are made.

One needs to be clear about the kinds of care owed to patients, how that care is determined, and what constitutes appropriate access to that care, given that there are diverse barriers to access. In instances where there is disagreement after repeated discussion, the patient's informed choices and best interests should prevail.

Distributive justice

With regard to access to care, distributive justice is particularly relevant to low-income countries where, especially in the public health sector, limited resources exist. When resources are limited, how does one distribute them fairly among those who need them? When determining rationing or setting priorities, it is critical that the process reflects a sense of fairness.

There are various theories that determine how to distribute social burdens, goods, and services, including: (i) Utilitarianism – which argues that the standard of justice depends on the principle of utility (e.g., the maximization of the overall good, with the greatest good for the greatest number of people). Public healthcare for as many people as possible is supported by this theory; (ii) Libertarianism – this theory of distributive justice is based on the ability of individuals to pay for their healthcare. Those who can pay are entitled to healthcare. This theory supports private healthcare; (iii) Communitarianism – principles of justice are regarded as pluralistic. Communities decide what their healthcare needs are and how resources will be distributed. The health needs of a community will be prioritized over the health needs of individuals; and (iv) Egalitarianism – this theory holds that all people should receive an equal distribution of healthcare, irrespective of their ability to pay.

Social inequities and access to oral health

In recent times, the world has seen a significant growth in social inequalities between the rich and the poor. Structural adjustment programs have diverted social and welfare spending away from the public to the private sector, resulting in a two-tier health service – one for the rich, and the other, limited and often of poorer quality, for the majority. Differences in accessibility, availability, and acceptability of oral healthcare and education have an impact on the availability of prevention and health promotion that affects the level of an individual's oral health. Current disparities and inequalities in global oral health reflect differences in socioeconomic development between countries in the same manner that they affect a wide range of other health issues. Tackling inequalities in health requires strategies tailored to the determinants and needs of different population group along the social gradient. Socioeconomic inequalities have severe consequences for both health and oral health, and individuals with lower socioeconomic status have been shown to have less access to oral health services. In many countries, public health services constitute the main resource for most of the underserved populations, especially for women and children of lower economic status. Health inequalities between social groups count as unjust or unfair when they result from an unjust distribution of the socially controllable factors that affect population health and its distribution.

Justice as fairness assures equal basic liberties and the worth of political participation and rights, fair equality of opportunity through public education, early childhood supports, and appropriate public health and medical services, and constrains socioeconomic inequalities in ways that make the worst-off groups as well-off as possible. It is anticipated that this distribution of key determinants of population health would significantly flatten the socioeconomic gradient of health and would minimize various inequities in health, including race and gender inequalities. The principle of justice concerns equal access to health services for all people, the distribution of resources, and the criteria to fairly resolve these issues. Public healthcare is usually based on the egalitarian doctrine that all persons are equal in fundamental worth or moral status and should have their health needs met. However, this may not always be possible in the current global economic climate. With the increasing population of the aged, increasingly expensive technologies, changes in epidemiology, and the emergence of new diseases and health problems, these universal doctrines now require broad ethical reflection regarding prioritization and limitations of the distribution of health resources. Access to care is not only restricted to curative care but also to preventive measures against oral diseases.

Financial considerations and pro bono care

Those populations who have access to oral healthcare are more likely to receive basic preventive services and education on how to attain and maintain good oral health and to have oral diseases detected in the earlier stages. In contrast, lack of access to oral healthcare, as is often experienced by underserved populations, has a major impact on levels of health and oral health, and often results in delayed diagnosis, untreated oral diseases and conditions, compromised health status, and, occasionally, even death. There has been a decline in access to and utilization of healthcare, mainly due to increasing financial barriers. In addition, the provision of oral healthcare has been hampered by factors related to the financing of preventive activities and services. Sociodemographic factors, including gender, age, income, and education, remain the main predictors of access to oral health services. While there has been progress in the investment in oral healthcare in recent years, the funding of these actions has often required large investments in the public sector by governments globally.

Improving access to care has become an important focus for many professional dental organizations, which have encouraged the profession to take a more active role in promoting reduced costs and pro bono care. Individual practitioners can play a significant role in improving access to care. But should all dental professionals do something for low-income or disadvantaged populations? Should they participate in public-initiated programs to improve access, even if they do not want to? Should the provision of care for the economically disadvantaged be part of every dentist's regular care? If dentists were to view pro bono care as an important consideration, then how much time should they set aside for it and how do they select patients who will benefit? The principle of justice suggests that they focus on those who are worst off. The principle of social utility would support giving attention to those who can be helped most. These contributions can be made either in their private practices or by offering their services at public dental facilities.

One of the concerns about pro bono care is that it is inevitably stigmatizing, condemning a patient to the classification of a *charity case*. Furthermore, pro bono care leaves it up to very vulnerable people to seek out the provider. For these reasons, a universal access to care is viewed as a fair way to make basic care available to all, rather than relying on the charity of the health professions.

Ethics training for dental professionals

Current debates have shown that the ethics training of most dental professionals is inappropriate and inadequate in meeting the health needs of the population. This controversy is due to the dominant ethos of most health professions, which has been found to be empiricist, quantitative, and oriented toward precise, definitive solutions to discrete problems.

There is a degree of indifference in dental professional training regarding social injustice and the need to improve the quality of oral health of the population, and this indifference has a direct influence on the quality and effectiveness of a health system. There is a need for the integration of education and service delivery, and this integration should serve to guide the process of ethical reflection on the role of universities and their contribution to the construction/reconstruction of good practice.

It has been shown that in the health field, the teaching of ethics lags behind the needs of society, and there is a need for the exchange of humanistic values in the ethical training of health professionals. Admission to university starts the process of professional socialization, when the incorporation of professional morality is determined by the adoption of models and the internalization of the behaviours and attitudes that are accepted among peers. Dental curriculums should highlight ethical-moral issues of professional attitudes and behaviours toward patients and institutions. Furthermore, dental school environments should promote personal and human development of students by ensuring high academic and professional integrity of faculty members.

Values, such as dignity, human rights, respect for autonomy and vulnerability, must be incorporated into academic practice to develop attitudes that go beyond the limits of clinical care. Ethics training of dental professionals should incorporate a framework that allows for reflection and a critical world view that focuses attention on social, cultural, and economic problems of populations, and that ultimately results in a social commitment to improve people's quality of life through one's professional actions. The theory of justice serves many roles by helping to focus attention on needs and by conceptualizing problems in ways that guide action and reform, and dental students need to be aware that poor health prospects are not just a matter of misfortune, but rather a matter of justice. Dental professionals must be educated to care for the community by showing sound judgment, the ability to recognize and analyze ethical issues, a tolerance for ambiguity, and a capacity for empathy within the broader context of human experiences and values.

Some strategies

The risk factors for several chronic diseases are common to most oral diseases, and the common risk factor approach has become the new public health strategy for the effective prevention of oral diseases, the most prevalent being dental caries and periodontal disease. Common risk factors, such as dietary and nutritional factors, must be addressed together with the socioenvironmental factors that are distal causes of oral diseases. In 2002, the World Health Organization's Global Oral Health Programme adopted a new strategy, whereby dental caries was included in chronic disease prevention and general health promotion. This approach was justified by the fact that dental caries is a chronic disease that progresses and needs to be managed throughout the lifetime of most people.

Patient education and vulnerable populations

It has become necessary to find strategies to decrease the incidence and burden of oral diseases, as many public health policies have been inefficient in catering for underserved and vulnerable groups. One of the strategies that has been proposed to reduce the burden and gravity of oral diseases, in view of the fact that dental caries has been defined as a chronic disease with the necessity for lifelong management, is the concept of *therapeutic patient education*. It was initially developed for other chronic diseases, such as asthma and diabetes. Therapeutic patient education enables patients to self-manage or adapt to treatments and cope with new processes and skills that allow them to optimally manage their lives and their disease. It is an ongoing process that is integrated into their overall healthcare and is designed to help patients understand the disease and associated treatment, cooperate with healthcare providers, live in good health, and maintain and improve their quality of life.

Ethical aspects of patient oral health education and promotion programs

Oral health education is the process of imparting and providing access to oral health information in such a way that patients understand it and are motivated to use the information to protect, improve, and maintain their own, their family's, or their community's oral health. Oral health promotion is the process of enabling patients to increase control over and improve their oral health. Both these processes require a patient to change his or her identity to meet a dental ideal and therefore poses ethical dilemmas. In some ways, health education can be an ideal public health intervention, as it is voluntary and attempts to empower people to make their own decisions regarding their own oral health once they have been provided with the relevant information on how to do so. However, despite its obvious advantages, health education and promotion programs may not be appropriate for all situations. They may not work in all settings, and a clearly defined population may need to be targeted. Population-specific interventions may be problematic, will raise questions, and may create tensions. For example, what criteria will be used to select who will take part in the program? How can these criteria be justified? Is the will to change the behaviour of a patient an instrument of social control that may infringe on the freedom of the patient, or is it an ethical imperative aimed at improving the patient's oral health?

In some instances, oral health education and promotion programs may use ethically questionable practices, such as manipulation or coercion, to increase their effectiveness. They also have the potential to be paternalistic by suggesting that certain traits are universally valued. The ethical principle of autonomy comes into play, and dental professionals need to be careful not to usurp patient's choices by assuming someone else's goal (societal and/or provider), nor to deprive the patient of the knowledge and skills necessary to exercise their choice. In this way, patients will be autonomous decision makers in their oral health management. Dental professionals need to be trained to educate their patients, so they may manage the treatment of their condition and prevent avoidable complications. However, this requires a paradigm shift from the traditional treatment-based culture to a culture of prevention, or a combination of the two.

Concluding remarks

While there are many reasons for the persistence of oral diseases, especially in underserved populations, a population's access to dental services directly contributes to the inequities in oral health. In many countries, the responsibility for the well-being of the population and its access to health services, including dental and other health programs, lies with the public health sector. However, the ethical principles of protection and responsibility are not the sole responsibility of the state and its representatives, but must be supported by every dental professional, whether within his or her practice or within the larger community. Questions of just and fair access to appropriate oral healthcare services, as well as just and fair allocation of limited oral healthcare resources, exist in many countries. Despite the pervasiveness of these questions, dental professionals often go about their day-to-day activities without thinking about them or even recognizing their impact on their patients and their patients' families. The principle of justice is applied when health professionals use the resources of epidemiology and social risk criteria to detect vulnerable individuals, especially those in underserved areas, and thereby facilitate their access to oral healthcare. Dental professionals need to be aware of the oral health services that are provided to all people, to consider what can be done to ensure universal access to appropriate dental services, and to think about just and fair approaches to the allocation of oral healthcare resources.

The teaching of ethics in dental schools is intellectually challenging but must be taught effectively and practiced in our dental schools, despite the fact that the field is not well unified and does not have a clear consciousness of itself as a profession. There is a need for a clear conceptual and intellectual ethical framework to develop a community oral health ethos, in both faculty and student bodies, that results in a health professional who is truly educated to caring for the community, with sound judgment, ability to recognize and analyze ethical issues, tolerance for ambiguity, and capacity for empathy within the broader context of human experiences and values.

Case study

Dr. Smith has a dental practice in a poor socioeconomic area. While some of his patients have health insurance, most patients pay cash for services rendered. A young woman attends the dental practice for the first time. On discovering that she does not have any health insurance or belong to a medical aid, the receptionist wonders if the young woman has money to pay for any dental treatment. She turns the patient away when she realizes that she will only be able to pay half of the initial consultation fee. Dr. Smith is not consulted.

Questions

- Is it ethical to turn away a patient who does not have enough money without the dentist establishing why the patient is there in the first place?
- What training has the receptionist received from Dr. Smith regarding quality of service to be offered to patients?
- Does the practice have a standard operating procedure to deal with nonpayments?

Discussion

This case scenario highlights the crucial role played by the reception staff, either in a private dental practice or in a public dental clinic. The receptionist is a critical interface between the dentist and the public. As such, the receptionist is an important member of the dental team and if he or she is unprofessional, it could quickly create a poor impression of the practice. As a practice manager, it is the dentist’s responsibility to ensure that reception staff have the necessary training and skills to function competently and professionally within the scope of the job description.

In public health facilities, patients often endure many hardships, including administrative delays, long waiting periods, and unfriendly or difficult reception staff, and this often results in an irate, angry, unhappy patient arriving in the dentist’s consulting room. This situation, if not managed diplomatically, could easily erode the dentist–patient relationship.

The receptionist contributes significantly to the reputation and success of a practice. In training, the ethical nature of dental care must be stressed, along with reception and communication skills. This training is the responsibility of the employer, and the need for respectful and fair treatment of patients must be encouraged. In addition, the importance of maintaining confidentiality at all times must be emphasized. In keeping with the theory of virtue ethics, the personal characteristics or virtues of reception staff and the dental assistant are as important as the virtues of the dentist.

The context or specific circumstances of a patient is important to bear in mind in cases of this nature. The issue of nonpaying patients is a complicated one that is not easily solved. Each dental practice will manage this issue in its own way. However, it is important that a policy be established, one that is applied fairly and professionally to all patients. It is also important that a receptionist discusses individual cases privately with the dentist, who should make the final decision. The situation of a patient who is turned away by a receptionist without the knowledge of the dentist, and who is later found to have had an emergency, can pose serious medico-legal problems.

From an ethical perspective, provision of emergency care is based on the principles of beneficence and nonmaleficence (do good and do no harm). From a legal perspective, all healthcare practitioners (in both the private and public sectors) are obliged to provide emergency care to all patients, irrespective of the patient's ability to pay for services. Ultimately, it becomes the dentist's responsibility if the dentist has not given the receptionist specific directives on the importance of assessing patients before referring them to other health facilities.

Options when a patient attends for treatment without any money include the following:

- The patient could be examined and given treatment irrespective of whether they will return to settle the account or not.
- The patient could be assessed briefly by the dentist, free of charge, and provided with a referral letter to a public dental clinic.
- Provided it is not an emergency, the dentist may decide that all such patients will not be treated in the practice.
- Only those patients in dire financial need will be seen and treated, at the dentist's discretion. This will form part of the corporate social responsibility of the practice.
- All such patients will be treated, but future consultations will be permitted only if the account for the initial visit has been settled.

Each dental practice can decide on the policy it wishes to adopt. Such a policy might be influenced by utilitarian principles, Kantianism (a sense of duty/obligation), liberal individualism (the rights of the dentist), communitarian theory (the good of the community), or virtue ethics (based on the personal traits of the dentist – compassion, integrity, altruism, and so on). What is important is that such a policy exists, and that staff members are aware of it and have guidelines to follow for such incidents.

(Case adapted from Moodley and Naidoo, 2009.)

This chapter was written by Sudeshni Naidoo

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Chapter 11:
Research

Summary

This chapter provides a historical background of research ethics, describes the evolution of international guidelines and accords that constitute the foundation on which international and national laws and guidelines for conducting human research are based, and explores the main principles of research ethics, including the importance of participant protection and how to limit risks associated with research.

Introduction

The growing complexity of oral health research – which can involve public–private partnerships, coordination of collaborators from diverse institutions and multiple countries, sponsors located far from the communities that host the research, growing commercial sponsorship of research, and the collection of biological samples – has been accompanied by increased international attention to ethical and legal issues. At the heart of this concern is the recognition that research has the potential to both benefit and harm the communities and populations involved. The risk of harm is especially high in settings where research participants are poor, illiterate, lack access to healthcare, and are socially and economically vulnerable.

Dental professionals may be involved in research for the development of safe, innovative, and efficacious dental treatment, so that dental procedures are based on rigorous evidence-based scientific studies. Such research must be scientifically valid and ethically sensitive, and therefore it is one of the responsibilities of the dental profession to acquire knowledge on the guidelines and legislation regarding how to conduct research ethically.

Research ethics involves the systematic analysis of ethical and legal questions to ensure that study participants are protected, and ultimately, that clinical research is conducted in a way that serves the needs of such participants and of society as a whole. A central tenet in the debates surrounding research ethics is the important distinction between the dentist–patient relationship in the clinical setting and the researcher–participant (patient) relationship in research activities. Dentists need to be aware of the differences in objectives, and hence of obligations, between dental treatment and dental research, because the trust of patients is tested when a dentist recruits a patient into a research study. How should a dentist, who is engaged in research, ensure that a patient, who is a potential research participant, is aware that a dental intervention is being undertaken to generate knowledge and not necessarily to advance the patient’s individual dental health interests?

Traditionally, the dentist–patient relationship is based on concern for individual patients, and the health of the patient is seen as the primary goal. In research, the patient as a research participant may stand to benefit to a certain degree, but the benefit to science and society may be significant enough to render the research participant a means to an end. As a result of this delicate relationship, the rights of the patient as a research participant require special protection in such settings. During and after World War II, many ethical problems arose either because the distinction between the dentist–patient relationship and researcher-patient participant relationship had not been recognized, or because special protection was not afforded to participants, resulting in a violation of their rights. What does a patient need to know before becoming a research participant, and how and by whom should this information be relayed?

A historical perspective

The basic principles of research ethics are well established today, but this has not always been the case. Many researchers in the 19th and 20th centuries conducted experiments on patients without their consent and with little if any concern for the patients' well-being. The end of World War II heralded in a new war – a war against disease – and several countries viewed research as a matter of national security to protect both the armed forces and the nation from infectious diseases and other illnesses. As a result, researchers were given considerable autonomy when conducting research. Adequate funding was also made available. Many scientists, in their eagerness to develop new drugs, aggressively pursued their scientific goals and agendas, while respect and compassion for their research participants were neglected.

Although there were some statements of research ethics dating from the early 20th century, physicians in Nazi Germany and elsewhere performed research on subjects that clearly violated fundamental human rights. Following World War II, some of these physicians were tried and convicted by a special tribunal at Nuremberg, Germany. The basis of the judgment in 1947 became known as the Nuremberg Code, which has served as one of the foundational documents of modern research ethics. It is based on 10 principles, the most important of which insists that research should be based on legitimate science and voluntary consent. These 10 principles include: (i) voluntary informed consent must be sought for all experiments; (ii) experiments should be for the good of society, and results must not be obtainable by other means; (iii) experiments on humans should be based upon prior animal studies; (iv) physical and mental suffering and injury should be avoided; (v) there should be no expectation that death or disabling injury will occur from the experiment; (vi) risks must be weighed against benefits; (vii) subjects must be protected against injury, disability or death; (viii) only scientifically qualified individuals should conduct human experiments; (ix) a subject can terminate his or her involvement; and (x) the investigator can terminate an experiment if injury, disability, or death is likely to occur.

As a direct result of the infamous Tuskegee study, the National Research Act was passed in 1974, and the Belmont Report published in 1979, both in the United States. The Tuskegee Syphilis Study began in 1932 and ended in 1972. Six hundred poor African-American men from Macon County, Alabama, were recruited into a project that set out to establish the natural history of syphilis. Four hundred of these men had syphilis, and 200 were used as controls. Patients were told that they had *bad blood* and should have regular medical examinations, including lumbar punctures. They were promised free transportation, hot lunches, free medical care for any disease other than syphilis, and free burial. However, they were not aware that they were participating in a research study. At the start of study, there was no definitive treatment for syphilis, and heavy metals were used for treatment. By 1945, penicillin had been discovered and was found to be effective against syphilis, but this treatment was deliberately withheld from the men, as the researchers wanted to see what the natural history of syphilis would be.

The Belmont Report maintained that human research should be based on three major principles. The first, respect for persons, was based on the assumption that human research subjects are autonomous agents and should be treated as such, and that protection should be provided for subjects with diminished autonomy, such as children and mentally incapacitated adults; the second principle, beneficence, maintained the position that researchers working with human subjects should maximize benefits and minimize harm to subjects; and the third principle, justice, implied that there should be a balance in research between benefit and risk, and that subjects should be treated fairly.

The Vipeholm Dental Caries Study (1945–1954)

With the very poor dental health in Scandinavia in the 1930s, research on prevention was prioritized. Clinical studies on diet and dental caries were undertaken at the Vipeholm Hospital – a hospital for people who were mentally challenged. The studies began in 1945 and ended in 1954. The so-called Carbohydrate Study was divided into two parts. In Part 1, "extreme conditions were applied with regard to carbohydrate consumption." Sugar was given in solution or in sticky form (toffees) between meals or at meals. In Part 2, sweets similar to those consumed by children outside the hospital, as well as toffees, were given to the children. The main finding revealed that sugar given in sticky form between meals increased caries levels significantly. The ethics of this research study have been widely criticized. Firstly, a study of this nature, in which vulnerable children were deliberately subjected to a diet high in sugar and carbohydrates, would not be approved by a research ethics committee (REC) anywhere in the world. It is unclear whether consent was sought from the parents/guardians of these children. Although the dentists involved in the study "did not see any ethical problems with the study itself," the government decided that patients at the Vipeholm Hospital should not be used as research subjects after July 1, 1955.

Research guidance documents

The World Medical Association (WMA) was established in 1947, the same year that the Nuremberg Code was set forth. Conscious of the violations of medical ethics before and during World War II, in 1954 the WMA, to ensure that physicians would at least be aware of their ethical obligations, adopted a set of principles for those in research and experimentation. This document was revised over the next 10 years and eventually adopted as the Declaration of Helsinki (DoH) in 1964. It was further revised in 1975, 1983, 1989, 1996, 2000, 2008, and 2013. The DoH is a concise summary of research ethics. Other much more detailed documents have been produced in recent years on research ethics in general (e.g., Council for International Organizations of Medical Sciences (CIOMS) International Ethical Guidelines for Biomedical Research Involving Human Subjects, 1993, revised in 2002, and the CIOMS International Ethical Guidelines for Epidemiological Studies and on specific topics in research ethics (e.g., Nuffield Council on Bioethics [UK], The Ethics of Research Related to Healthcare in Developing Countries, 2002). Despite the different scope, length, and authorship of these documents, they contain the basic principles of research ethics that address the ethical responsibilities of practitioners when conducting research. These principles have been incorporated into the laws and/or regulations of many countries and international organizations.

The DoH currently includes 32 principles stating in various ways that: (i) research with humans should be based on laboratory and animal experimentation; (ii) experimental protocols should be reviewed by an independent committee; (iii) informed consent should be required; (iv) subjects who are minors or those with physical or mental incapacity should be protected; (v) research should be conducted by medically/scientifically qualified individuals; (vi) risks and benefits should be balanced; (vii) the privacy of the subjects and confidentiality of the information should be maintained; (viii) research results should be published; (ix) conflicts of interest should be avoided; and (x) placebos should be used under strict guidelines.

Clinical trial research in dentistry

Clinical trials have contributed significantly to the knowledge base in dentistry. Examples of such dental trials include the evaluation of antibiotics for control of attachment loss during periodontitis, randomized clinical trials of toothpastes for the control of caries, randomized trials of diagnostic agents for the early identification of oral epithelial carcinoma, and clinical research on local anesthetics for adequate pain control. Similar research is underway and will continue in the future. It is imperative that all such trials are conducted according to the principles of good clinical practice (GCP), which include the following:

- Clinical trials should be conducted in accordance with the ethical principles that have their origin in the DoH and are consistent with GCP and the applicable regulatory requirement(s).
- Before a trial is initiated, foreseeable risks and inconveniences should be weighed against the anticipated benefit for the individual trial subject and society. A trial should be initiated and continued only if the anticipated benefits justify the risks.

- The rights, safety, and well-being of the trial subjects are the most important considerations and should prevail over the interests of science and society.
- The available nonclinical and clinical information on an investigational product should be adequate to support the proposed clinical trial.
- Clinical trials should be scientifically sound and described in a clear, detailed protocol.
- A trial should be conducted in compliance with the protocol that has received prior institutional review board or REC approval.
- The medical/dental care given to, and medical/dental decisions made on behalf of, subjects should always be the responsibility of a qualified dentist/physician.
- Each individual involved in conducting a trial should be qualified by education, training, and experience to perform his or her respective task(s).
- Freely given informed consent should be obtained from every subject prior to clinical trial participation.
- All clinical trial information should be recorded, handled, and stored in a way that allows its accurate reporting, interpretation, and verification.
- The confidentiality of records that could identify subjects should be protected, respecting the privacy and confidentiality rules in accordance with the applicable regulatory requirement(s).
- Investigational products (drugs or devices) should be manufactured, handled, and stored in accordance with applicable good manufacturing practice. They should be used in accordance with the approved protocol.
- Systems with procedures that ensure the quality of every aspect of the trial should be implemented.

What makes clinical research ethical?

The following concepts, adapted from Emanuel et al. (2008), have been described as the benchmarks of ethical research:

- Relevance, scientific, clinical, and social value
- Scientific validity
- Fair subject selection
- Risk–benefit ratio
- Independent review
- Informed consent
- Respect for participants
- Action, policy, publication, and professional ethics

Relevance, scientific, clinical, and social value

One of the more controversial requirements of research is that it should contribute to the well-being of society in general. However, as resources available for research continue to dwindle, social value has emerged as an important criterion for judging whether the research should be carried out. For any research to have value it must contribute to generalizable scientific knowledge that leads to an improvement in the health and well-being of society. Research that lacks social or scientific value is unethical, as it results in the waste of limited resources, exploits human subjects by exposing them to potential harm, and weakens the reputation of research as a contributing factor to human health and well-being.

The importance of the research objectives, including those of both scientific and social importance, should not outweigh the risks and burdens to research subjects. Furthermore, the populations in which the research is carried out should benefit from the results of the research. This is especially important in countries where there is potential for unfair treatment of research subjects who undergo the risks and discomfort of research, while the drugs developed as a result of the research only benefit patients elsewhere. Often the social worth of a research project is more difficult to determine than its scientific merit. Researchers and ethics review committees must ensure that patients are not subjected to tests that are unlikely to serve any useful social purpose.

Scientific validity

All research must be conducted in a methodologically sound and rigorous manner. This requires a research protocol whose:

- aims and objectives are clear and scientific;
- study design is relevant, appropriate, and uses accepted principles;
- sample size has sufficient power to definitively test the objectives;
- statistical power is adequate to produce valid results;
- methods are valid, reliable, and practically feasible;
- data analysis is clear and plausible.

Clinical research that compares therapies must have an *honest null hypothesis* or *clinical equipoise*, meaning that there must be no controversy within the scientific community about whether the new intervention is better than standard therapy. Research conducted in low-income or resource-poor countries requires that the research be sensitive to the social, cultural, political, and economic context of the country and community in which the research will take place, and the study design should avoid exploiting the population. The ethical justification of scientific validity relies on the same principles that apply to value – limited resources and avoidance of exploitation. Only scientifically qualified persons should conduct research on human subjects.

Fair subject selection

The appropriateness and validity of scientific design are not the only ethical issues that a researcher should consider when planning a study. Subject and site selection must be fair and free from exploitation of vulnerable groups. Recruitment, enrolment, inclusion, and exclusion regarding the study are also important and should be done fairly and according to the scientific aims and objectives of the study and not according to vulnerability, privilege, or other unrelated purposes. From the standpoint of justice, the research should not impose risks and burdens on an arbitrarily selected subset of people. Research participants who bear the risks and burdens of the research should be in a position to enjoy its benefits.

Most research studies that involve human participation target specific categories or groups of people. Some groups may be more vulnerable than others to harm associated with taking part in research, and may require special considerations in the evaluation and protection against possible research risks. The following groups of people are regarded as vulnerable research participants or special populations: children and adolescents; pregnant women; the elderly; captive populations (e.g., prisoners, students, soldiers); those at risk due to impaired decision-making capacity (e.g., people with mental illnesses and substance abuse disorders); ethnic and minority populations – all identifiable and targeted communities. Vulnerable communities usually experience limited economic development, inadequate human rights protection, discrimination based on health status, inadequate understanding of scientific research, limited healthcare and treatment options, and limited ability to provide individual informed consent.

Researchers are in a position of power with respect to their choice of human research participants. Using individuals or groups who are in a dependent relationship with the researcher is ethically questionable. They may include students, patients, employees, or even family members. In addition, practitioners who directly recruit patients for research, and clinicians who receive compensation to *enroll* their patients for participation in clinical research, are also in contravention of conflict-of-interest guidelines. It is good ethical practice to declare potential conflicts of interests prospectively if there could be perceived bias in one's primary duties and in relation to other parties.

Risk–benefit ratio

Once the relevance, scientific merit, clinical, and social value of the research has been established, it is necessary for the researcher to demonstrate that the risks to the research subjects are not unreasonable or disproportionate to the expected benefits of the research. Research with human participants raises ethical concerns because it usually involves drugs, devices, and procedures about which there is limited knowledge, and which might not always serve the participant's best interests.

As such, there is inherent uncertainty about the degree of risks and benefits associated with experimental interventions. Risk of harm to research participants is one of the most difficult issues to consider and weigh. What risks are acceptable to achieve the anticipated benefits? Who should be asked to accept these risks? Who should decide what level of risk is acceptable? In the context of research in low- and lower-middle-income countries, resolving issues raised by such questions is crucial to ensuring ethical research.

A risk is the potential for an adverse outcome (harm) to occur. It has two components: (i) the likelihood of the occurrence of harm (from highly unlikely to very likely), and (ii) the severity of the harm (from trivial to permanent severe disability or death). A highly unlikely risk of a trivial harm would not be problematic; however, a likely risk of a serious harm would be unacceptable, unless the research provided the only hope of treatment for terminally ill research subjects. In between these two extremes, researchers are required to adequately assess the risks and be sure that they can be managed. In some instances, it is difficult to say when a risk is justified in view of the possible benefits related to the research. In many countries one cannot depend on participants always being able to fully appreciate the risks associated with scientific research, therefore the researcher has an obligation to exercise some responsibility over the risks to which participants are allowed to expose themselves. If the risk is entirely unknown, then the researcher should not proceed with the project until some reliable data are available, for example, from laboratory studies or experiments on animals.

In any research, the net expected benefit to patients must outweigh the anticipated risks. Clinical research can be justified only if: (i) the potential risks to the individual participants are minimized; (ii) the potential benefits to the individual participants are enhanced; and (iii) the potential benefits to the individual participants and society are proportionate to or outweigh the risks.

The ethical principles of nonmaleficence and beneficence embody the requirement for a favorable risk–benefit ratio. Nonmaleficence states that one ought not to inflict harm, and this justifies the need to reduce risks associated with research, while beneficence refers to acting for the benefit of others, and this translates into the need to enhance the potential benefits of research to both the study participants and society as a whole.

Independent review

All clinical trials and other research proposals on human subjects must be reviewed and approved by an independent ethics committee before they can proceed. In order to obtain approval, researchers must explain the purpose and methodology of the project: demonstrate how research subjects will be recruited, how their consent will be obtained, and how their privacy will be protected; specify how the project is being funded; and disclose any potential conflicts of interest on the part of the researchers. The ethics committee may approve the research as presented, require changes before it can start, or refuse approval altogether. The committee has a further role of monitoring projects that are underway to ensure that the researchers fulfill their obligations, and it can, if necessary, stop research because of serious unexpected adverse events. The reason why ethics committee approval is required is that neither researchers nor research subjects are always knowledgeable and objective enough to determine whether a project is scientifically and ethically appropriate. Researchers need to demonstrate to an impartial expert committee that the project is worthwhile, that they are competent to conduct it, and that potential research subjects will be protected against harm to the greatest extent possible. If multicenter research takes place in different countries, review and approval of the research is generally required in each country.

In addition, if a drug or device is part of the research, approval from the medicines regulatory agencies is required. In the United States, approval from the Food and Drug Administration (FDA) is required, depending on the device used in the research project. If the device is safe and noninvasive to a research participant, it is regarded as a nonsignificant risk (NSR) device and does not need FDA approval. Only REC approval is required in such cases. If the device is classified as a significant risk (SR) device, both REC and FDA approval is necessary. Examples of SR devices in dentistry include: (i) absorbable materials that aid in the healing of periodontal defects and other maxillofacial conditions; (ii) bone morphogenic protein with and without bone; (iii) dental lasers for hard tissue applications; (iv) endosseous implants and associated bone filling and augmentation materials used in conjunction with implants; and (v) subperiosteal implants and temporomandibular joint prostheses.

Informed consent

Although informed consent appeared in codes of ethics for scientific research as early as the 19th century, its central importance was affirmed following the Nuremberg trials and consequent elaboration of the Nuremberg Code. Informed consent as an underlying principle of ethical research implies and depends upon each research participant's legal capacity to give consent, and the ability to make a decision autonomously and without the intervention of force, fraud, deceit, duress, or coercion, along with sufficient knowledge and comprehension of the matter involved as to enable him or her to make an understanding and enlightened decision. In order to make an affirmative decision, the participant needs to be informed about the nature, duration, and purpose of the research, the methods and means by which it is to be conducted, and the effects upon his or her health, oral health, or person, which may result from his or her participation in the research. The duty and responsibility for obtaining valid consent rests upon each person who initiates, directs, or engages in the research. It is a personal duty and responsibility, which may not be readily delegated to another. Without consent from the individual research participant, no research can proceed.

The Nuremberg Code's first principle emphasizes three essential qualities for valid consent: (i) the person must have the capacity to give consent; (ii) the person must be acting voluntarily; and (iii) the person must be provided with sufficient comprehensible information to make an enlightened decision. The following sections expand on these points.

Capacity to give consent

The capacity to give consent has two aspects – firstly, that individuals are legally empowered to make their own decisions, and secondly, that they have the capacity to understand and question the information on which they base their decisions. The first dimension is often taken for granted when dealing with adults, while the second is often ignored in the context of research. Research often involves terminology, methods, and assumptions that are unfamiliar and often incomprehensible to study participants. In some instances, individual autonomy may hold a much lower value and may even be seen as challenging established structures where culture, custom, or other factors having to do with safety or trust, for example, may place a higher value on the prerogative of another (e.g., a community leader, a head of the household) to make decisions for others.

Voluntariness

Voluntariness can sometimes be overlooked, even assumed, because even though researchers do not use force, duress, or other forms of overt coercion, potential participants might feel that they have little choice as to whether or not to participate. Therefore, research subjects should be informed that they are free to withdraw their consent to participate at any time, even after the research has begun, without any sort of reprisal from the researchers or other practitioners, and without any compromise of their dental care.

When the potential participants' dentist becomes the researcher, this changes the dentist's role from therapeutic helper to recruiter of participants, and two challenges to voluntariness can occur. Firstly, the patients may not fully comprehend the conflict between treatment (arising from the dentist–patient relationship) and research (arising from a researcher–participant relationship). The second challenge is that the patients may feel that they must agree to participate or face repercussions. To ensure voluntariness, a new research contract must be entered into.

In many low- and lower-middle-income countries, and in some wealthy countries, dental diseases are more prevalent among marginalized populations, the disadvantaged poor, and the vulnerable. However, to provide informed consent, individuals must be accurately informed of the purpose, methods, risks, benefits, and alternatives to the research, and they must understand the information provided. There are many issues relevant for informed consent, including comprehension of information; communication of risks; decisional authority to consent to research; and community consultation, awareness of, and sensitivity to social position and power inequality.

Provision of sufficient information

Unlike in the clinical dental situation, where informed consent often includes information of material relevance to a reasonable person in the research setting, obtaining informed consent is much more comprehensive and should include: (i) a full disclosure/declaration of all anticipated and potential benefits and risks, including death; (ii) a clear statement of the purpose of the research and alternatives to the research; (iii) the name of the study sponsors; (iv) a declaration of any potentially conflicting interest on the part of the researcher; and (v) an account of the care and compensation that participants would receive if any adverse event or other injuries occurred.

These must be disclosed in a written consent form or by an oral equivalent for participants who are illiterate. However, the information in itself is insufficient to ensure informed participation of the individual, who must also understand the information provided. For complex research that involves considerable risks, researchers also have an obligation to formally assess how well the research participants have understood the information provided to them.

There are many other issues relevant to obtaining informed consent, including decisional authority to consent to research; and community consultation, awareness of, and sensitivity to social position and power inequality. Despite the many challenges that arise during the consent process, voluntary, valid, informed consent requires special consideration in oral health research. A signed informed consent should not be seen as adequate assurance that the participant has understood and agreed to the research, but rather as a process that is sensitive to contextual specificities. Culturally appropriate ways of disclosing information about research should be found, as should an appropriate way of manifesting true consent by those with authority to make decisions for themselves or others, and assent by those without the capacity to make their own decisions.

Respect for participants

Respect for participants does not end once they have signed the informed consent form and have enrolled in the study, or when they have declined to participate. Respecting potential and enrolled participants includes: (i) respect for privacy by maintaining confidentiality; (ii) allowing participants to withdraw from the study without penalty; (iii) providing any new information (positive or negative) that becomes available during the course of the study; and (iv) carefully monitoring the participants throughout the duration of the study, and informing them about the outcomes of the research.

Duties of privacy (an interest or right of either individuals or groups of people) and confidentiality (duty of professionals) might be jeopardized by research-related activities. This also has consequences for data protection, for who controls access to information, and for public health. As with patients in clinical care, research subjects have a right to privacy with regard to their personal health information. Unlike clinical care, however, research often requires the disclosure of personal health information to others, including the wider scientific community and, sometimes, the general public.

Privacy interests in research may be grouped into three categories: (i) control of who has access to participant information; (ii) control of who has the right to observe someone when they are not in a public space; and (iii) control over specific decisions concerning oneself. The definition of what is perceived as an infringement of privacy varies from culture to culture, and this variation should be taken into consideration. In order to protect research participants' privacy, researchers must ensure that they obtain the informed consent of participants to use their personal health information for research purposes, which requires that they are told in advance about the uses to which their information is going to be put. As a general rule, the information should be de-identified, de-linked, and stored and transmitted securely.

Confidentiality involves fulfillment of an obligation not to disclose private information. The obligation arises within a relationship when it is necessary to share information with someone who would not otherwise be privy to it. In most countries, dental professionals pledge to keep confidence because the profession sees confidentiality as essential, but more importantly to protect the trust that is placed in dentists by their patients. There may, however, be instances where the researcher is legally bound to disclose information (even if it is obtained on the premise of confidentiality) to relevant authorities, for example, researcher knowledge of child abuse, violence against women, and diagnosis of a contagious disease that could pose a public health threat.

Expansive electronic healthcare databases can facilitate research studies and offer opportunities to uncover promising new treatments, to study the safety and efficacy of pharmaceuticals and vaccines, or to improve the quality of health services. However, these studies usually require the exchange of vast amounts of health information related to health outcomes, existing conditions, and individual behaviours and characteristics. In this regard, how does one balance individual privacy interests with communal research needs? This is a debate that requires difficult choices and trade-offs. If it is easy to access, acquire, and use sensitive health data, individual privacy is threatened. This will result in people avoiding participation in research.

Action, policy, publication, and professional ethics

Making research findings publicly available to inform policy and practice is an ethical obligation of all researchers. Research that is not published cannot contribute to generalizable knowledge.

Researchers have a conflict of interest if they stand to achieve personal gain (money or equivalent) by failing to discharge their professional obligation to protect the welfare of participants or to uphold the integrity of the scientific process. In clinical research, conflicts of interest can arise from the actions of pharmaceutical industries in relation to health professionals, universities and research institutes, and RECs and their members. For example, the trend toward commercially funded research and testing has been accompanied by a variety of financial incentives for researchers to recruit patients rapidly and to allow other ethically questionable practices, such as ghostwriting. Such arrangements threaten the integrity of researchers and of science. Universities or research institutes themselves also have conflicts of interest, as the sponsored projects may help increase their budgets, both directly and indirectly, the latter via the improvement of physical infrastructure of laboratories or clinics. Independent review by individuals unaffiliated with the proposed research helps minimize the potential of such conflicts of interest and safeguards social accountability.

Dependent relationships

As researchers are often put into a position of power with respect to their choice of human research participants, the use of individuals or groups who are in a dependent relationship with the researcher is ethically questionable. This includes students, patients, employees, or even family members. Researchers should avoid using their own students; the health professions have a history of using students as a convenient sample of volunteers in research and clinical trials. Other convenient samples include research colleagues or laboratory personnel who may be dependent on the principal investigator for career advancement or their livelihood. In addition, practitioners who directly recruit patients for research, and clinicians who receive compensation to enroll their patients for participation in clinical research, also stand in contravention of conflict-of-interest guidelines. Good ethical practice requires the researcher to declare any potential conflicts of interests prospectively if there is a perceived bias in the researcher's primary duties and in relation to other involved parties.

Honest reporting of results

It should not be necessary to require that research results be reported accurately, but there have been numerous recent accounts of scientific misconduct and dishonest practices in the publication of research results. Scientific misconduct includes deliberate fabrication, falsification of scientific data, or a distortion in the reporting of scientific data, plagiarism, duplicate publication and gift authorships. Such practices may benefit the researcher, but they can cause great harm to patients, who may be given incorrect treatments based on inaccurate or false research reports, and to other researchers, who may waste much time and resources trying to follow up the studies.

Whistleblowing

Ethical dilemmas often arise when deciding how to respond to misconduct. To whom does the responsibility fall to report and investigate allegations? Technically, anyone who has knowledge of such behaviour has an obligation to disclose this information to the appropriate authorities. Whistleblowing is not always appreciated or even acted on, and whistleblowers are sometimes punished or stigmatized for exposing wrongdoing. Members of a research team should refuse to participate in practices that they consider clearly unethical, for example, lying to research subjects or fabricating data. If they observe others engaging in such practices, they should take whatever steps they can to alert the relevant authorities, either directly or anonymously.

Concluding remarks

It was noted earlier in this chapter that the dentist's role in the dentist–patient relationship is different from the researcher's role in the researcher–participant relationship, even if the dentist and the researcher are the same person. The DoH specifies that in such cases, the dentist's role must take precedence. This means, among other things, that the dentist must be prepared to recommend that the patient not take part in a research project if the patient seems to be doing well with the current treatment and the research requires that patients be randomized to different treatments and/or to a placebo. Only if the dentist, on solid scientific grounds, is truly uncertain whether the patient's current treatment is as suitable as a proposed new treatment, or even a placebo, should the dentist ask the patient to take part in the research project.

There is growing public debate around the use of digital technology, advances in gene therapy, cloning, research on embryonic and fetal tissue, and applications of stem cell research, and the public has a great investment in promoting strong ethics in research. Ethical issues are vital to the future of dental research, as much pioneering research is already being carried out in gene therapy, stem cell research, and regenerative medicine as applied to oral health problems.

Full disclosure and acceptable risk for researcher, participant, and society are the minimal expectations. While patient autonomy, informed consent, confidentiality, protection of privacy, professional competence, standards of care, and rational, sound, scientific evidence are critical factors in distinguishing between acceptable and unacceptable dental research, the determination of whether research is acceptable is ultimately an ethical one and devolves to preparedness, clarity, transparency, and respect for human rights and justice. The principle of discursive ethics, that those who are affected by decisions should have a voice in the decisions, means that the profession generally, and society as a whole, must decide where the boundaries of acceptable research practice lie.

Knowledge of relevant local laws and regulations, the maintenance of personal and professional integrity, and detailed execution of a research plan are crucial to ensure outcomes that enhance and promote dental practice, ultimately improving the management of oral diseases.

Case study

A general dental practitioner in a small rural town is approached by a contract research organization (CRO) to participate in a research clinical trial of a new nonsteroidal anti-inflammatory drug (NSAID) for postoperative pain. He is offered a sum of money for each patient that he enrolls in the trial. The CRO representative has assured him that the trial has received all the necessary approvals, including one from an ethics review committee. The dental practitioner has never participated in a research trial before and is pleased to have this opportunity and to earn extra money. He immediately accepts the offer without inquiring further about the scientific or ethical aspects of the research trial.

Commentary

The dental practitioner should not have accepted the offer without first finding out more about the research project and ensuring that it had met all the requirements for ethical research. In particular, he should have asked to see the protocol that was submitted to the ethics review committee and to look for any comments or conditions by the committee on the project. Generally, participants in research projects should only participate in those projects that are in their area of practice, and should satisfy themselves about the scientific merit and social value of the project. If they are not confident in their ability to evaluate the project, they should seek the advice of academic colleagues.

If a practitioner does agree to be part of the research trial, he or she should be sure to act in the best interests of his or her patients and only enroll those who will not be harmed by changing their current treatment to the experimental one or to a placebo. The practitioner must be able to explain the alternatives to his or her patients, so that they can give fully informed consent to participate or not. The practitioner should not agree to enroll a fixed number of patients as participants, as this could lead him or her to pressure patients to agree, perhaps against their best interests. Thereafter, the practitioner should carefully monitor the patients in the study for unexpected adverse events and be prepared to adopt rapid corrective action. Finally, the practitioner should communicate to the participating patients the results of the research as they become available.

This chapter was written by Sudeshni Naidoo

Further reading

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Chapter 12:
Culture, altruism, and the environment

Summary

History shows that the movement of people within and between countries has never been as rapid and diverse. No longer are cultures insulated from one another. Even remote communities that do not have running water or sanitation in the home may have electricity in the village and a television set. People can see conditions of others and the environment, and they want to help where they can. Within each of these very broad topics there are specific ethical dilemmas that confront the dental profession, and this chapter provides a brief insight into some of them.

Introduction

The chapter introduces three topics: culture, altruism, and the environment. While it may seem contrived to link them, they do have some common threads. All three are global as well as domestic, and there is a thread of disparity between rich and poor in each topic.

Culture

Why is an understanding of culture important in dentistry?

As is repeated throughout this manual, the application of moral values in which the patient is the prime focus is at the core of sound dental care. Each patient is an individual, but because humans tend to be part of a group, patients will adopt the values and norms of the group to which they belong. Dentists also belong to groups – both privately and professionally – so an understanding of diversity is valuable. Concentrating on the differences between cultures can be counterproductive if it produces stereotypes, but an understanding of differences is useful in identifying and dealing with potential barriers between oneself and others.

What is culture?

Groups of people are bound together by a shared set of beliefs and values. These are learned though traditions, stories, and lifestyle. People use a shared language, dialect, or jargon. Breaking cultural norms can promote a response from the group that may range from disapproval and censure to ostracism or expulsion. Primary cultural linkages can be based on race, ethnicity, or religion, but within broad cultures, linkages can be subcultures, such as gender, economic status, social status, physical attributes or disabilities, minority status, professional, school or workplace affinity, and individuals will belong to more than one of these at the same time. While one's core values and beliefs are not easily changed, other cultural characteristics may be modified or blended, depending on personal attitudes and circumstances. Particular clothing that is part of a culture, for example, may be retained or discarded either totally or depending on the situation. Few cultures are so closed that they do not permit or even encourage personal diversity.

Knowledge of cultural differences and similarities

Some core differences among cultures include attitudes toward autonomy, equality, truth and trust, and behaviours such as assertiveness or reticence, openness, and delegation of control or power. Other differences may include clothing, diet, and oral hygiene methods. The knowledge of cultural norms will assist with removing barriers and gaining cooperation, especially when behaviour change is needed for disease prevention.

While it is important not to create stereotypes or make assumptions, some generalizations may help illustrate differences in culture, as they may impact dentists in practices and in public health. It is a valuable starting point for a dentist to understand his or her own values and cultural characteristics, both personal and professional.

Autonomy

Autonomy is a core ethical value providing the right to make decisions about what happens to oneself. Cultures differ in their understanding of what is an appropriate decision-making process. Some cultures permit and even encourage individuals to make their own decisions, while others favor sharing the role with family or a close community, and some accept (or require) the delegation of the role of decision maker to another person. Some of the information needed to make a health-related decision may be confidential.

There are two dilemmas for dentists:

- Shared decision-making: The dentist believes that autonomy rests with an individual, but the patient has a different view. Dentists should try to understand why the patient holds this view and whether it is sufficiently important to impose the responsibility for a decision on this particular patient. Can a compromise be reached? If the patient requests another person to assist him or her and has agreed to the sharing of information, the dentist should use a communication method in which the discussion always includes the patient; for example, using eye contact and language to include the patient, and then defer to the patient for the final decision. In this way, it is easier to identify the wishes of the patient and detect any inappropriate coercion from others.
- Delegated decision-making: The dentist believes that the patient should make his or her own decision, but the patient's culture gives that right to someone else, such as a spouse or religious leader. Is it ever acceptable for a decision to be imposed on the patient by a third person, even if the culture requires it? When this occurs in a dental situation, the patient is usually a female in a male-dominated culture (although the patient could be an elderly dependent person in any culture). The person making the decision is often a senior man (husband, father, brother, or religious representative) who may have financial as well as social power. It is sometimes difficult to determine if the patient is voluntarily compliant or not. If the patient is being forced to undertake treatment that he or she does not agree to, the dentist must observe the needs and wishes of the patient.

Truth

Veracity on the part of dentists is a key ethical duty. Likewise, dentists ask questions of their patients and anticipate that the answers will be truthful. Unless cultural differences in managing truth are understood, problems can airse. When a question is asked but the patient does not know the answer or does not want to divulge the information, he or she may act in several ways. The patient may say directly that he or she cannot answer or does not want to answer, give a vague answer, tell a lie because it is impolite to refuse to answer, or respectfully give the answer that he or she thinks the dentist wants to hear. In some cultures and among many indigenous populations, there is a strong superstition that voicing bad news will cause it to happen. This has implications for preventive programs or early diagnosis aimed at serious health problems, such as oral cancers, where it is believed that warning of death is to predict it.

Justice

The distribution of oral healthcare is based on the principle of justice, but this has different cultural variations. Fairness may be achieved by charity – those who have, provide for those who have not. Some cultures find this unacceptable and seek to spread resources equally through taxation or social welfare. Many religions have strong philanthropic requirements of their members, but some emphasize the giving of money and others the giving of time. There are cultures with hierarchies based on birth, wealth or education and others with egalitarian values. Such variations matter in planning public health programs.

Respect

Dentists can show respect by listening and asking questions sensitively when they do not understand. Misunderstandings may occur but can be solved with goodwill on both sides. In an earlier chapter, the ethics of receiving gifts was discussed. For some cultures, gift-giving is not just a form of gratitude, but shows respect and acknowledges a relationship. Rejection of such a gift is considered an insult and a breaking of the relationship. There are other cultures where bribes are part of normal business practice to ensure reliable or quality outcomes. Rejecting excessive or expensive gifts and deflecting bribes based on cultural norms can be difficult but should be negotiated. To anticipate a problem is to partly solve it. What would you do if the $5 lottery ticket given as a gift turned into a million dollars or $1,000 or $100?

Managing cultural differences

Dentists who understand their own culture and their own personal values are better placed to recognize individual qualities that are important to others. There is much more of a blending of cultures today, particularly for young educated people, and in many cases the differences among age groups within a culture may be greater than the differences among cultures. Some guidelines that may help with cultural sensitivity include the following:

- Information about cultural differences is readily available, and dentists should seek a general understanding as a background to treating patients. Consent, diet, fasting, and oral hygiene habits are some of the practices that will vary between cultures. However, it is important not to make assumptions – the patient may identify with a culture or religion, but may not follow all of the rules.
- When in doubt, ask. Seeking to understand and listening to the patient's explanations is a sure way to establish rapport and show respect.
- If there is a potential cultural clash between you and the patient on any important issue (consent, request for a dentist of the same gender, reluctance to cooperate with requests), there should be a negotiation between you and the patient and/or a cultural representative of the patient's choice.

To ensure that the patient understands the treatment requirements and is able to consent, the dentist and the patient must be able to communicate. When direct communication is not possible (language differences or deafness), an intermediary is needed for communication. The most reliable means to accomplish this is using a registered interpreter who has the training, understanding, and professional obligation to translate the words of each party impersonally and accurately and maintain confidentiality. Interpreters provide a conduit and are not part of the discussion. Unfortunately, they are expensive, not always available for specific dialects (although telephone interpreting services cover most languages), and may not be acceptable to the patient due to differences, such as gender, religion, or political affiliation. Using family (especially children) or friends of the patient may be efficient, but there is the danger of the patient being reluctant to disclose sensitive information. There is also the potential for the companion to make assumptions rather than ask for clarification, or to become part of the decision-making process without the knowledge of the patient or dentist. This may be deliberate, but most often occurs as a misguided way of helping.

Torture

The purpose of this section is to introduce readers to the topic and is merely a summary. Dentists who are directly impacted by any of the issues raised are strongly recommended to seek more comprehensive information and advice.

Dentists have found themselves in situations where their participation is demanded in administering torture or acts that are harmful or threatening to the patient, either directly through their skills and knowledge, or indirectly. They may be asked to provide access to clinics, materials, or equipment. They could be asked to provide information that may assist in identifying individuals or share confidential information about patients who may become targets, and they may be asked to falsify records to hide or omit acts that have occurred. Many dental associations, including the World Dental Federation (FDI), have policies and guidelines that reinforce a dentist's duty of beneficence and justice and condemn the use of torture in any form and under any circumstance. Dentists should not condone or participate in any way in torture. They should resist pressure and report any such activities that occur. The local and international dental community should ensure support for these dentists against reprisals.

The survivors of torture and trauma who seek dental care need to be handled sensitively. While it is difficult to judge the extent of torture, various accounts report that 25–50 % of refugees have experienced or observed torture or have been threatened with torture. In many situations the head or mouth is the target area. Dentists should treat anyone who has been a refugee as a possible survivor of such events, even if they have not mentioned them to the dentist. These patients are likely to exhibit high levels of fear and unpredictable behaviour due to flashbacks. The dentist should ensure that the patient has as much control as possible during the appointment, is in a calm, supportive environment, and has a continuity of care that builds trust, especially in government or public health facilities. They may have a fear of authority, and they may need support from a trusted person who is chosen by the patient. Family members may not be aware of the patient's story, and clinical staff with a common language may rouse suspicion about their prior background.

Global dentistry

The ease of travel and communication, accompanied by a willingness of more and more people to be part of multicultural societies, has many benefits, such as widespread sharing of research, knowledge, and education. Unfortunately, some less-welcome impacts of globalization need to be considered, such as the ethical issues discussed earlier in this manual involving global research (Chapter 11) and the asymmetry of disease and oral healthcare resources (Chapter 10).

The movement of oral health professionals from one country to another creates another ethical issue. If the migration is temporary, and the dentists return to share their expertise, or if the movement of dentists is similar in both directions, everyone wins. However, there is pattern of migration of dentists from poor countries to wealthy countries on a permanent basis. The ethical dilemma lies in acknowledging, on the one hand, that the individuals and their families could benefit in many ways – professional and personal – and should have the opportunity for free movement. On the other hand, the countries from which the dentists come could suffer. They lose expertise, they lose the money expended on dental education, and they lose continuity while training a replacement. Wealthy countries should not deliberately recruit dentists from poorer countries but focus on training sufficient professionals for their needs. As migration will occur even without targeted recruitment, it is important that wealthy countries support efforts to find solutions – permanent, not temporary – to improve oral health, dental services, and facilities in these disadvantaged countries.

Altruism

One of the most compelling problems in oral health is the widening disparity in the distribution of oral diseases and in the access to dental care. This disparity is occurring both within countries and between countries. The distribution of dentists and other health professionals is contrary to oral health needs. Dentists concentrate in cities, in affluent districts and in wealthy counties. Yet here the health needs are fewer because disease is under control or there are more resources. This is not an indication that dentists should be forced to move (although a more balanced distribution would be welcome), but rather a challenge to find a means for universal basic care within the existing reality. As with any complex social problem, there are many causes and potential solutions.

Prevention of disease and supply of adequate resources are two of the more important components of reducing disparity, and are discussed in other chapters. This chapter concentrates on charity and volunteering. While these make a relatively small contribution to the overall imbalance, they can be essential to those who receive help. The need for altruism will not diminish, no matter how much improvement is made by governments or other health providers. There will always be some who fall through the cracks in any system.

Why do people engage in altruistic activities?

There are moral, personal, and social reasons for people undertaking activities that help others in addition to – and well beyond – their duties or obligations. The motivation may be to fulfill a professional duty of social responsibility, or it may be based on a personal desire to share one's relative affluence and, in doing so, return something to society. Anger at injustices, compassion for others, guilt, empathy, or sympathy can stimulate acts of altruism. Less noble but equally common are the motivations stemming from the need for social recognition, justifying of social status, or receiving of praise. Is the source of motivation important? Probably not, so long as the actions satisfy the moral imperatives to do good and do no harm. Ethical guidelines or codes of dental associations present altruism as an integral part of being a professional, and they encourage their members to get involved.

Giving

Pro bono treatment is mentioned in several chapters in this manual. It can take the form of reduced or waived fees for those who cannot pay, or the provision of emergency care for those who are not regular patients. Pro bono treatment is an inefficient means of increasing access to underserviced populations, but it is useful as a means of helping some individuals. In some cultures, pro bono dentistry is successfully established as a routine for supporting the poor, but some other cultures find charity hard to ask for or accept because of a loss of dignity. This deters them from seeking help until their situation is critical.

Philanthropy is relied upon in every aspect of dentistry, from small clinics to major international research projects. Donations (large or small) constitute a universal means of helping countless charities that provide excellent services. Unfortunately, the situation is too easily exploited by unscrupulous so-called charities. As soon as one scam is uncovered, another takes its place. It is recommended that a charity be checked before one supports it.

Nongovernmental organizations (NGOs), well-known international charity groups, and major religions undertake the evaluation of charities to identify the percentage of administrative costs, genuine activities, and outcomes of their work. Dental associations know of reliable dental charities. It is worthwhile checking before donating.

Volunteering

Dentists and other health professionals volunteer their time and expertise to provide treatment to those in need, in a setting that is not part of their regular workplace. Dental volunteering is increasing in scale and, in some circumstances, showing signs of being a victim of its popularity – hundreds of websites promote volunteering. Sorting the reliable from the scams is not easy. On returning from a visit to Cambodia in 2017, an Australian senator (Linda Reynolds) wrote about one such scam – orphanage tourism. (She subsequently found many others like it.) Service clubs, church groups, students, and well-intentioned people are targeted. They donate to or visit orphanages to provide unneeded work – often while local workers are unemployed. Even worse, the so-called orphans are children who have been removed from their families and are not genuine orphans. The volunteers are exploited by paying travel agents' fees and other costs that are higher than normal. Any work that the volunteers do profits the operators, not the children or communities. The children are groomed to play the part or suffer the consequences, and the sophistication of the scammers leaves the volunteers ignorant and willing to promote the charity to others or raise money for it. While most instances like this do not involve dentistry, they easily could. Worse than the wasted money is the exploitation of the children and the community. It is therefore important to undertake thorough and independent checks.

Established groups or NGOs know the pitfalls and can guide the volunteers' activities efficiently and effectively. Those who attempt to set up a volunteer dental service, either alone or within an existing charity or religious group, may have the best of intentions but are likely to meet with difficulties.

People such as the homeless and the poor, as well as indigenous, refugee, and rural communities attract domestic volunteers. Some of these people receive their only dental care through volunteers, even within affluent societies. Issues such as registration, travel, and international laws do not apply. The assessment of activities and any subsequent program modification is easier. However, many of the issues discussed next are relevant for both domestic and international volunteers.

In addition to being motivated by compassion, sharing, and justice, volunteers may have other motives. The desire to travel, meet locals away from tourist routes, have a safe adventure, be part of a different culture are some benefits of volunteering. Dental schools and their students can have difficulty finding suitable patients for some clinical experiences, particularly in extractions and rampant caries, and can benefit from traveling to the towns or countries with a high need for this treatment. Religious groups may wish to include missionaries who are also health workers. Dentists (and dental companies) may receive favorable tax arrangements for volunteer work or for donating materials and equipment. All these examples, and more, are among the benefits of volunteering, but they may present conflicts of interest, especially if they are the prime reason for undertaking volunteering.

Legislation

It is the duty of dentists to practice under the laws of the country in which they work. They are required to obtain registration and, in addition, may have to take a test, be supervised for a period of time, or be restricted in other ways. Dental hygienists or therapists may not be included in the legislation, and students may not be able to provide clinical treatment. As well as complying with the law, all dental volunteers should be aware of not exceeding their skill levels. Being covered for professional liability may or may not be required, but such insurance should be obtained. Some governments have laws that require volunteers to obtain authority before undertaking a project, so that the project is one that is wanted, necessary, and does not duplicate what is currently provided. Where such laws do not exist, it is still important to confirm projects with local authorities.

Community liaison

Most governments or communities have oral health programs (even if they are loose, ineffective, or may seem not to exist). Unless volunteers understand what is needed, the community can be worse off when they leave. Some of the unwanted outcomes of poor preparation include raising false expectations of what the community should expect of local services, then leaving the host community feeling that the local services are incompetent, substandard, or inappropriate. Local dentists may feel that the materials and practices introduced are superior (not merely different) to those normally provided, but when volunteers take their jobs, even for a couple of weeks, the local dentists may lose the respect of the community and may also lose money. Some techniques and equipment could even be inappropriate in the conditions, and volunteers should listen to local staff in this regard. Where possible, everything should be purchased locally so that the profit remains in the host country. Where materials and instruments are donated, they should not be out of date, flawed, or unusable (e.g., requiring 120-volt power when local power is 240 or 32 volt).

Cultural differences

Learning to work and live within a different culture is a valuable experience for domestic and international volunteers. There are many characteristics of such situations that enable volunteers and the host community to gain maximum pleasure from the encounter. The best volunteers are those who are genuinely interested in the hosts, willing to learn, open to new ideas, and nonjudgmental. In clinics, they learn the local ways before offering new methods or criticism. They are willing to do everything that needs to be done, from extracting teeth to sweeping floors. Wherever possible, they should arrive with a basic understanding of a common language. In many countries, a European language is a second language for education and spoken by health professionals. Some behaviour annoys both hosts and fellow volunteers. Lack of humility, a superior attitude, being autocratic, expecting to teach but not learn, not respecting host behaviour in dress, drinking, or sexual relations, being unwilling to either adapt to local rules or take directions from a local boss – these are always unacceptable. There are also two traits that are incompatible with good volunteering. One is the desire to undertake volunteering because of the feeling of power that it gives. The other is an obsession with compassion and beneficence, a paternalistic attitude that offends people and causes the volunteer to lose sight of the fact that he or she is a guest of the host community.

Volunteers should be well prepared with information about local customs, such as the extraction of teeth for ceremonial or cosmetic purposes. The situation should be understood in advance and protocols put in place. The more serious dilemmas are those where the volunteer observes domestic violence, abuse of children, human slavery, bribery, stealing of dental equipment, aggressive patients, and other such incidents and conditions. Well-planned projects will have an understanding of the local culture, will have considered and anticipated some of the problems – often with the support of a local person as liaison – and will have prepared the volunteer. When a volunteer is faced with situations where the proper reaction or behaviour is not evident, courtesy, curiosity, and openness to guidance will blunt any potential offense.

Impediments to autonomy

One of the main impediments to autonomy is a lack of power or unequal power, particularly for people who rely on volunteers for oral healthcare. The volunteers and the local patients may lack a common language or independent interpreters to assist in understanding the information provided. There may be limited choices of treatment available. Patients may feel that they have to comply with the wishes of the volunteers or be denied treatment now or in the future. When the dentist is part of a religious missionary group, the patient may feel that he or she must be involved in the religious side of the program to get much-needed dental treatment. It would be unethical to use dental treatment to gain converts, and dentists should ensure that this is clearly understood by the hosts.

Length of stay

Volunteers can stay for lengths of time from a weekend to several years. Domestic volunteers often provide weekend assistance. To gain maximum benefit, the assistance should be regular, predictable, and ongoing – for example, a three-day visit every six months to a small rural town, or a mobile clinic every Saturday in a park frequented by homeless people.

For international volunteer projects (and domestic projects for indigenous communities), there are some schemes, such as preplanned visits by an oral surgeon, that may only last a week at a time and be very successful. However, in most instances it can take at least a week to gain the trust of the local people and to settle into the local surroundings. It is said that a minimum of three weeks is needed to achieve any realistic goals. The most appropriate length of stay varies between countries and depends on the set-up of the clinic (an established clinic with a regular rotation of volunteers or a temporary facility), the status of the volunteer dentists (unpaid and independent, or employed at local rates of pay), the conditions of the patients (emergency treatment or routine planned program), and whether any formal teaching of local personnel is undertaken during the visit.

Guidelines

Many government websites have recommendations to keep international volunteers safe and informed. Dental associations have guidelines, manuals, and checklists to help project planners and ensure the host communities gain the maximum benefit from the time, money, and enthusiasm of the volunteer dentists. It is not difficult to access these websites, and those considering volunteering are advised to do so.

The World Health Organization has prepared a manual for oral health in Africa that is useful for other areas of high need. Oral health projects should be evaluated on cost-effectiveness, impact, sustainability, and level of prevention for both populations and individuals. To satisfy these goals, a Basis Package of Oral Care was devised. The following three prongs can provide a basis for treatment in many of the communities that depend on volunteers:

- Promote fluoride toothpaste that is affordable.
- Provide urgent treatment for relief of pain.
- Use atraumatic restorative treatment for the treatment and prevention of dental caries.

Overall, there is agreement on what is essential in any volunteer activity. The project should:

- not leave the community with added expense or post-treatment complications to manage after the volunteers leave;
- be planned in collaboration with the local community, so that the project is necessary, wanted and does not duplicate or clash with other projects;
- be linked with established and approved programs;
- respect the local culture, and the volunteers should be good guests;
- comply with legal requirements and regulations, and protect the safety of the hosts and volunteers;
- be evaluated on completion, and both the planning and the evaluation should be provided to the host community for comment and improvement;
- be undertaken within the ethical principles of beneficence, nonmaleficence, autonomy, justice, and veracity.

Environment: Impact of dentistry on environmental sustainability

Bioethics is understood to mean the relationships among individuals, and the environment is generally thought to relate to air and water, and flora and fauna, rather than to people. Some commentators claim that the environment introduces a new concept of ethics and should not constitute an extension of existing moral principles. As stated by Benson, this can be a nice philosophical discussion, but is not really relevant to the core debate that poses three main questions: “Are the effects harmful? Can we do anything? Is it morally incumbent on us to do so?”

In the past, it was rare to find comments on the environment in books or journal articles about bioethics, and ever rarer in relation to dental ethics. In the 21st century, pollution and damage to the environment are recognized as among the most important public health concerns. Health professionals are starting to debate their moral implications, and in 2017 the FDI passed the Policy Statement on Sustainability in Dentistry to highlight those issues that involve dentistry in particular.

Sustainable development is a term referring to the importance of managing the environment so that future generations may continue to enjoy the natural resources currently available. Dentistry produces a variety of waste products, from harmless domestic waste to toxic waste, and appropriate management is mandated in some countries, voluntary in others, and, unfortunately, ignored in some. While unsafe use and disposal of toxic products would be considered unethical, disposal is only one component of sustainable management. Consistent with the adage that *prevention is better than cure,* it is useful to consider that reducing the burden of dental disease will reduce the amount of environmentally challenging products used in dentistry. When lobbying for increased public oral health funding, the environmental benefit of prevention is often overlooked.

The bulk of dental surgery waste is general waste that goes directly into landfill. The key elements of environmental care are relevant here: reduce (less packaging or plastics, longer-lasting alternatives, such as light-emitting diode [LED] lights, quantities of anything that are enough and not excessive); reuse (use china rather than disposable cups, do double-sided printing); recycle (buy recycled paper, return used paper for recycling, use eco-friendly cleaning products); and remove (manage rubbish effectively). Adopting good habits for general waste develops a mindset that flows throughout the practice or clinic.

The principles used above (reduce, reuse, recycle, and remove) apply to more damaging dental waste. Mercury (amalgam restorations), silver (radiograph fixer and unused film), lead (radiograph packets), and a variety of chemical and pharmaceutical waste products are toxic to the environment and should not be included in general waste. Infectious waste includes those items that have been exposed to blood and may include needles and other sharp objects. Protocols dictate how each should be disposed of safely, and detail what is included in which category (e.g., extracted teeth with or without amalgam, saliva-soaked cotton roll, or blood-splattered paper bibs). The environmental impact and energy used in the removal of toxic and infectious waste is higher than the disposal of general waste because of the need for incineration and other chemicals, as well as the cost of separate storage and removal. To reduce the impact and energy usage, dentists should train their staff to make sure that they do not include unnecessary items with the hazardous waste.

Dentists should be familiar with their local regulations and comply with them. They have a duty of care to ensure that those on their staff handling waste are trained to do so safely and are vaccinated, where appropriate. They also need to ensure that the firms they use to dispose of the waste are registered and reliable.

There is a global dimension to sustainable practices in dentistry. One example involved the pressure to reduce mercury in the environment. Although dental amalgam is only a small component of the overall problem, there were calls for it to be discontinued. In wealthy communities, the reduction in the use of amalgam has occurred due to caries reduction and the substitution of alternative restorations; this probably would have happened regardless of environmental demands. In those communities and countries that continue to experience rampant caries, amalgam remains a cost-effective and durable material. Nonetheless, the focus on reducing mercury has stimulated funding for research into alternative restoration materials, and a consideration of the environmental impact of new materials.

To promote ethical management of the environmental impact of dentistry, everyone involved in dentistry should become aware of the part they can play – learning and teaching, researching more environmentally-friendly products, reducing disease, revisiting the impact of waste, and thinking of the environment for future generations.

This chapter was written by Suzette Porter

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Appendix:
A step-wise approach to ethical decision-making

The dental team encounters on a daily basis several clinical situations that can pose complex ethical dilemmas. An understanding of the ethical principles discussed elsewhere in this manual will make it easier to work through solutions to dilemmas. This appendix uses a structured step-wise approach to provide an example of the application of theoretical knowledge to resolve clinical/ethical dilemmas.

There are many problem-solving approaches available, but most follow similar systematic steps. Ethical decision-making can be challenging, and working through an ethical dilemma does not come easily – if it does, it is not a dilemma – but takes practice and careful consideration. The approach outlined next is intended as a guide to the ethical decision-making process. It may need to be amended on a case-by-case basis, and is intended to serve as a guide to assist in resolving ethical dilemmas.

- Step 1: Identify the ethical dilemma – what are the conflicting values?
- Step 2: Establish all the necessary information – medical, legal, ethical, sociopolitical norms; patient preferences; dentist's personal value system.
- Step 3: Analyze the information obtained.
- Step 4: Formulate solutions, make recommendations, justify them with arguments, then act accordingly.
- Step 5: Implement the plan and necessary policies in the dental practice.
- Step 6: Reflect on the outcome of the ethical decision-making process.

Case study

A 50-year-old female patient requests that her dentist replace her partial dentures with dental implants. Her dentist explains that he has not had any training or experience in the placement of dental implants and refers her to a maxillofacial surgeon. The surgeon examines and assesses her, and agrees to place the implants.

Following the extraction of half a dozen teeth, the surgeon anticipates that bone resorption will occur and advises bone augmentation to ensure that there will be adequate support for the implants. The patient is not keen on bone augmentation, as this will require removal of bone from the iliac crest of her hip bone, and the surgeon agrees to proceed without bone augmentation. The surgeon places 12 implants and refers the patient to a prosthodontist to prepare the crowns.

Despite the fact that the prosthodontist has noticed that two of the implants were not correctly placed, she nevertheless proceeds with the placement of the crowns on the implants. The patient is not happy with the outcome of the treatment and notices that she has difficulty with her speech following the placement of the implants. She then consults another prosthodontist, who attempts to rectify the problem. She has spent all her medical savings and a huge amount of her personal funds and is still unhappy with the outcome. She informs the maxillofacial surgeon and prosthodontists about her dissatisfaction, but no solutions to her problems are proposed.

Step 1: Identify the ethical dilemma

- Identify the conflicting values, rights, or professional responsibilities the dental professionals have with the patient's request.
- Consider autonomy vs. beneficence (do good) and nonmaleficence (do no harm) in the attempt to treat the patient.
- What meanings and limitations are typically attached to these competing values?
- In acquiescing to the requests of the patient, did the dental team cause more harm than good?

Step 2: Establish all the necessary information

Before ethical analysis of this case, it is necessary to establish all the pertinent scientific and clinical dental information related to the case.

Some general questions to consider:

Is implant therapy safe?

Titanium has been established as a safe implant material with no recorded incidences of toxicity or allergy. The surgical placement of implants requires a detailed understanding of the relevant anatomy, a good working knowledge of oral surgery, oral pathology, periodontics, and restorative dentistry. Complications can occur, even in the hands of experienced surgeons.

How well can the treatment work under ideal conditions in the hands of an experienced clinician?

The efficacy of endosseous dental implants has been reported to be as high as 96.5 %, and the effectiveness of dental implants in practice has been reported to be as low as 79.1 % in terms of implant survival.

How well can the treatment be expected to work in the dentist's hands?

Dental implant placement requires appropriate training. Collaboration with an experienced clinician can help maximize results and minimize problems.

Will the dentist apply the same selection criteria for the technique in his or her own practice as advocated by studies with high success rates?

Obviously, if the proven guidelines are not adhered to, and less stringent selection criteria are used, failure of the implants is more likely. Choice of techniques and materials is a critical component for success. A clinician who works beyond his or her clinical experience has a duty of care to make the situation very clear to prospective patients. An honest description of one's own experience and long-term results may defuse any disappointment if the implants fail.

Specific questions

1. Was this patient an appropriate candidate for dental implants?
2. If bone augmentation was indicated, why was it not done?
3. If the patient refused bone augmentation, should the procedure have continued?
4. Was there adequate communication and planning between the maxillofacial surgeon and the prosthodontist?
5. Should the first prosthodontist have agreed to proceed with crowns even though she perceived that some implants were not adequately placed?
6. Was the quality of dental work acceptable?
7. What would an independent opinion contribute to the clinical dilemma?
8. Why was the patient's speech affected after placement of the implants?
9. Did the dental team have all the relevant information related to implants and their placement (as outlined above) written into a patient information leaflet?

Ethical issues to consider

- What is the ethical standpoint? How do the ethical principles of autonomy, nonmaleficence, and beneficence interact? Did the patient make an autonomous decision? Was the consent truly informed? What information was presented to the patient regarding the full extent of a very complex dental procedure? Was this information provided in writing? Did the patient sign a consent document indicating her understanding of and agreement with the procedure? In order to be *beneficent* – to do good – one has to be competent to perform the procedure requested by the patient. What was the level of competence of the maxillofacial surgeon and prosthodontist/s? Was a risk–benefit assessment made? Was it communicated/discussed with the patient? Did the benefits of the procedure outweigh the risks? Was justice done in this case? Justice as a principle refers to fairness. In dentistry, justice refers to the fair treatment of patients. Did the patient experience fairness in the way in which she was treated? These principles must be balanced against each other.

- How do the theories impact this case? Can a universal ethical theory influence a decision to treat? Were the outcomes considered at the outset, and was the greatest good for the greatest number achieved? At the end of the process, were all parties happy? Was the intention of all the practitioners to help the patient? Did all the practitioners set out with a duty to do good and provide the best level of care possible? In attempting to respect and to help the patient (beneficence), was harm caused inadvertently? What motivated the practitioners to proceed with the patient's request? What would the good practitioner do? Did the practitioners display integrity? Were they motivated by self-interest or financial gain from this very expensive procedure?
- What were the patient's preferences? Clearly, she chose implants over dentures in the first place. Did the clinical evidence support her preference to forgo the bone augmentation?
- What does your personal value system dictate? Usually, this will influence the final decision significantly. In your country, how are these value systems influenced by medical education, parental influence, political beliefs, and personal experiences?
- What are the sociopolitical norms of the day? Are they acceptable? How will they influence medical decision-making?

Step 3: Analyze the information

Considering all the information gathered in Step 2, rank the values or ethical principles. Which are the most relevant to the dilemma? It is important to confer different weighting to the principles. What reasons can be given for choosing one competing value or principle over another? Respecting patient autonomy does not mean that dentists must always do exactly what patients request. The obligation of informed consent created by the principle of respect for autonomy requires a thorough consent process to occur between dentist and patient, in this case between maxillofacial surgeon and patient.

An inadequate consent process invalidates the weight carried by the principle of autonomy and tips the balance in favor of beneficence – that is, acting in the best interest of the patient. This may mean that the maxillofacial surgeon may have to decline to do a procedure that is not medically sound. When respecting the patient's request – in this case, to have the implants without bone augmentation – will lead to foreseeable harm (unstable implants), it is important for the oral healthcare practitioner to inform the patient that the practitioner is not prepared to undertake a procedure that will lead to harming the patient. It may be advisable to use different approaches to the core problem and examine different outcomes. This process will culminate in the development of moral arguments to justify the position taken. Well-constructed premises using logic and rationality will lead to rational conclusions.

Step 4: Formulate solutions, make recommendations, then act

In this step one considers possible solutions, makes recommendations, and then develops an action plan that is consistent with the ethical priorities that have been identified as central to the dilemma. The ethical rigor of this plan hinges on the ability to justify it through arguments. These arguments should be convincing to those involved in the case, such as the patient, family members, and other members of the healthcare team, all of whom could ask: "Why this plan?". To be an ethically responsible dentist is to be able to respond to such "why-did-you-do-that?" questions.

Possible solutions include:

- The development of a treatment protocol for dental implants based on scientific evidence that can support or justify the action plan with the values and principles on which the plan is based. Such a protocol will include inclusion and exclusion criteria, as well as a detailed planning process incorporating other team members.

- Establishment of an appropriate oral health team to consult with the patient before the procedure commences about the potential risks and consequences of alternative actions.
- Development of a comprehensive consent document for prospective patients to read before embarking on such an expensive treatment. Risks, benefits, costs, and complications must be outlined.
- Sourcing of a video to provide patients with information on the surgical process to be followed.

Step 5: Implementation of the plan or policy

The plan should be implemented utilizing the most appropriate skills and competencies. Policy may have to be implemented, created, or amended in the dental practice. Any policy development will be based on how the case was handled in the end. Guidelines may have to be drawn up so that the management of a similar problem in the future is much clearer. These guidelines can be incorporated into the standard operating procedures of the practice.

Step 6: Reflect on the outcome of this ethical decision-making process

How should the consequences of this process for those involved – the patient, colleagues, the practice – be evaluated?
(Case study adapted from Moodley and Naidoo, 2010.)

This appendix was written by Sudeshni Naidoo

Further reading

Five-step approach adapted from the curriculum in medical ethics, courtesy of Dr. Eugene Bereza, family physician/clinical ethicist, Department of Family Medicine, McGill University, Canada.

Moodley K, Naidoo S (2010). Ethics and the Dental Team. Pretoria, South Africa: Van Schaik Publishers.

Glossary

Advance directive Instructions by a patient to a healthcare provider given in advance of that patient becoming incompetent. Usually in written form and legally enforceable in many countries.

Allocation Distribution of scarce resources.

Altruism Virtue of giving priority to the interests of others over the interests of oneself.

Argument Statement that clarifies, such that any reasonable person can agree with the conclusions.

Art In philosophy of dentistry: the practice of achieving unique results from interventions on individual patients. Compare with science.

Autonomy Self-law or self-determination. Originally used as a political term to mean ruled or governed by the self. In bioethics, the term refers primarily to a patient's determining his or her own medical care. Patients have a right to respect for their autonomy, that is, healthcare providers must take a patient's own healthcare-related wishes, values, and choices very seriously.

Bioethics Critical study of moral issues that arise in healthcare and the life sciences.

Beneficence The act of fostering another person's well-being or best interests. In bioethics, beneficence is used to indicate the healthcare provider's obligation to act in the patient's best interests, to act for the good of the patient. Beneficence ranges from preventing illness altogether, to preventing a downhill course by maintaining the status quo, to improving the patient's health status, curing the disease altogether, and finally, rehabilitating functions lost as a result of past disease.

Best interest judgment A judgment by a professional healthcare giver or by a patient's surrogate about what is objectively the best treatment for the patient. Opposite of substituted judgment.

Commercial Following the principles of commerce, that is, the trading of goods and services between an individual seller or service provider and his or her clients.

Communitarian Reflecting the sociopolitical idea that human beings in essence are members of a community (rather than lone individuals). In other words, social relationships among people do not arise out of agreements between individuals. Such relationships always exist, irrespective of any specific agreements between particular individuals.

Compassion Virtue of suffering together or feeling along with the suffering of another human being and staying close to that suffering patient.

Competence If said of a dentist: the ability of a dentist to practice dentistry in a manner that is scientifically and technically sound. If said of a patient: the ability of a patient to make autonomous decisions about his or her own healthcare.

Competent professional standard The standard by which the actions of a dentist are assessed by comparing the work of the dentist with the work of the average yet competent peer, that is, with the work of colleagues in his or her community. Compare with the reasonable patient standard.

Compliance Degree to which the patient cooperates in the treatment plan, specifically outside of the dentist's office.

Confidentiality The state of being (kept) secret, specifically regarding patient-related information and documentation. The dentist's duty to maintain confidentiality arises out of the trust vested in the dentist by the patient. Confidentiality sustains a respectful relationship between patient and dentist. The word also pertains to information that is readily available or in the public domain, but is held by the dentist.

Consent Authorization by the patient to proceed with a proposed diagnostic or therapeutic intervention.

Contract Formally binding and legally enforceable agreement between two or more parties to exchange certain specified goods and/or services.

Descriptive Factual; describing some past, present, or future state of affairs. Compare with prescriptive.

Dilemma Situation in which one has to choose between two (di-) mutually exclusive options (-lemma).

Distributive justice Fairness in the allocation of resources.

Duty Obligation.

Egalitarian Emphasizing the equality of all people.

Empirical Observational or experiential. Based on observations of the state of affairs.

Etiquette Code of instructions for proper and fitting behaviour, typically based on traditions and conventions.

Experimental Aimed at gaining new knowledge by testing certain yet-to-be-proven hypotheses.

Explicit consent Consent that is given by the patient for a specified intervention. Compare with implied consent and presumed consent.

Expressed consent Synonymous with explicit consent.

Fairness Virtue of treating all people in a manner that does justice to the needs of each, without undue discrimination or favoritism.

Fallacy Statement that appears to have argumentative force, but on closer inspection is deceptive.

Fiduciary Based on trust.

Futile Useless. When said of a dental treatment: not protecting or fostering a patient's overall health (even though it may be effective in restoring the function of a particular organ or body part).

Honesty Virtue of being genuine, sincere; being truthful in communications with other people.

Humility Virtue of being modest.

In dubio (dubiis) abstine When in doubt, abstain. Ancient medical-ethical guideline not to proceed with diagnostic or therapeutic interventions when their effectiveness or benefit is unlikely.

Impaired When said of dentists: no longer able to practice competently, usually due to physical or mental handicaps.

Implicit consent Synonymous with implied consent.

Implied consent Authorization to proceed with diagnostic or therapeutic interventions that are necessary components of a more comprehensive diagnostic or therapeutic plan to which the patient has already consented. Compare with explicit consent.

Incompetent see Competence.

Indication Grounds to begin dental treatment based on the medical needs (rather than simply the wishes) of a patient.

Informed consent Consent that is based on information (about diagnosis, prognosis, treatment options, and so on) provided by the dentist.

Invalid Of an argument: formally, logically incorrect, resulting in a conclusion the truth of which is not known.

Libertarianism Political theory that assumes all individuals, once their freedom is protected by the state, can and should be responsible for their own well-being.

Negative right The right not to be restrained in some form. Also called liberal right.

Neglect Failure to intervene when one should have intervened.

Nonmaleficence Abstaining from doing harm (to patients).

Normative Setting or implying a norm, that is, a binding rule of conduct.

Paternalism Treating patients as a father treats his small children. In other words, making decisions on behalf of one's patient for the presumed good of the patient but without involving the patient in the decision-making process. Soft or weak paternalism: Making decisions on behalf of one's patient when one does not know the patient's own opinion about the matter. Hard or strong paternalism: Making decisions on behalf of one's patient contrary to the patient's expressed wishes.

Patient of record See Regular patient

Patient of the practice See Regular patient

Peer review Process of quality assurance, whereby members of the same profession evaluate one another's work. More narrowly used to indicate the process whereby members of the profession mediate in a conflict between a patient and a professional.

Pluralism Thesis that there exists at present a plurality of largely diverse and even incompatible moral opinions.

Positive right Entitlement. Claim to certain goods or services to be realized by another person or, more commonly, society at large (hence, positive rights are often called *social rights*).

Prescriptive Dictating; prescribing how the present or future ought to be, even if factually it is not so. Opposite of descriptive.

Presumed consent Authorization to proceed with medical or dental treatment that is based on the presumption that the patient would have consented to the treatment had he or she been competent to consent. Presumed consent can only be invoked in an emergency-type situation, where there is no proxy who can consent on the patient's behalf, and then only for the kind of emergency care to which a patient typically consents.

Primum non nocere Ancient Latin guideline, the meaning of which can also be found in the Hippocratic Oath: "First and foremost, do no harm."

Privacy Not having personal knowledge about oneself possessed by another. Privacy pertains to facts that are not widely known, and the person does not want to be known. Once in the public domain, the facts are no longer private.

Profession An occupation that is characterized by: (i) a high degree of expertise; (ii) extensive power over needy and vulnerable clients/patients; and (iii) a commitment to apply this expertise in the best interests of clients/patients (rather than capitalizing on the vulnerability of the clients/patients). Some professions still require their members to profess literally, that is, to make this commitment in the form of a public oath. Others do not require the swearing of an oath, but all professions are socially structured such that this commitment is part of their identity. Clients/patients thus expect and trust that professionals abide by this commitment.

Proxy Synonym of surrogate: someone close to the patient who can make decisions about healthcare on behalf of the patient.

Reasonable patient standard Standard by which the actions of a dentist are assessed by comparing the work of this dentist with what most other patients could have reasonably expected from the dentist. Compare with competent professional standard.

Regular patients Also called patients of record or patients of the practice. Patients who have indicated that they wish to have a long-term professional relationship with that specific dentist or dental practice, and the dentist or the practice has accepted them. These patients do not come to a dental office for a single visit (such as emergency treatment), but they are expected to undergo regular dental care at this particular office.

Right Claim of entitlement on the part of a person either not to act in some way (negative right), or to act in some way (positive right).

Right not to know Patient's right to decline the receiving of information about proposed dental interventions.

Rule In ethics: a moral guideline that applies to a category of acts.

Side effect Undesirable and unintended effect of an intervention or medication.

Science In philosophy of dentistry: the practice of building generic knowledge that holds true of classes of patients and can be applied with predictable, generic results. Compare with art.

Social contract This is an agreement, usually voluntary, between members of society that guides behaviour by defining their rights, responsibilities, and duties.

Substituted consent A specific form of consent by a proxy where the proxy tries to substitute the patient and consents to what the proxy thinks the patient would have consented to had the patient been able to decide for him- or herself. See also Substituted judgment.

Substituted judgment Judgment that mimics what the patient would have decided had the patient been competent. See also Substituted consent.

Sustainability A focus on providing for the needs of the present while ensuring that the environment and economy are not depleted for future generations.

Surrogate Synonym of proxy.

Therapeutic exception Also called therapeutic privilege. Privilege claimed by the dentist not to have to (fully) inform the patient, because informing the patient would cause serious harm to the patient.

Theory Consistent and comprehensive body of knowledge that explains a particular class of phenomena or experiences.

Truth Quality of a proposition to adequately describe the reality. See also Validity.

Utilitarianism Ethical theory holding that an action is morally justified to the extent that it yields the greatest benefits to the greatest number of people.

Validity Formal, logical correctness of an argument, yielding a truthful conclusion if the premises are true as well.

Value Quality that makes something of interest and worth.

Veracity Truthfulness and trustworthiness. It includes providing the whole truth as well as anticipating information that may be needed to complete an understanding of the facts. It is not merely the absence of lies.

Virtue A person's disposition toward moral behaviour.

Voluntary Freely, in accordance with one's free will.

Whistleblowing Exposing the incompetence or immorality of a fellow dentist or other colleague.