

*FDI World Dental Federation*

# Dental Ethics Manual



*FDI World Dental Federation*

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## FOREWORD

It is a privilege and a pleasure to introduce the FDI Dental Ethics Manual.

I want to congratulate and thank each and every one who collaborated in this Dental Ethics Manual. This publication is the result of the FDI's involvement and active promotion of dental ethics over many years.

The FDI World Dental Federation is the global dental association representing more than 135 member countries. One of the FDI's roles is to assist the member associations and each dentist in their daily challenges.

The FDI International Principles of Ethics for the Dental Profession states that:

The professional dentist:

- will practice according to the art and science of dentistry and to the principles of humanity
- will safeguard the oral health of patients irrespective of their individual status

The importance of ethics as an integral part of the medical profession – and thus by implication also the dental profession, as dentistry is part and parcel of general health – has been highlighted already by Hippocrates more than 2,000 years ago. The core values of “first, do no harm” and “put the patient first” apply to this very day.

Practicing dentistry gives rise to a wide spectrum of potential ethical dilemmas. Modern technology, age-

old cultural beliefs and diverse lifestyles could easily give rise to misunderstanding and conflict. This manual does not list what is right and what is wrong, but provides values and practical examples that will give food for thought and will guide practitioners in making sound ethical decisions in the best interests of their patients.

Dental education and training will never be complete unless the curricula of dental schools incorporate a course on dental and medical ethics. The FDI trusts that this Manual will become a source of reference for dental students and practitioners alike.

During my Presidency I decided to focus on Excellence, Medical positioning of our profession and Ethics.

- Excellence in our daily practice is an ethical behaviour
- Oral health is an intrinsic part of general health; the same fundamental ethos, values and norms guide its practice. Oral healthcare should therefore be approached with the same diligence as medical care.
- Ethical behaviour gives credibility and trust - indispensable for the good outcome of our treatments

As dentists we experience daily the privileged patient – practitioner relationship and we have to nurture it.



In order to live up to the age-old adage of putting the patient first, a few practical aspects should always be upfront in our minds: respect all patients and empower them by providing them with adequate information and by involving them in determining treatment plans and decisions about their health. The primary consideration must always be the patient's health and well-being.

The FDI hopes this Manual will be an inspiration for everyone in the oral health professions and in the best interests of their patients.

A handwritten signature in black ink, appearing to read 'M. Aerden', enclosed in a light grey rectangular box.

**Dr. Michèle Aerden**

*President*

FDI World Dental Federation

## PREFACE

Every day oral health professionals are subject to strict routines and stressful situations which can easily result in decisions or actions that could on reflection seem to be doubtful and maybe even unethical. This Manual provides the opportunity for dental practitioners, educators, students and all involved in patient care to reflect on the role that we as professionals have to play and how we should act to ensure that in all circumstances we maintain the trust and confidence placed in us by our patients.

The Dental Ethics Manual provides easy and enjoyable, yet educational, reading. The old adage of “when in doubt, it is probably not ethical” is a good personal guideline. The many practical examples in the Manual cover the wide scope of issues applicable to daily practice and will ensure that readers can relate to the situation and contemplate how they would and should handle similar situations in their work environment.

The Manual is published in a practical pocket size format and we hope that it will become an invaluable aid to the work routine of dental practices and dental schools around the globe. We also hope that this Manual will eventually be translated into many languages in order to give all involved in dental education and care around the world the opportunity to benefit from the principles conveyed in this book.

We wish to express our appreciation to the World Medical Association for providing the stimulus for this publication through their Medical Ethics Manual and especially to our author, Dr John Williams. We also wish to acknowledge with gratitude the unrestricted grant from Johnson & Johnson which made the production of this publication possible.


This publication of this Manual fulfils in part the FDI mission "to advance and promote the ethics, art, science and practice of dentistry". Ethical issues are part of our daily lives. Let us all strive to live up to the high ideals of our profession by acting professionally and ethically in all circumstances in our professional and private lives.



**Dr. JT Barnard**

*Executive Director*

FDI World Dental Federation



**Dr. Peter Swiss**

*Chairman*

FDI Ethics & Dental Legislation Working Group

## SUMMARY

Dentists everywhere are members of a profession with very high ethical standards. For many years the FDI World Dental Federation has been actively engaged in developing ethics policies for dentistry, most notably the **International Principles of Ethics for the Dental Profession**. In order to assist dentists in understanding and implementing these principles, the FDI has commissioned this Dental Ethics Manual. The Manual is offered as an educational resource to dental students and practising dentists throughout the world.

There already exists an excellent and rapidly expanding literature on dental ethics, and this Manual is intended to complement rather than compete with these books and articles. The Manual provides a concise introduction to the basic concepts of ethics and their application to the most common issues encountered by dentists in their daily practice. Learning objectives are provided for the Manual as a whole and for each chapter. Most chapters begin with a typical case that is revisited at the end of the chapter in the light of what was presented there. Resources for further study and reflection are given in the Manual's appendices.

In addition to its emphasis on the practical application of ethical principles, the Manual focuses on the relationship among ethics, professionalism and human rights. Human rights are the basis of the ethical duties and responsibilities that dentists share with all other persons. However, as members of a profession, dentists have duties and responsibilities over and above those of other citizens. The Manual identifies and discusses these requirements as they arise in dentists' relationships with their patients, society and colleagues and in the context of dental research.

The Manual concludes with a consideration of the rights and privileges of dentists, their responsibilities to themselves, and the future of dental ethics.

## INTRODUCTION

### What is dental ethics?

Ethics is an intrinsic component of dental practice. Every day dentists are faced with situations that call for ethical judgment and behaviour. Here are four typical cases:

1. Dr. P has been in practice for 32 years. His older patients appreciate his devoted service and are generally quite happy to let him decide what treatment they will have. Some of his younger patients, on the other hand, resent what they consider to be his paternalistic approach and the lack of information about treatment options. When Carole J, a 28-year-old accountant, asks Dr. P for a referral to an orthodontist to correct a mild overbite, Dr. P refuses because it is his professional opinion that the treatment is unnecessary. He is willing to lose a patient rather than compromise his principle that he should only provide beneficial treatments to patients and will neither mention nor refer patients for treatments that he considers unnecessary or harmful.
2. Dr. S is one of only two dentists in her community. Between them they have just managed to provide basic oral care to the population. Recently her colleague has changed his practice to focus on technically and aesthetically advanced services that only adequately insured or middle and upper class patients can afford. As a result, Dr. S is overwhelmed by patients requiring basic care. She is reluctant to ration her services but feels that she has no choice. She wonders what is the fairest way to do so: by favouring her previous patients over

those of her colleague; by giving priority to emergency cases; by establishing a waiting list so that all will get treated eventually; or by some other way.

3. Dr. C, a newly qualified endodontist, has just taken over the practice of the only endodontist in a medium-sized community. The four general practice dentists in the community are relieved that they can continue their referrals without interruption. During his first three months in the community, Dr. C is concerned that a significant number of the patients referred by one of the general practice dentists show evidence of substandard treatment. As a newcomer, Dr. C is reluctant to criticise the referring dentist personally or to report him to higher authorities. However, she feels that she must do something to improve the situation.
4. Dr. R, a general practice dentist in a small rural town, is approached by a contract research organisation (C.R.O.) to participate in a clinical trial of a new sealant. He is offered a sum of money for each patient that he enrolls in the trial. The C.R.O. representative assures him that the trial has received all the necessary approvals, including one from an ethics review committee. Dr. R has never participated in a trial before and is pleased to have this opportunity, especially with the extra money. He accepts without inquiring further about the scientific or ethical aspects of the trial.

These case studies will be discussed further in the following chapters. Each of them invites ethical reflection. They raise questions about the **behaviour**

and **decision-making** of dentists – not scientific or technical questions such as how to apply a local anaesthetic or extract an impacted wisdom tooth, but questions about *values*,<sup>1</sup> rights and responsibilities. Dentists face these kinds of questions just as often as scientific and technical ones.

In dental practice, no matter what the specialty or the setting, some questions are much easier to answer than others. For example, repairing a caries lesion is generally unproblematic for dentists who are accustomed to performing this procedure. At the other end of the spectrum, there can be great uncertainty or disagreement about how to treat some conditions, even common ones such as periodontal disease. Likewise, ethical questions in dentistry are not all equally challenging. Some are relatively easy to answer, mainly because there is a well-developed *consensus* on the right way to act in the situation (for example, the dentist should always obtain valid consent to treatment). Others are much more difficult, especially those for which no consensus has developed or where all the options have drawbacks (for example, rationing of scarce resources).

So, what exactly is ethics and how does it help dentists deal with such questions? Put simply, ethics is the study of morality — careful and systematic reflection on and analysis of moral decisions and behaviour, whether past, present or future. Morality is the value dimension of human decision-making and behaviour. The language of morality includes nouns such as ‘rights’, ‘responsibilities’ and ‘*virtues*’ and adjectives such as ‘good’ and ‘bad’ (or ‘evil’), ‘right’ and ‘wrong’, ‘just’ and ‘unjust’. According to these definitions, ethics is primarily a matter of **knowing**



whereas morality is a matter of **doing**. Their close relationship consists in the concern of ethics to provide *rational* criteria for people to decide or behave in some ways rather than others.

Since ethics deals with all aspects of human behaviour and decision making, it is a very large and complex field of study with many branches or subdivisions. The focus of this Manual is **dental ethics**, the branch of ethics that deals with moral issues in dental practice. Dental ethics is closely related, but not identical, to *bioethics*. Whereas dental ethics focuses primarily on issues arising in the practice of dentistry, bioethics is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally. Bioethics also differs from dental ethics insofar as it does not require the acceptance of certain values that are specific to a particular health care practice, in our case to oral health care. In Chapter One we will discuss which values are fundamental to the practice of dentistry.

As an academic discipline, dental ethics has developed its own specialised vocabulary, including many terms that have been borrowed from philosophy. However, dental ethics is not philosophy applied to the practice of dentistry, and this Manual does not presuppose any familiarity with philosophy in its readers. Therefore definitions of key terms are provided either where they occur in the text or in the glossary at the end of the Manual.

### Why study dental ethics?

“As long as the dentist is a knowledgeable and skilful clinician, ethics doesn’t matter.”

“Ethics is learned in the family, not in dental school.”

“Dental ethics is learned by observing how senior dentists act, not from books or lectures.”

“Ethics is important, but our curriculum is already too crowded and there is no room for ethics teaching.”

These are some of the common reasons given for not assigning ethics a major role in the dental school curriculum. Each of them is partially, but only partially, valid. Increasingly throughout the world, dental schools are realising that they need to provide their students with adequate time and resources for learning ethics. They have received strong encouragement to move in this direction from organisations such as the FDI World Dental Federation as well as many other international and national organisations concerned with dental health. By way of example Appendix C contains a digest of statements on the ethical competencies of dentists as developed by the Association for Dental Education in Europe, the General Dental Council (U.K.), the Association of Canadian Faculties of Dentistry and the (USA) Commission on Dental Accreditation.

The importance of ethics in dental education will become apparent throughout this Manual. To summarise, ethics is and always has been an essential component of dental practice. Ethical principles such as respect for persons, informed consent and confidentiality are basic to the dentist-patient relationship. However, the application of these principles in specific situations is often problematic, since dentists, patients, their family members and other oral health personnel may disagree about what

is the right way to act in a situation. Moreover, developments in dental science and technology and changes in societal values and structures are constantly posing new ethical challenges. The study of ethics prepares dental students and practising dentists to recognise and deal with such issues in a rational and principled manner, whether in their interactions with patients, society or their colleagues and in the conduct of dental research.

### Dental Ethics, Professionalism, Human Rights and Law

Dentistry has been a recognised *profession* for less than two centuries. Previously it overlapped with medicine and so the origins of dental ethics can be found in traditional medical ethics. As will be seen in Chapter One, ethics has been an integral part of medicine at least since the time of Hippocrates, the fifth century B.C.E. (before the Christian era) Greek physician who is regarded as a founder of medical ethics. The concept of medicine as a profession is often attributed to Hippocrates, whereby physicians make a public promise that they will place the interests of their patients above their own interests (see Chapter Three for further explanation). The close relationship of ethics and professionalism in dentistry will be evident throughout this Manual.

In recent times both medical ethics and dental ethics have been greatly influenced by developments in **human rights**. In a *pluralistic* and multicultural world, with many different moral traditions, the major international human rights agreements can provide a foundation for dental ethics that is acceptable across national and cultural boundaries. Moreover, dentists sometimes have to deal with

dental problems resulting from violations of human rights, such as forced migration and torture. They are greatly affected by the debate over whether health care is a human right, since the answer to this question in any particular country determines to a large extent who has access to dental care. This Manual will give careful consideration to human rights issues as they affect dental practice.

Dental ethics is also closely related to **law**. In most countries there are laws that specify how dentists are required to deal with ethical issues in patient care and research. In addition, the dental licensing and regulatory officials in each country can and do punish dentists for ethical violations. Usually the requirements of dental ethics and law are similar. But ethics should not be confused with law. One difference between the two is that laws can differ significantly from one country to another while ethics is generally applicable across national boundaries. In addition, ethics quite often prescribes higher standards of behaviour than does the law, and occasionally situations may arise where the two conflict. In such circumstances dentists must use their own best judgement whether to comply with the law or follow ethical principles. Where unjust laws conflict with ethical principles, dentists should work individually and collectively to change the laws. Although dentists should be familiar with the legal aspects of dentistry, the focus of this Manual is on ethics, moral values and professional commitments rather than law.

## Conclusion

Dentistry is both a science and an art. Science deals with what can be observed and measured, and a competent dentist recognises the signs of oral disease and knows how to restore good oral health. But scientific dentistry has its limits, particularly in regard to human individuality, culture, religion, freedom, rights and responsibilities. The art of dentistry involves the application of dental science and technology to individual patients, families and communities, no two of which are identical. By far the major part of the differences among individuals, families and communities is non-physiological, and it is in recognising and dealing with these differences that the arts, humanities and social sciences, along with ethics, play a major role. Indeed, ethics itself is enriched by the insights and data of these other disciplines; for example, a theatrical presentation of a clinical dilemma can be a more powerful stimulus for ethical reflection and analysis than a simple case description.

This Manual can provide only a basic introduction to dental ethics and some of its central issues. It is intended to give you an appreciation of the need for continual reflection on the ethical dimension of dentistry, and especially on how to deal with the ethical issues that you will encounter in your own practice. A list of resources is provided in Appendix B to help you deepen your knowledge of this field.

## CHAPTER ONE – PRINCIPAL FEATURES OF DENTAL ETHICS

### Objectives

After working through this chapter you should be able to:

- explain why ethics is important to dentistry
- identify the major sources of dental ethics
- recognise different approaches to ethical decision-making, including your own.

### What's Special about Dentistry?

In virtually every part of the world, being a dentist has meant something special. People come to dentists for help with some of their most pressing needs – relief from pain and suffering and restoration of oral health and well-being. They allow dentists to see, touch and manipulate their bodies and they disclose information about themselves that they would not want others to know. They do this because they trust their dentists to act in their best interests.

As noted above, dentistry is a recognised **profession**. At the same time, however, it is a commercial enterprise, whereby dentists employ their skills to earn a living. There is a potential tension between these two aspects of dentistry and maintaining an appropriate balance between them is often difficult. Some dentists may be tempted to minimise their commitment to professionalism in order to increase their income, for example by aggressive advertising and/or specialising in lucrative cosmetic procedures. If taken too far, such activities can diminish the public's respect for and trust in the entire dental profession,

with the result that dentists will be regarded as just another set of entrepreneurs who place their own interests above those of the people they serve. Such behaviour is in conflict with the requirement of the **FDI International Principles of Ethics for the Dental Profession** that “the dentist should act in a manner which will enhance the prestige and reputation of the profession.”

Because the commercial aspect of dentistry sometimes seems to prevail over the professional aspect, the status of dentists is deteriorating in some countries. Patients who used to accept dentists’ advice unquestioningly sometimes ask dentists to defend their recommendations if these are different from information obtained from other oral health practitioners or the Internet. If they are dissatisfied with the results of dental treatment, no matter what the cause, an increasing number of patients are turning to the courts to obtain compensation from dentists. Moreover, many dentists feel that they are no longer as respected as they once were. In some countries, control of oral health care has moved steadily away from dentists to non-dental managers and bureaucrats, some of whom tend to see dentists as obstacles to rather than partners in the provision of health care for all in need. Some procedures that formerly only dentists were capable of performing are now done by dental hygienists, therapists, assistants or denturists.

Despite these changes impinging on the status of dentists, dentistry continues to be a profession that is highly valued by the people who need its services. It also continues to attract large numbers of the most gifted, hard working and dedicated students. In order

to meet the expectations of patients, students and the general public, it is important that dentists know and exemplify the core values of dentistry, especially compassion, competence and autonomy. These values, along with respect for fundamental human rights, serve as the foundation of dental ethics.

### What's Special About Dental Ethics?

Compassion, competence and autonomy are not exclusive to dentistry. However, the practice of dentistry requires dentists to exemplify these values to a higher degree than in other occupations, including some other professions.

**Compassion**, defined as understanding and concern for another person's distress, is essential for the practice of dentistry. In order to deal with the patient's problems, the dentist must identify the symptoms that the patient is experiencing and their underlying causes and must want to help the patient achieve relief. Patients respond better to treatment if they perceive that the dentist appreciates their concerns and is treating them rather than just their illness.

A very high degree of **competence** is both expected and required of dentists. A lack of competence can have serious consequences for patients. Dentists undergo a long training period to ensure competence, but considering the rapid advance of dental knowledge, it is a continual challenge for them to maintain their competence. Moreover, it is not just their scientific knowledge and technical skills that they have to develop and maintain but their ethical knowledge, skills and attitudes as well, since new ethical issues arise with changes in dental practice and its social and political environment.



**Autonomy**, or self-determination, is the core value of dentistry that has evolved the most over the years. Individual dentists have traditionally enjoyed a high degree of clinical autonomy in deciding where and how to practice. Dentists collectively (the dental profession) have been free to determine the standards of dental education and dental practice. As do physicians, dentists consider that clinical and professional autonomy benefits not just themselves but patients as well, since it frees dentists from government and corporate restraints on providing optimal treatment for patients. As will be evident throughout this Manual, governments and other authorities are increasingly restricting the autonomy of dentists. Nevertheless, dentists still value their autonomy and try to preserve it as much as possible. At the same time, there has been a widespread acceptance by dentists worldwide of patient autonomy, which means that patients should be the ultimate decision makers in matters that affect themselves. This Manual will deal with examples of potential conflicts between the dentist's autonomy and respect for patient autonomy.

Besides its adherence to these three core values, dental ethics differs from the general ethics applicable to everyone by being publicly proclaimed in a code of ethics or similar document. Codes vary from one country to another and even within countries, but they have many common features, including commitments that dentists will consider the interests of their patients above their own, will not discriminate against patients on the basis of race, religion or other human rights grounds and will protect the confidentiality of patient information. In 1997 the FDI adopted the **International Principles of Ethics for the Dental Profession** for dentists everywhere.

## **FDI World Dental Federation International Principles of Ethics for the Dental Profession**

These International Principles of Ethics for the Dental Profession should be considered as guidelines for every dentist. These guidelines cannot cover all local, national, traditions, legislation or circumstances.

The professional dentist:

- will practice according to the art and science of dentistry and to the principles of humanity
- will safeguard the oral health of patients irrespective of their individual status

The primary duty of the dentist is to safeguard the oral health of patients. However, the dentist has the right to decline to treat a patient, except for the provision of emergency care, for humanitarian reasons, or where the laws of the country dictate otherwise.

- should refer for advice and/or treatment any patient requiring a level of competence beyond that held

The needs of the patient are the overriding concern and the dentist should refer for advice or treatment any patient requiring a level of dental competence greater than he/she possesses.

- must ensure professional confidentiality of all information about patients and their treatment

The dentist must ensure that all staff respect patients confidentiality except where the laws of the country dictate otherwise.

- must accept responsibility for, and utilise dental auxiliaries strictly according to the law

The dentist must accept full responsibility for all treatment undertaken, and no treatment or service should be delegated to a person who is not qualified or is not legally permitted to undertake this.

- must deal ethically in all aspects of professional life and adhere to rules of professional law
- should continue to develop professional knowledge and skills

The dentist has a duty to maintain and update professional competence through continuing education through his/her active professional life.

- should support oral health promotion

The dentist should participate in oral health education and should support and promote accepted measures to improve the oral health of the public.

- should be respectful towards professional colleagues and staff

The dentist should behave towards all members of the oral health team in a professional manner and should be willing to assist colleagues professionally and maintain respect for divergence of professional opinion.

- should act in a manner which will enhance the prestige and reputation of the profession.

## Who Decides What is Ethical?

Ethics is pluralistic. Individuals disagree among themselves about what is right and what is wrong, and even when they agree, it is often for different reasons. In some societies, this disagreement is regarded as normal and there is a great deal of freedom to act however one wants, as long as it does not violate the rights of others. This individual freedom may present a challenge for dentists and their patients, whose ethical differences must be overcome in order to reach their common goal. In more traditional societies, there is greater agreement on ethics and greater social pressure, sometimes backed by laws, to act in certain ways rather than others. In such societies culture and religion often play a dominant role in determining ethical behaviour.

The answer to the question, “who decides what is ethical for people in general?” therefore varies from one society to another and even within the same society. In liberal societies, individuals have a great deal of freedom to decide for themselves what is ethical, although they will likely be influenced by their families, friends, religion, the media and other external sources. In more traditional societies, family and clan elders, religious authorities and political leaders usually have a greater role than individuals in determining what is ethical.

Despite these differences, it seems that human beings everywhere can agree on some fundamental ethical principles, namely, the basic human rights proclaimed in the United Nations **Universal Declaration of Human Rights** and other widely accepted and officially endorsed documents. The human rights that are especially important for dental ethics include the

rights to freedom from discrimination, to freedom of opinion and expression, to equal access to public services in one's country, and to health care.

For dentists, the question, "who decides what is ethical?" has until recently had a somewhat different answer than for people in general. During the past two centuries the dental profession has developed its own standards of behaviour for its members, which are expressed in codes of ethics and related policy documents. At a global level, the FDI has set forth a broad range of ethical statements that specify the behaviour required of dentists no matter where they live and practise (see Appendix B). In many, if not most, countries dental associations have been responsible for developing and enforcing the applicable ethical standards. Depending on the country's approach to health law, these standards may have legal status.

The dental profession's privilege of being able to determine its own ethical standards has never been absolute, however. For example:

- Dentists have always been subject to the general laws of the land and have sometimes been punished for acting contrary to these laws.
- Some dental organisations are strongly influenced by religious teachings, which impose additional obligations on their members besides those applicable to all dentists.
- In many countries the organisations that set the standards for dentists' behaviour and monitor their compliance now have a significant non-dentist membership.

The ethical directives of dental associations are general in nature; they cannot deal with every situation that dentists might face in their practice. In most situations, dentists have to decide for themselves what is the right way to act, but in making such decisions, it is helpful to know what other dentists would do in similar situations. Dental codes of ethics and policy statements reflect a general consensus about the way dentists should act and they should be followed unless there are good reasons for acting otherwise.

### **Does Dental Ethics Change?**

There can be little doubt that some aspects of dental ethics have changed over the years. Until recently dentists had the right and the duty to decide how patients should be treated and there was no obligation to obtain the patient's informed consent. In contrast, the U.K. General Dental Council now advises dentists that: "It is a general legal and ethical principle that you must get valid consent before starting treatment or physical investigation, or providing personal care, for a patient. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice." Many individuals now consult the Internet and other sources of health information and are not prepared to accept the recommendations of dentists unless these are fully explained and justified. Although this insistence on informed decision making is far from universal, it does seem to be spreading and is symptomatic of a more general evolution in the patient-dentist relationship that gives rise to different ethical obligations for dentists than previously.

Until recently, dentists generally considered themselves *accountable* only to themselves, to their colleagues in the dental profession and, for religious believers, to God. Nowadays, they have additional accountabilities – to their patients, to third parties such as *managed health care* organisations, to dental licensing and regulatory authorities, and often to courts of law. These different accountabilities can conflict with one another, as will be evident in the discussion of dual loyalty in Chapter Three.

Dental ethics has changed in other ways. Whereas until recently the sole responsibility of dentists was to their individual patients, nowadays it is generally agreed that dentists should also consider the needs of society, for example, in allocating scarce health care resources (cf. Chapter Three). Moreover, advances in dental science and technology raise new ethical issues that cannot be answered by traditional dental ethics. Health informatics and electronic patient records, changing patterns of practice and expensive new devices have great potential for benefiting patients but also potential for harm depending on how they are used. To help dentists decide whether and under what conditions they should utilise these resources, dental associations need to use different analytic methods than simply relying on existing codes of ethics.

Despite these obvious changes in dental ethics, there is widespread agreement among dentists that the fundamental values and ethical principles of dentistry do not, or at least should not, change. Since it is inevitable that human beings will always be subject to oral disease, they will continue to have need of compassionate, competent and autonomous dentists to care for them.

## Does Dental Ethics Differ from One Country to Another?

Just as dental ethics can and does change over time, in response to developments in dental science and technology as well as in societal values, so does it vary from one country to another depending on these same factors. On advertising, for example, there is a significant difference of opinion among national dental associations. Some associations forbid it but others are neutral and still others accept it under certain conditions. Likewise, regarding access to oral health care, some national associations support the equality of all citizens whereas others are willing to tolerate great inequalities. In some countries there is considerable interest in the ethical issues posed by advanced dental technology whereas in countries that do not have access to such technology, these ethical issues do not arise. Dentists in some countries are confident that they will not be forced by their government to do anything unethical while in other countries it may be difficult for them to meet their ethical obligations, for example, to maintain the confidentiality of patients in the face of police or army requirements to report 'suspicious' injuries; any such encouragement of dentists to act unethically should be a matter of great concern.

Although these differences may seem significant, the similarities are far greater. Dentists throughout the world have much in common, and when they come together in organisations such as the FDI, they usually achieve agreement on controversial ethical issues, though this often requires lengthy debate. The fundamental values of dental ethics, such as compassion, competence and autonomy, along with dentists' experience and skills in all aspects of dentistry, provide a sound basis for analysing ethical



issues in dentistry and arriving at solutions that are in the best interests of individual patients and citizens and public health in general.

### **The Role of the FDI**

As the only international organisation that seeks to represent all dentists, regardless of nationality or specialty, the FDI has undertaken the role of establishing general standards in dental ethics that are applicable worldwide. In addition to the **International Principles of Ethics for the Dental Profession**, the FDI has adopted policy statements on many specific ethical issues as well as other issues related to oral health, oral health policies and the dental profession (see Appendix B). The FDI General Assembly frequently revises existing policies and adopts new ones.

### **How Does the FDI Decide What is Ethical?**

Achieving international agreement on controversial ethical issues is not an easy task, even within a relatively cohesive group such as dentists. The FDI Working Group on Ethics and Dental Legislation, through the Dental Practice Committee, is responsible for preparing statements on ethical issues, and amendments to existing statements, for consideration and approval by the Council and General Assembly. In deciding what is ethical, the FDI draws upon the history of dental ethics as reflected in its previous ethical statements. It also takes note of other positions on the topic under consideration, both of national and international organisations and of individuals with skill in ethics. On some issues, such as informed consent, the FDI finds itself in agreement with the majority view. On others, such as the

confidentiality of personal dental information, the position of dentists may have to be promoted forcefully against those of governments, health system administrators and/or commercial enterprises. A defining feature of the FDI's approach to ethics is the priority that it assigns to the individual patient or research subject. As the **International Principles of Ethics for the Dental Profession** state, "The needs of the patient are the overriding concern...."

### **How Do Individuals Decide What is Ethical?**

For individual dentists and dental students, dental ethics does not consist simply in following the recommendations of the FDI or other dental organisations. These recommendations are usually general in nature and individuals need to determine whether or not they apply to the situation at hand. Moreover, many ethical issues arise in dental practice for which there is no guidance from dental associations. Individuals are ultimately responsible for making their own ethical decisions and for implementing them.

There are different ways of approaching ethical issues such as the ones in the cases at the beginning of this Manual. These can be divided roughly into two categories: non-rational and rational. It is important to note that non-rational does not mean irrational (that is, contrary to reason) but simply that it is to be distinguished from the systematic, reflective use of reason in decision making.

## Non-rational approaches:

- **Obedience** is a common way of making ethical decisions, especially by children and those who work within authoritarian structures (for example, the military, police, some religious organisations, many businesses). Morality consists in following the rules or instructions of those in authority, whether or not you agree with them.
- **Imitation** is similar to obedience in that it subordinates one's judgement about right and wrong to that of another person, in this case, a role model. Morality consists in following the example of the role model. This has been perhaps the most common way of learning dental ethics by aspiring dentists, with the role models being the senior dentists and the mode of moral learning being observation and assimilation of the values portrayed.
- **Feeling or desire** is a subjective approach to moral decision-making and behaviour. What is right is what feels right or satisfies one's desire; what is wrong is what feels wrong or frustrates one's desire. The measure of morality is to be found within each individual and, of course, can vary greatly from one individual to another, and even within the same individual over time.
- **Intuition** is an immediate perception of the right way to act in a situation. It is similar to desire in that it is entirely subjective; however, it differs because of its location in the mind rather than the will. To that extent it comes closer to the rational forms of ethical decision-making than do

obedience, imitation, feeling and desire. However, it is neither systematic nor reflexive but directs moral decisions through a simple flash of insight. Like feeling and desire, it can vary greatly from one individual to another, and even within the same individual over time.

- **Habit** is a very efficient method of moral decision-making since there is no need to repeat a systematic decision-making process each time a moral issue arises similar to one that has been dealt with previously. However, there are bad habits (for example, lying) as well as good ones (for example, truth-telling); moreover, situations that appear similar may require significantly different decisions. As useful as habit is, therefore, one cannot place all one's confidence in it.

### Rational approaches:

As the study of morality, ethics recognises the prevalence and usefulness of these non-rational approaches to decision-making and behaviour. However, it is primarily concerned with rational approaches. Four such approaches are deontology, consequentialism, principlism and virtue ethics:

- **Deontology** involves a search for well-founded rules that can serve as the basis for making moral decisions. An example of such a rule is, "Treat all people as equals." Its foundation may be religious (for example, the belief that all God's human creatures are equal) or non-religious (for example, human beings share almost all of the same genes). Once the rules are established, they have to be applied in specific situations, and there is often

room for disagreement about what the rules require (for example, whether the equality of all human beings entitles them to basic oral health care).

- **Consequentialism** bases ethical decision-making on an analysis of the likely consequences or outcomes of different choices and actions. The right action is the one that produces the best outcomes. Of course there can be disagreement about what counts as a good outcome. One of the best-known forms of consequentialism, namely **utilitarianism**, uses 'utility' as its measure and defines this as 'the greatest good for the greatest number'. Other outcome measures used in healthcare decision-making include cost-effectiveness and quality of life as measured in QALYs (quality-adjusted life-years) or DALYs (disability-adjusted life-years). Supporters of consequentialism generally do not have much use for principles; principles are too difficult to identify, prioritise and apply, and in any case they do not take into account what in their view really matter in moral decision making — the outcomes. However, this setting aside of principles leaves consequentialism open to the charge that it accepts that 'the end justifies the means', for example, that individual human rights can be sacrificed to attain a social goal. Moreover, consequentialists have been unable to agree on which outcomes should be decisive for evaluating decisions and behaviour.
- **Principlism**, as its name implies, uses ethical principles as the basis for making moral decisions. It applies these principles to particular cases or situations in order to determine what is the right thing to do, taking into account both rules and consequences. Principlism has been extremely

influential in recent ethical debates, especially in the USA. Four principles in particular, respect for autonomy, *beneficence*, *non-maleficence* and *justice*, have been identified as the most important for ethical decision making in health care. Principles do indeed play an important role in rational decision making. However, the choice of these four principles, and especially the prioritisation of respect for autonomy over the others, is a reflection of Western liberal culture and is not necessarily universal. Moreover, these four principles often clash in particular situations and there is need for some criteria or process for resolving such conflicts.

- **Virtue ethics** focuses less on decision making and more on the character of decision makers as reflected in their behaviour. A virtue is a type of moral excellence or competence. As noted above, one virtue that is especially important for dentists is compassion. Others include honesty, prudence and dedication. Dentists who possess these virtues are more likely to make good decisions and to implement them in a good way. However, even virtuous individuals often are unsure how to act in particular situations and are not immune from making wrong decisions.

None of these four approaches, or others that have been proposed, has been able to win universal assent. This can be explained partly by the fact that each approach has both strengths and weaknesses. Ethical theories are similar to scientific theories in that they are all plausible but some are eventually proven superior to the others. Moreover, individuals differ among themselves in their preference for a rational approach to ethical decision making just as they do in

their preference for a non-rational approach. However, to the extent that principlism takes into account both rules and consequences, it may be the most helpful for making clinical ethical decisions at the chairside, as long as all the relevant rules and consequences are considered. Virtue ethics is especially important for ensuring that the behaviour of the decision maker both in coming to a decision and in implementing it is admirable.

What does all this mean in practice? When faced with a problem for which there is no obvious answer, a dentist can use one of the following algorithms:

## 1. DECIDE

- Determine whether the issue at hand is an ethical one.
- Educate yourself about authoritative sources such as dental association codes of ethics and policies and consult respected colleagues to see how dentists generally deal with such issues.
- Consider alternative solutions in light of the principles and values they uphold and their likely consequences.
- Inform those whom your proposed solution will affect and discuss it with them.
- Make your Decision and act on it, with sensitivity to others affected.
- Evaluate your decision and be prepared to act differently in future.

## 2. ACD

### Assess

- Is it true?
- Is it accurate?
- Is it fair?
- Is it quality?
- Is it legal?

### Communicate

- Have you listened?
- Have you informed the patient?
- Have you explained outcomes?
- Have you presented alternatives?

### Decide

- Is now the best time?
- Is it within your ability?
- Is it in the best interests of the patient?
- Is it what you would want for yourself?



## Conclusion

This chapter sets the stage for what follows. When dealing with specific issues in dental ethics, it is good to keep in mind that dentists have faced many of the same issues in the past and that their accumulated experience and wisdom can be very valuable today. The FDI and other dental organisations carry on this tradition and provide much helpful ethical guidance to dentists. However, despite a large measure of consensus among dentists on ethical issues, individuals can and do disagree on how to deal with specific cases. Moreover, the views of dentists can be quite different from those of patients and of other health care providers. As a first step in resolving ethical conflicts, it is important for dentists to understand different approaches to ethical decision making, including their own and those of the people with whom they are interacting. This will help them determine for themselves the best way to act and to explain their decisions to others.

## Objectives

After working through this chapter you should be able to:

- explain why all patients are deserving of respect and equal treatment;
- identify the essential elements of informed consent;
- explain how treatment decisions should be made for children and for patients who are incapable of making their own decisions;
- explain the justification for patient confidentiality and recognise legitimate exceptions to confidentiality;
- understand your ethical obligations towards uncooperative patients;
- consider how to deal with patients who cannot afford needed oral health care.

## Case Study #1

Dr. P has been in practice for 32 years. His older patients appreciate his devoted service and are generally quite happy to let him decide what treatment they will have. Some of his younger patients, on the other hand, resent what they consider to be his paternalistic approach and the lack of information about treatment options. When Carole J, a 28-year-old accountant, asks Dr. P for a referral to an orthodontist to correct a mild overbite, Dr. P refuses because it is his professional opinion that the treatment is unnecessary. He is willing to lose a

patient rather than compromise with his principle that dentists should only provide beneficial treatments to patients. He will neither mention nor refer patients for treatments that he considers unnecessary or harmful.

### **What's Special About the Dentist-Patient Relationship?**

The dentist-patient relationship is the cornerstone of dental practice and therefore of dental ethics. As noted above, the **International Principles of Ethics for the Dental Profession** states, "The needs of the patient are the overriding concern...." As discussed in Chapter One, the traditional interpretation of the dentist-patient relationship as a paternalistic one, in which the dentist made the decisions and the patient submitted to them, has been widely rejected in recent years, both in ethics and in law, in favour of an equal partnership. However, since many patients are either unable or unwilling to make decisions about their dental care, patient autonomy is often very problematic. Equally problematic are other aspects of the relationship, such as the dentist's obligation to maintain patient confidentiality in an era of computerised dental records and demands from agencies with competing interests for access to patient data, and the provision of treatment to patients who cannot afford it. This section will deal with six topics that pose particularly challenging problems to dentists in their daily practice: respect and equal treatment; communication and consent; decision-making for incompetent patients; confidentiality; uncooperative patients; and financial restraints on treatment. .

## Respect and Equal Treatment

The belief that all human beings deserve respect and equal treatment is relatively recent. In most societies disrespectful and unequal treatment of individuals and groups used to be regarded as normal and natural. Slavery was one such practice that was not eradicated in the European colonies and the USA until the 19th century and, though illegal, it still exists in some parts of the world. Women still experience lack of respect and unequal treatment in many countries. Discrimination on the basis of race, age, disability or sexual orientation is widespread. Clearly, there remains considerable resistance to the claim that all people should be treated as equals.

The gradual and still ongoing conversion of humanity to a belief in human equality began in the 17th and 18th centuries in Europe and North America. It was led by two opposed ideologies: a new interpretation of Christian faith and an anti-Christian rationalism. The former inspired the American Revolution and Bill of Rights; the latter, the French Revolution and related political developments. Under these two influences, democracy very gradually took hold and began to spread throughout the world. It was based on a belief in the political equality of all men (and, much later, women) and the consequent right to have a say in who should govern them.

In the 20th century there was considerable elaboration of the concept of human equality in terms of human rights. One of the first acts of the newly established United Nations was to develop the **Universal Declaration of Human Rights** (1948), which states in article 1, "All human beings are born free and equal in dignity and rights." Many other

international and national bodies have produced statements of rights, either for all human beings, for all citizens in a specific country, or for certain groups of individuals ('children's rights', 'patients' rights', 'consumers' rights', etc.). Numerous organisations have been formed to promote action on these statements. Unfortunately, though, human rights are still not respected in many countries.

The dental profession has had somewhat conflicting views on patient equality and rights over the years. On the one hand, dentists have been told not to "refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex or national origin" (American Dental Association: **Principles of Ethics and Code of Professional Conduct**). At the same time the FDI **International Principles of Ethics for the Dental Profession** asserts the dentist's right "to decline to treat a patient, except for the provision of emergency care, for humanitarian reasons, or where the laws of the country dictate otherwise." Although the legitimate grounds for such refusal include a full practice, (lack of) educational qualifications and specialisation, if dentists do not have to give any reason for refusing a patient, they can easily practise discrimination without being held accountable. A dentist's conscience, rather than the law or disciplinary authorities, may be the only means of preventing abuses of human rights in this regard.

Even if dentists do not offend against respect and human equality in their choice of patients, they can still do so in their attitudes towards and treatment of patients. As noted in Chapter One, compassion is one of the core values of dentistry and is an essential

element of a good therapeutic relationship. Compassion is based on respect for the patient's dignity and values but goes further in acknowledging and responding to the patient's vulnerability in the face of illness and/or disability. If patients sense the dentist's compassion, they will be more likely to trust the dentist to act in their best interests, and this trust can contribute to the healing process.

In order to safeguard the trust that is essential to the dentist-patient relationship, dentists should not abandon patients whose care they have undertaken. The American Dental Association's **Principles of Ethics and Code of Professional Conduct** states: "Once a dentist has undertaken a course of treatment, the dentist should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Care should be taken that the patient's oral health is not jeopardised in the process."

There are many reasons for a dentist wanting to terminate a relationship with a patient, for example, the dentist's moving or stopping practice, the patient's refusal or inability to pay for the dentist's services, dislike of the patient and the dentist for each other, the patient's refusal to comply with the dentist's recommendations, etc. The reasons may be entirely legitimate, or they may be unethical. When considering such an action, dentists should consult their Code of Ethics and other relevant guidance documents and carefully examine their motives. They should be prepared to justify their decision to the patient and to a third party if appropriate. If the motive is legitimate, the dentist should help the patient find another suitable dentist or, if this is not

possible, should give the patient adequate notice of withdrawal of services so that the patient can find alternative dental care. If the motive is not legitimate, for example, racial prejudice, the dentist should take steps to deal with this defect.

Many dentists, especially those in the public sector, often have no choice of the patients they treat. Some patients are violent and pose a threat to the safety of the dentist or the office staff. Others can only be described as obnoxious because of their antisocial attitudes and behaviour. Have such patients forsaken their right to respect and equal treatment, or are dentists expected to make extra, perhaps even heroic, efforts to establish and maintain therapeutic relationships with them? With such patients, dentists must balance their responsibility for their own safety and well-being and that of their staff with their duty to promote the well-being of the patients. They should attempt to find ways to honour both of these obligations. If this is not possible, they should try to make alternative arrangements for the care of the patients.

Another challenge to the principle of respect and equal treatment for all patients arises in the care of infectious patients. The focus in this respect is often on HIV/AIDS, not only because it is a life-threatening disease but also because it is associated with social prejudices. However, there are many other serious infections including some that are more easily transmissible to health care providers than HIV/AIDS. Some dentists hesitate to perform invasive procedures on patients with such conditions because of the possibility that they, the dentists, might become infected. However, dental codes of ethics make no

exception for infectious patients with regard to the dentist's duty to treat all patients equally. According to the FDI's **Policy Statement on Human Immunodeficiency Virus Infection and Other Blood Borne Infections**, "Patients with HIV and other blood borne infections should not be denied oral health care solely because of their infections." The Statement recommends that "universal infection control procedures should be employed for all patients irrespective of their health status" in order to prevent transmission of infectious diseases from patients to dentists or other oral health care providers or from them to patients.

The intimate nature of the dentist-patient relationship can give rise to sexual attraction. A fundamental rule of traditional medical ethics, equally applicable to dentists, is that such attraction must be resisted. The Oath of Hippocrates includes the following promise: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons...." In recent years some dental associations have restated this prohibition of sexual relations between dentists and their patients. The reasons for this are as valid today as they were in Hippocrates' time, 2500 years ago. Patients are vulnerable and put their trust in dentists to treat them well. They may feel unable to resist sexual advances of dentists for fear that they will not receive needed dental treatment. Moreover, the clinical judgment of a dentist can be adversely affected by emotional involvement with a patient. This latter reason applies as well to dentists treating their family members. However, the application of this principle can vary according to circumstances. For



example, solo practitioners working in remote areas may have to provide dental care for their family members, especially in emergency situations.

### **Communication and Consent**

Informed consent is one of the central concepts of present-day dental ethics. The right of patients to make decisions about their health care has been enshrined in legal and ethical statements throughout the world. As noted in Chapter One, the U.K. General Dental Council advises dentists that: “It is a general legal and ethical principle that you must get valid consent before starting treatment or physical investigation, or providing personal care, for a patient. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice”.

A necessary condition for informed consent is good communication between dentist and patient. When dental paternalism was normal, communication was relatively simple; it consisted of dentists telling their patients what treatment they were going to perform. Nowadays communication requires much more of dentists. They must provide all the information patients need to make their decisions. This involves explaining complex dental diagnoses, prognoses and treatment regimes in simple language, confirming or correcting information that the patients may have obtained elsewhere (e.g., from another health practitioner, magazines or the Internet), ensuring that patients understand the treatment options (including the option of no treatment) and the costs, advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision the patient has reached and, if

possible, the reasons for it. Good communication skills do not come naturally to most people; they must be developed and maintained with conscious effort and periodic review.

Three major obstacles to good dentist-patient communication are differences of language and culture and patient speech impairment during treatment. If the dentist and the patient do not speak the same language, an interpreter will be required. In many settings there are no qualified interpreters and the dentist must rely on family members or seek someone else for the task. Culture, which includes but is much broader than language, can raise additional communication issues. Because of different cultural understandings of the nature and causes of illness, patients may not understand the diagnosis and treatment options provided by dentists. Moreover, what is considered a disfigurement in one culture may be a sign of beauty in another. In such circumstances dentists should make every reasonable effort to probe their patients' understanding of health and healing and communicate their recommendations to the patients as best they can. During treatment patients may well be unable to talk, thus significantly reducing their decision making ability. For this reason patients should be fully informed, in advance, of all relevant information about their treatment and dentists should take steps to facilitate two-way communication during treatment, for example, by providing a writing tablet for patients to ask and answer questions.

If the dentist has successfully communicated to the patient all the information the patient needs and wants to know about his or her diagnosis, prognosis

and treatment options, the patient will then be in a position to make an informed decision about how to proceed. Although the term 'consent' implies agreement to treatment, the concept of informed consent applies equally to refusal of treatment or to choice among alternative treatments. Competent patients have the right to refuse treatment, even when the refusal will result in pain or disability.

Evidence of consent can be explicit or implicit (implied). Explicit consent is given orally or in writing. Consent is implied when the patient indicates a willingness to undergo a certain procedure or treatment by his or her behaviour. For example, consent for an oral examination is implied by the action of opening one's mouth. For treatments that entail risk or involve more than mild discomfort, it is preferable to obtain explicit rather than implied consent.

There are two exceptions to the requirement for informed consent by competent patients:

- Situations where patients voluntarily give over their decision-making authority to the dentist or to a third party. Because of the complexity of the matter or because the patient has complete confidence in the dentist's judgement, the patient may tell the dentist, "Do what you think is best." Dentists should not be eager to act on such requests but should provide patients with basic information about the treatment options and encourage them to make their own decisions. However, if after such encouragement the patient still wants the dentist to decide, the dentist should do so according to the best interests of the patient.

- Instances where the disclosure of information would cause harm to the patient. The traditional concept of 'therapeutic privilege' is invoked in such cases; it allows dentists to withhold dental information if disclosure would be likely to result in serious physical, psychological or emotional harm to the patient, for example, if the patient would be likely to forgo needed treatment if it will be painful. This privilege is open to great abuse and dentists should only make use of it in extreme circumstances. They should start with the expectation that all patients are able to cope with the facts and reserve nondisclosure for cases in which they are convinced that more harm will result from telling the truth than from not telling it. Outright lying, however, is never justified since it does serious harm to the trust relationship of patient and dentist.

In keeping with the growing trend towards considering health care as a consumer product and patients as consumers, patients and their families not infrequently demand access to dental services that, in the considered opinion of dentists, are either substandard or unnecessary. The case described at the beginning of the chapter is an example of this trend. Dentists need to consider such requests carefully and ensure that, on the one hand, they do not act unprofessionally by providing substandard treatment or by wasting scarce health care resources. On the other hand, they must guard against imposing their personal values on their patients and always base their treatment recommendations on current professional practice standards. Here, again, good communication between dentists and patients is essential for understanding and evaluating the

reasons that patients may have for their treatment preferences.

### **Decision-making for incompetent patients**

Many patients are not competent to make decisions for themselves. Examples include young children and individuals affected by certain psychiatric or neurological conditions such as dementia. These patients require substitute decision-makers, either the dentist or another person. Ethical issues arise in the determination of whether or not the patient is competent to make decisions and, if not, of the appropriate substitute decision-maker and in the choice of criteria for decisions on behalf of incompetent patients.

When dental paternalism prevailed, the dentist was considered to be the appropriate decision-maker for incompetent patients. Dentists might consult with parents or other family members about treatment options, but the final decisions were theirs to make. Dentists have been gradually losing this authority in many countries as patients are given the opportunity to name their own substitute decision-makers to act for them when they become incompetent. In addition, some jurisdictions specify the appropriate substitute decision-makers in descending order (e.g., for children, the parents, grandparents, etc.; for adults, husband or wife, adult children, brothers and sisters, etc.). In such cases dentists make decisions for patients only when the designated substitute cannot be found.

Problems arise when those claiming to be the appropriate substitute decision-makers, for example divorced parents, do not agree among themselves or

when they do agree, their decision is, in the dentist's opinion, not in the patient's best interests. In the first instance the dentist can attempt to mediate between the parties. If this fails, as well as in cases of serious disagreement between the substitute decision-maker(s) and the dentist, the dentist may have to challenge the decision in the relevant legal institution. The principles and procedures for informed consent that were discussed in the previous section are just as applicable to substitute decision-making as to patients making their own decisions. Dentists have the same duty to provide all the information the substitute decision-makers need to make their decisions.

The principal criteria to be used for treatment decisions for children and mentally disabled adults are their best interests, although their expressed preferences should be honoured to the greatest extent possible compatible with their best interests. For adult patients who have become incompetent, the principal criteria are their preferences, if these are known. If these are not known, treatment decisions should be based on the patients' best interests.

Competence to make decisions about one's oral health care can be difficult to assess, especially in adolescents and those whose capacity for reasoning has been impaired by acute or chronic illness. A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent — a person may be rational at certain times of the day and not at others. Although such patients may not be legally competent, their preferences should be taken into account when decisions are being made for them.

Not infrequently, patients are unable to make a reasoned, well thought-out decision regarding different treatment options due to the discomfort and distraction caused by their disease. However, they may still be able to indicate their rejection of a specific intervention, for example, by refusing to open their mouth. In such cases, these expressions of dissent should be taken very seriously, although they need to be considered in light of the overall goals of their treatment plan.

In all instances, dentists must keep in mind that a patient's refusal of a recommended treatment does not mean that the patient is incompetent; it may be that the patient has failed fully to understand the dentist's recommendation and the reasons for it. Likewise, patients are not necessarily competent because they readily agree to the dentist's proposed treatment. Refusing patients may well be competent whereas agreeing patients may well be incompetent, thus making their agreement invalid.

### **Confidentiality**

The duty to keep patient information confidential has been a cornerstone of medical ethics since the time of Hippocrates. The Hippocratic Oath states: "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 such things shameful to be spoken about." This duty is central to dental ethics as well. For example, the FDI's **International Principles of Ethics for the Dental Profession** requires that the professional dentist "must ensure professional confidentiality of all information about

patients and their treatment.” However, the duty of confidentiality is not absolute. The possibility that breaches of confidentiality are sometimes justified calls for clarification of the very idea of confidentiality.

The high value that is placed on confidentiality has three sources: autonomy, respect for others and trust.

**Autonomy** relates to confidentiality in that personal information about an individual belongs to him or her and should not be made known to others without his or her consent. When an individual chooses to reveal personal information to another, a dentist, dental hygienist or nurse for example, or when information comes to light through a dental test, those in the know are bound to keep it confidential unless the individual concerned allows them to divulge it.

Confidentiality is also important because human beings deserve **respect**. One important way of showing them respect is by preserving their privacy. In the dental setting, privacy is often greatly compromised, but this is all the more reason to prevent further unnecessary intrusions into a person’s private life. Since individuals differ regarding their desire for privacy, we cannot assume that everyone wants to be treated as we would want to be. Care must be taken to determine which personal information a patient wants to keep secret and which he or she is willing to have revealed to others.

**Trust** is an essential part of the dentist-patient relationship. In order to receive dental care, patients have to reveal personal information to dentists and others who may be total strangers to them—information that they would not want anyone else to



know. They must have good reason to trust their caregivers not to divulge this information. The basis of this trust is the ethical and legal standards of confidentiality that health care professionals are expected to uphold. Without an understanding that their disclosures will be kept secret, patients may withhold personal information. This can hinder dentists in their efforts to provide effective interventions.

The U.K. General Dental Council's **Principles of Patient Confidentiality** summarises the dentist's responsibilities for respecting confidentiality as follows:

- Treat information about patients as confidential and only use it for the purposes for which it is given.
- Prevent information from being accidentally revealed and prevent unauthorised access by keeping information secure at all times.
- In exceptional circumstances, it may be justified to make confidential patient information known without consent if it is in the public interest or the patient's interest.

As this guidance document states, there are exceptions to the requirement to maintain confidentiality. Some of these are relatively non-problematic; others raise very difficult ethical issues for dentists.

Some breaches of confidentiality occur frequently in health care settings. Individuals other than dentists—dental assistants, receptionists, etc.—require access to a patient’s health records in order for the patient to be provided adequate care. Where patients speak a different language than their dentists, there is a need for interpreters to facilitate communication. In cases of patients who are not competent to make their own dental decisions, other individuals have to be given information about them in order to make decisions on their behalf and to provide follow-up care for them. These breaches of confidentiality are usually justified, but they should be kept to a minimum and those who gain access to confidential information should be made aware of the need not to spread it any further than is necessary for the patient’s benefit. As the FDI’s **International Principles of Ethics for the Dental Profession** states, “The dentist must ensure that all staff respect patients confidentiality except where the laws of the country dictate otherwise.” Normally, patients should be informed that such breaches of confidentiality will occur and that the duty of confidentiality applies to those who have access to the patients’ information.

Another generally accepted reason for breaching confidentiality is to comply with legal requirements. For example, many jurisdictions have laws for the mandatory reporting of suspected child abuse. Dentists should be aware of the legal requirements

for the disclosure of patient information where they work. However, legal requirements can conflict with the respect for human rights that underlies dental ethics. Therefore, dentists should view with a critical eye any legal requirement to breach confidentiality and assure themselves that it is justified before adhering to it.

If dentists are persuaded to comply with legal requirements to disclose their patients' dental information, it is desirable that they discuss with the patients or guardians the necessity of any disclosure before it occurs and enlist their co-operation. For example, it is preferable that a parent suspected of child abuse call the child protection authorities in the dentist's presence to self-report, or that the dentist obtain the parent's consent before the authorities are notified. This approach will prepare the way for subsequent interventions. If such co-operation is not forthcoming and the dentist has reason to believe that any delay in notification may put a child at risk of further harm, then the dentist ought to immediately notify child protection authorities and subsequently inform the parent or guardian that this has been done.

In the case of an HIV-positive patient, disclosure to a spouse or current sexual partner may not be unethical and, indeed, may be justified when the patient is unwilling to inform the person(s) at risk. Such disclosure requires that all of the following conditions are met: the partner is at risk of infection with HIV and has no other reasonable means of knowing the risk; the patient has refused to inform his or her sexual partner; the patient has refused an offer of assistance by the dentist to do so on the patient's

behalf; and the dentist has informed the patient of his or her intention to disclose the information to the partner. When considering how to proceed in such circumstances, the dentist is advised to seek appropriate legal advice and to consult with the patient's physician.

### **Dealing with uncooperative patients**

As every practising dentist knows, some patients are very difficult to treat, not because of their oral health status but because of their attitudes or behaviour. The **FDI International Principles of Ethics for the Dental Profession** requirement that "The needs of the patient are the overriding concern" may seem impossible to fulfil when the patient refuses to cooperate. Two categories of such patients are fearful children and noncompliant adults.

There are many reasons why some children resist dental diagnosis and treatment. Some of these are irrational, such as a belief that any dental treatment necessarily involves excruciating pain. Others are completely rational, for example, a dentist may previously have told the child that "this won't hurt a bit" when in fact he did cause the child pain. Whatever the reasons, good communication with the patient is the key to overcoming resistance. Such communication has to take into account the child's age and ability to understand what is involved in diagnosis and treatment, as well as any bad experiences the child may have had with dental treatment. In some cases, referral to a paediatric dentist may be advisable.

It is likely that relatively few patients are fully compliant with the recommendations of their dentist

for both self care and continuing professional care. Continuing the care of mildly noncompliant patients poses no serious ethical issues for dentists. However, there are some patients whose blatant disregard for their oral health seriously compromises the efforts of their dentists to care for them. They may neglect to brush their teeth or they may cancel follow-up appointments and then return later with advanced oral diseases. Some dentists may consider the treatment of such patients a waste of their time and decide to terminate the professional relationship with them. As noted above, dental ethics does allow for such termination under certain conditions: the dentist should have made reasonable efforts to encourage a change of behaviour on the part of the patient, including a gentle warning that if there is no such change, the patient may have to find another dentist; the dentist should be prepared to justify his/her decision to the patient and to a third party if appropriate; the dentist should help the patient find another suitable dentist or, if this is not possible, should give the patient adequate notice of withdrawal of services so that the patient can find alternative dental care.

### **Financial restraints on treatment**

In contrast to medical care, which is widely regarded as a basic human right, oral health care receives relatively little financial support from governments. Consequently, the costs of dental services are often a more pressing issue for patients, even in wealthy countries, than the costs of medical care. In lower and middle income countries, the acute shortage of dentists compounds the problem of access to oral health care.

In most countries, the vast majority of dentists are private practitioners. They have to ensure the financial viability of their practice while remaining faithful to the ethical foundations of their profession. Fulfilling both these obligations is often very difficult, especially when patients cannot afford needed dental treatment. In such situations, the requirement of the **FDI International Principles of Ethics for the Dental Profession** that “The needs of the patient are the overriding concern” clashes with the financial reality that dental services cannot be provided free of charge to everyone in need.

The more general problem of access to oral health care will be treated in the next chapter. Here the discussion will be limited to the responsibilities of individual dentists towards their patients who do not have sufficient means, either through insurance or their personal assets, to pay for needed dental care. Although dentists are generally not required, either by law or by professional regulations, to provide care to those who cannot afford it, except in an emergency, their membership in a recognised healthcare profession entails a responsibility to consider how they can meet the dental needs of at least some of these patients. Ways of doing this include the following:

- accepting patients covered by insurance that provides compensation below the rate usually charged by the dentist;
- allowing patients to pay over an extended period;
- reducing or eliminating fees for some patients;

- lobbying for better oral health insurance coverage for those in need.

The amount of charity care expected from dentists cannot be quantified, since they differ greatly with regard to their financial circumstances. As professionals concerned with the welfare of their patients, however, they will want to consider how they can make their services available to people who cannot afford them.

### Back to the Case Study

According to the analysis of the dentist-patient relationship presented in this chapter, Dr. P's conduct is ethically questionable. He is clearly a man of principle, which is to be admired. However, his conviction that his principles should take precedence over those of his patients is contrary to the growing legal and ethical consensus that patients have the right to make decisions about their health care. If Dr. P is genuinely concerned about the harmful consequences of orthodontic treatment for this patient, rather than bluntly refusing to refer he should begin by explaining his concerns to the patient. If for professional or conscience reasons a dentist refuses to provide a particular service, it does not automatically follow that he or she should not refer the patient to another dentist. Although the **FDI International Principles of Ethics for the Dental Profession** requires referrals only "for advice and/or treatment ...requiring a level of competence beyond that held", respect for the patient's autonomy would seem to require the dentist at the very least to assist the patient in finding another dentist who would consider her request. Given the rapid progress of dental technology, the different values that individuals

attach to facial appearance, and the lack of agreement among dentists on practice standards, a dentist should not be too certain that his or her outlook is the only right one, or even the best one.



## CHAPTER THREE – DENTISTS AND SOCIETY

### Objectives

After working through this chapter you should be able to:

- recognise conflicts between the dentist's obligations to patients and obligations to society and identify the reasons for the conflicts
- identify and deal with the ethical issues involved in allocating scarce dental resources
- recognise dentist responsibilities for public and global health.

### Case Study #2

Dr. S is one of only two dentists in her community. Between them they have just managed to provide basic oral care to the population. Recently her colleague has changed his practice to focus on technically and aesthetically advanced services that only adequately insured or middle and upper class patients can afford. As a result, Dr. S is overwhelmed by patients requiring basic care. She is reluctant to ration her services but feels that she has no choice. She wonders what is the fairest way to do so: by favouring her previous patients over those of her colleague; by giving priority to emergency cases; by establishing a waiting list so that all will get treated eventually; or by some other way.

## What's Special About the Dentist-Society Relationship?

Dentistry is a profession. The term 'profession' has two distinct, although closely related, meanings: (1) an occupation that is characterised by dedication to the well-being of others, high moral standards, a body of knowledge and skills, and a high level of autonomy; and (2) all the individuals who practise that occupation. 'The dental profession' can mean either the practice of dentistry or dentists in general.

Dental professionalism involves not just the relationship between a dentist and a patient, as discussed in Chapter Two, and relationships with colleagues and other health professionals, which will be treated in Chapter Four. It also involves a relationship with society. This relationship can be characterised as a 'social contract' whereby society grants the profession privileges, including exclusive or primary responsibility for the provision of certain services and a high degree of self-regulation, and in return, the profession agrees to use these privileges mainly for the benefit of others and only secondarily for its own benefit.

Although most dentists may consider themselves first and foremost as private practitioners, dentistry is in fact both a social and an individual activity. It takes place in a context of government and corporate regulation and funding. It relies on academic and corporate dental research and product development for its knowledge base and treatments. It treats diseases that are as much social as biological in origin.

The Hippocratic background of dental ethics has little guidance to offer with regard to relationships with society. To supplement this approach, present-day dental ethics addresses the issues that arise beyond the individual patient-dentist relationship and provides criteria and processes for dealing with these issues.

To speak of the 'social' character of dentistry immediately raises the question – what is society? In this Manual the term refers to a community or nation. It is not synonymous with government; governments should, but often do not, represent the interests of society, but even when they do, they are acting **for** society, not **as** society.

Dentists have various relationships with society. Because society, and its physical environment, are significant factors in the health of patients, both the dental profession in general and individual dentists have important roles to play in public health, health education, environmental protection, laws affecting the health or well-being of the community, and testimony at judicial proceedings. Dentists are also called upon to play a role in the allocation of society's scarce healthcare resources, and sometimes they have a duty to prevent patients from accessing services to which they are not entitled. Implementing these responsibilities can raise ethical conflicts, especially when the interests of society seem to conflict with those of individual patients. Moreover, dentistry's relationships with society are evolving and need regular review to ensure that the needs of the community are met.

## Dual Loyalty

When dentists have responsibilities and are accountable both to their patients and to a third party and when these responsibilities and accountabilities are incompatible, they find themselves in a situation of conflict of interests or 'dual loyalty'. Third parties that demand dentists' loyalty include governments, employers (e.g., hospitals and managed health care organisations), insurers, military officials, police, prison officials and family members. Where the **FDI International Principles of Ethics for the Dental Profession** states that "The needs of the patient are the overriding concern," that is, not the only concern, it implies that dentists may in exceptional situations have to place the interests of others above those of the patient. The ethical challenge is to decide when and how to protect the patient in the face of pressures from third parties.

Dual loyalty situations comprise a spectrum ranging from those where society's interests should take precedence to those where the patient's interests are clearly paramount. In between is a large grey area where the right course of action requires considerable discernment.

At one end of the spectrum are requirements for mandatory reporting of patients who suffer from designated infectious diseases or those suspected of child abuse. Dentists should fulfil these requirements without hesitation, although patients should normally be informed that such reporting will take place. At the other end of the spectrum are requests or orders by the police or military to take part in practices that violate fundamental human rights, such

as torture. In such situations, dentists should fulfil their professional responsibility to determine the best interests of the patient and should observe, as far as possible, the normal ethical requirements of informed consent and confidentiality. Any breach of these requirements must be justified and must be disclosed to the patient. Dentists should report to the appropriate authorities any unjustified interference in the care of their patients, especially if fundamental human rights are being denied. If the authorities are unresponsive, help may be available from a national dental association, the FDI and human rights organisations.

Closer to the middle of the spectrum are the practices of some managed health care programmes that limit the clinical autonomy of dentists to determine how their patients should be treated. Although such practices are not necessarily contrary to the best interests of patients, they can be, and dentists need to consider carefully whether they should participate in such programmes. If they have no choice in the matter, for example, where there are no alternative programmes, they should *advocate* vigorously for their own patients and, through their dental associations, for the needs of all the patients affected by such restrictive policies.

A particular form of a dual loyalty issue faced by dentists is the potential or actual conflict of interest between a commercial organisation on the one hand and patients and/or society on the other. Pharmaceutical companies, manufacturers of dental devices and supplies and other commercial organisations not infrequently offer dentists gifts and other benefits that range from free samples to travel

and accommodation at educational events to excessive remuneration for research activities (see Chapter Five). A common underlying motive for such company largesse is to convince the dentist to use or prescribe the company's products, which may not be the best ones for the dentist's patients and/or may add unnecessarily to a society's health costs. The primary ethical principle for dealing with such situations is that dentists should resolve any conflict between their own interests and those of their patients in their patients' favour. More specifically, dentists are well advised to follow the advice of the American Dental Association's **Principles of Ethics and Code of Professional Conduct** where it states: "In the case of a health-related product, it is not enough for the dentist to rely on the manufacturer's or distributor's representations about the product's safety and efficacy. The dentist has an independent obligation to inquire into the truth and accuracy of such claims and verify that they are founded on accepted scientific knowledge or research."

### Resource allocation

In every country in the world, including the richest ones, there is an already wide and steadily increasing gap between the needs and desires for healthcare services and the availability of resources to provide these services. The existence of this gap requires that the existing resources be rationed in some manner. Healthcare rationing, or 'resource allocation' as it is more commonly referred to, takes place at three levels:

- At the highest ('macro') level, governments decide how much of the overall budget should be allocated to health; which healthcare expenses will

be provided at no charge and which will require payment either directly from patients or from their insurance plans; within the health budget, how much will go to remuneration for health care workers, to capital and operating expenses for hospitals and other institutions, to research, to education of health professionals, to treatment of specific conditions such as tuberculosis or AIDS, and so on.

- At the institutional ('meso') level, which includes hospitals, clinics, healthcare agencies, and dentists' offices, authorities decide how to allocate their resources: which services to provide; how much to spend on staff, equipment, security, other operating expenses, renovations, expansion, etc.
- At the individual patient ('micro') level, dentists decide whether and how often radiographic tests should be performed, whether to recommend simple or more complex treatment, whether a referral to another dentist is needed, etc. Despite the growing encroachment of managed care, dentists have considerable discretion as to which resources their patients will have access.

The choices that are made at each level have a major ethical component, since they are based on values and have significant consequences for the health and well-being of individuals and communities. Individual dentists are involved in decisions at all levels.

As noted above, dentists are expected to act primarily in the interests of their own patients. Their core ethical values of compassion, competence and autonomy are directed towards serving the needs of

their own patients. This individualistic approach to dental ethics has survived the transition from dentist paternalism to patient autonomy, where the will of the individual patient is the main criterion for deciding what resources he or she should receive. However, another value, justice, is becoming an important factor in dental decision-making. It entails a more social approach to the distribution of resources, one that considers the needs of other patients. According to this approach, dentists are responsible not just for their own patients but, to a certain extent, for others as well.

This new understanding of the dentist's responsibility to society is reflected in the FDI **International Principles of Ethics for the Dental Profession** where it states: "The dentist should...support and promote accepted measures to improve the oral health of the public." One way that dentists can exercise this responsibility insofar as it involves the allocation of resources is by avoiding wasteful and inefficient practices, even when patients request them. Clinical practice guidelines are available for some dental conditions; they help to distinguish between effective and ineffective treatments. Dentists should familiarise themselves with these guidelines, both to conserve resources and to provide optimal treatment to their patients.

A type of allocation decision that almost all dentists must make is the choice among patients who are in need of their care, including those who cannot afford to pay for needed treatment. Dentists must decide which patients will have access to their services and which will not, knowing full well that those who are denied may suffer as a result.



In dealing with these allocation issues, dentists must not only balance the principles of compassion and justice but, in doing so, must decide which approach to justice is preferable. There are several such approaches, including the following:

- **libertarian** — resources should be distributed according to market principles (individual choice conditioned by ability and willingness to pay, with limited charity care for the destitute);
- **utilitarian** — resources should be distributed according to the principle of maximum benefit for all;
- **egalitarian** — resources should be distributed strictly according to need;
- **restorative** — resources should be distributed so as to favour the historically disadvantaged.

Unlike medicine, dentistry has traditionally favoured the libertarian approach, which has also been accepted by many governments for whom oral health care is a very low priority. However, the growing awareness of the nature and requirements of professionalism and the intrinsic connection of oral health and overall health are giving rise to a more social conception of dentistry. From this perspective the libertarian approach is seen to be inadequate because it leaves a segment of the population with limited or no access to oral health care. Dentists as an organised profession are beginning to consider that they have a responsibility for these individuals in addition to those who do have access to dental care, namely, their own patients. This responsibility is not

theirs alone, however, but requires the support of political authorities to provide the funding for basic oral health care for those who cannot afford it. As mentioned above in Chapter Two, individual dentists should consider how they can meet the needs of at least some of these actual or potential patients. However, the professional associations of dentists also have a role to play, first by developing policies promoting universal access to oral health care and secondly by lobbying forcefully the political authorities to fund such access.

If the libertarian approach to justice cannot meet the needs of all those in need of dental care, can one of the other three approaches serve this purpose? Those who have considered this matter have reached no consensus on which approach is superior. Each one clearly has very different results when applied to the issues mentioned above, whether at the macro, meso or micro level. The utilitarian approach can be useful for health planners but is probably the most difficult for individual dentists to practise, since it requires a great deal of data on the probable outcomes of different interventions, not just for the dentist's own patients but for all others. The choice between the other two (or three, if the libertarian is included) will depend on the dentist's own personal morality as well as the socio-political environment in which he or she practises. Some countries, such as the U.S.A., favour the libertarian approach; others, e.g., Sweden, are known for their longstanding egalitarianism; while still others, such as post-apartheid South Africa, are attempting a restorative approach. Despite their differences, two or more of these concepts of justice often coexist in national health systems, and in these countries dentists may be able to choose a practice

setting (e.g., wealthy or poor neighbourhood, urban or rural community) that accords with their own preferred approach.

### Public health

The term 'public health', as used here, refers both to the health of the public and also to the dental specialty that deals with oral health from a population perspective rather than on an individual basis. There is a great need for specialists in this field in every country to advise on and advocate for public policies that promote good oral health, as well as to engage in activities to protect the public from preventable diseases and other oral health hazards. The practice of public health (sometimes called 'public health dentistry' or 'community dentistry') relies heavily for its scientific basis on **epidemiology**, which is the study of the distribution and determinants of health and disease in populations. All dentists need to be aware of the social and environmental determinants that influence the health status of their individual patients.

Public health measures such as community water fluoridation and tobacco-free workplaces are important factors in the oral health of individuals but social factors such as housing, nutrition and employment are equally, if not more, significant. Dentists are seldom able to treat the social causes of their individual patients' illnesses, although they should be able refer the patients to available social services. However, they can contribute, even if indirectly, to long-term solutions to these problems by participating in public health and health education activities, monitoring and reporting environmental hazards, identifying and publicising adverse health

effects from social problems such as abuse and violence, and advocating for improvements in public health services.

Sometimes, though, the interests of public health may conflict with those of individual patients, for example, when notification is required for certain contagious diseases or for cases of child or elder abuse. These are examples of dual-loyalty situations as described above. Procedures for dealing with these and related situations are discussed under 'confidentiality' in Chapter Two of this Manual. In general, dentists should attempt to find ways to minimise any harm that individual patients might suffer as a result of meeting public health requirements. For example, when reporting is required, the patient's confidentiality should be protected to the greatest extent possible while fulfilling the legal requirements.

A different type of conflict between the interests of individual patients and those of society arises when dentists are asked to assist patients to receive benefits to which they are not entitled, such as insurance payments. Dentists have been vested with the authority to certify that patients have the appropriate dental condition that would qualify them for such benefits. Although some dentists are unwilling to deny requests from patients for certificates that do not apply in their circumstances, they should rather help their patients find other means of support that do not require unethical behaviour.

### Global Health

The recognition that dentists have responsibilities to the society in which they live can be expanded to

include a responsibility for global health. This term refers to health problems, issues and concerns that transcend national boundaries, that may be influenced by circumstances or experiences in other countries, and that are best addressed by cooperative actions and solutions at the international level. Global health is part of the much larger movement of globalization that encompasses information exchange, commerce, politics, tourism and many other human activities.

The basis of globalization is the recognition that individuals and societies are increasingly interdependent. This is clearly evident with regard to human health, as the rapid spread of diseases such as influenza and SARS has shown. Such epidemics require international action for their control. The failure to recognise and treat highly contagious diseases in one country can have devastating effects on patients in other countries. For this reason, the ethical concerns of dentists extend far beyond their individual patients and even their communities and nations.

The development of a global view of health has resulted in an increasing awareness of health disparities throughout the world. Despite large-scale campaigns to combat premature mortality and debilitating morbidity in the poorest countries, which have resulted in certain success stories such as the elimination of smallpox, the gap in health status between high and low-income countries continues to widen. This is partly due to HIV/AIDS, which has had its worst effects in poor countries, but it is also due to the failure of low-income countries to benefit from the increase in wealth that the world as a whole has experienced during the past decades.

Although the causes of poverty are largely political and economic and are therefore far beyond the control of dentists and their associations, dentists do have to deal with the oral health problems that result from poverty. In low-income countries dentists have few resources to offer these patients and are constantly faced with the challenge of allocating these resources in the fairest way. Even in middle and high-income countries, dentists encounter patients who are directly affected by globalization, such as refugees, who often do not have access to the dental coverage that many citizens of those countries enjoy. In its **Nairobi Declaration on Oral Health in Africa** the FDI recognises these disparities and encourages all efforts to promote access to oral health care for all. As professionals concerned about their patients, dentists should actively promote interventions, behaviours and policies that help to narrow the oral health gap between the rich and poor

Another feature of globalization is the international mobility of health professionals, including dentists. The outflow of dentists from developing to highly industrialised countries has been advantageous for the receiving countries but not for the exporting countries. The FDI, in its **Policy Statement on Ethical International Recruitment of Oral Health Professionals**, makes four specific recommendations to national dental associations for preventing the exploitation of both the developing countries and dentists from those countries:

- Collaborate with their governments to ensure that an adequate number of dentists are educated and licensed to practise, taking into account national needs and resources;
- Promote policies and strategies that enhance effective retention of dentists in their countries;
- Promote strategies with partners to lessen the adverse effects of emigration of dentists and minimise their impact on health systems; and
- Encourage their governments to provide oral health professionals legally recruited from abroad who meet the destination countries' practice requirements with employment rights and protections equivalent to other oral health professionals in their countries, including careers support and access to continuing professional development.

Dentists have a long tradition of volunteering their experience and skills in underserved areas, both in humanitarian disasters and emergencies and in situations of chronic need. Volunteer dentists working in development projects run by non-governmental organisations (NGOs) provide improved access to oral health care for many communities and can be an important means of knowledge transfer from developed to developing countries. However, such projects should be properly coordinated and integrated into the local health care system in order to address the real needs of the communities. The FDI's policy statement, **Guidelines for Dental Volunteers**, underlines the importance of project

planning and integration for sustainable and long-term development in receiving communities.

### **Back to the Case Study**

According to the analysis of the dentist-society relationship presented in this chapter, Dr. S has correctly diagnosed the problem she faces as ethical in nature, requiring consideration of justice (fairness) in dealing with patients. When one is faced with an ethical issue for which the alternatives all have serious drawbacks, it is often helpful to explore new approaches. In this case, Dr. S may try to recruit an additional dentist to share the patient load. If this is not possible, she could remind her former colleague that at least one dental code of ethics, that of the American Dental Association, states: "Once a dentist has undertaken a course of treatment, the dentist should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Care should be taken that the patient's oral health is not jeopardised in the process." The colleague may then be willing to retain at least some of his patients. If none of these strategies proves successful, Dr. S can consider how the different approaches to justice mentioned above would determine her choice of patients. She can then implement a policy that accords most closely with her preferred approach.



## CHAPTER FOUR – DENTISTS AND COLLEAGUES

### Objectives

After working through this chapter you should be able to:

- describe how dentists should behave towards one another
- justify reporting unethical behaviour of colleagues
- identify the main ethical principles relating to cooperation with others in the care of patients
- explain how to resolve conflicts with other healthcare providers

### Case Study #3

Dr. C, a newly qualified endodontist, has just taken over the practice of the only endodontist in a medium-sized community. The four general practice dentists in the community are relieved that they can continue their referrals without interruption. During his first three months in the community, Dr. C is concerned that a significant number of the patients referred by one of the general practice dentists show evidence of substandard treatment. As a newcomer, Dr. C is reluctant to criticise the referring dentist personally or to report him to higher authorities. However, she feels that she must do something to improve the situation.

### The need for collaboration

Although most dentists may think of themselves first and foremost as private practitioners, they are increasingly reliant on others to meet the oral health

needs of their patients. This chapter will deal with ethical issues that arise in the relationships of dentists both with their dentist colleagues and with other oral health care personnel. Some issues are common to both; others arise only in one or the other relationship. Many of these issues are relatively new, since they result from recent changes in dentistry and health care. A brief description of these changes is in order, since they pose significant challenges to the traditional practice of dentistry.

With the rapid growth in scientific knowledge and its clinical applications, dentistry has become increasingly complex. Individual dentists cannot possibly be experts in all their patients' oral diseases and potential treatments and they need the assistance of other specialist dentists and skilled health professionals such as dental hygienists and assistants, laboratory technicians, physicians, pharmacists and speech therapists. Dentists need to know how to access the relevant skills that their patients require and that they themselves lack. Moreover, it is normal for dentists in many countries to delegate certain clinical procedures to ancillary dental workers if those persons have undergone the necessary training and are legally permitted to practise.

As discussed in Chapter Two, dental paternalism has been gradually eroded by the increasing recognition of the right of patients to make their own health care decisions. As a result, a cooperative model of decision-making has replaced the authoritarian model that was characteristic of traditional dental paternalism. The same thing is happening in relationships between dentists and other health professionals. The latter are increasingly unwilling to

follow dentists' orders without knowing the reasons behind the orders. They see themselves as professionals with specific ethical responsibilities towards patients; if their perception of these responsibilities conflicts with the dentist's orders, they feel that they must question or even challenge the orders. Whereas under the authoritarian model of decision-making there was never any doubt about who was in charge and who should prevail when conflict occurred, the cooperative model can give rise to disputes about appropriate patient care. Developments such as these are changing the 'rules of the game' for the relationships of dentists with their dentist colleagues and other health professionals. The remainder of this chapter will identify some problematic aspects of these relationships and suggest ways of dealing with them.

### **Relationships among Dentist Colleagues, Teachers and Students**

As members of the dental profession, dentists have traditionally been expected to treat their colleagues respectfully and to work cooperatively to maximise patient benefit. The **FDI International Code of Dental Ethics states that dentists** "should refer for advice and/or treatment any patient requiring a level of competence beyond that held." The following two relationships between dentists have generally been considered unethical: (1) paying or receiving any fee or any other consideration solely to procure the referral of a patient ('fee-splitting'); and (2) luring patients from colleagues. These two practices, along with a third obligation, to report unethical or incompetent behaviour by colleagues, are discussed below.

In the Hippocratic tradition of dental ethics, dentists owe special respect to their teachers. Although present-day dental education involves multiple student-teacher interactions rather than the one-on-one apprentice relationship that was the norm before the 20th century, it is still dependent on the good will and dedication of practising dentists, who often receive no remuneration for their teaching activities. Dental students owe a debt of gratitude to their teachers, without whom dental education would be reduced to self-instruction.

For their part, teachers have an obligation to treat their students respectfully and to serve as good role models in dealing with patients. The so-called 'hidden curriculum' of dental education, i.e., the standards of behaviour exhibited by practising dentists, is much more influential than the explicit curriculum of dental ethics, and if there is a conflict between the requirements of ethics and the attitudes and behaviour of their teachers, dental students are more likely to follow their teachers' example.

Teachers have a particular obligation not to encourage or allow students to engage in unethical practices, such as providing treatments that meet the students' educational needs rather than the patients' clinical needs. Given the unequal power balance between students and teachers and the consequent reluctance of students to question or refuse such suggestions, teachers need to ensure that they are not pressuring students to act unethically. In many dental schools, there are class representatives or dental student associations that, among their other roles, may be able to raise concerns about ethical issues in dental education. Students should have

access to such mechanisms where they can raise concerns without necessarily being identified as the *whistle-blower*, as well as access to appropriate support if it becomes necessary to take the issue to a more formal process.

For their part, dental students are expected to exhibit high standards of ethical behaviour as appropriate for future dentists. They should treat other students as colleagues and be prepared to offer help when it is needed, including corrective advice in regard to unprofessional behaviour. They should also contribute fully to shared projects and duties such as study assignments.

### **Fee-splitting and Advertising**

Since dentistry is primarily a profession and only secondarily a business, not all means of maximising income, even if legal, are considered to be ethical. For example, fee-splitting, which involves a payment from one dentist to another simply for referring a patient, is forbidden in codes of ethics such as the American Dental Association **Principles of Ethics and Code of Professional Conduct**. The reason for this prohibition is the danger that dentists will, simply for financial gain, refer patients who do not need specialist treatment.

An apparently more common technique for maximising income, often at the expense of other dentists, is advertising. Until fairly recently, advertising was considered unprofessional – suitable for promoting sales of consumer products but not of health services. As a result of social and legal changes in some countries, advertising by dentists is no longer forbidden and there is no mention of it in the FDI

**International Principles of Ethics for the Dental Profession.** However, various national dental associations place restrictions on advertising by their members. For example, the Canadian Dental Association **Code of Ethics** states, “Dentists should build their reputation on their professional ability and integrity. Dentists should participate in health promotion programs that are in the best interest of the public and supported by the profession. Dentists shall conduct any promotional activity in accordance with acceptable professional standards and within applicable legislation.”

Besides these legitimate goals, advertising can also be used for unethical purposes, such as luring patients from other dentists and convincing patients to undergo treatment, especially cosmetic procedures, that they do not need. Not only are these purposes harmful to other dentists and to patients but they reflect poorly on the dental profession as a whole, contrary to the requirement of the FDI **International Principles of Ethics for the Dental Profession** that the dentist “should act in a manner which will enhance the prestige and reputation of the profession.”

### **Reporting unsafe or unethical practices**

Dentistry has traditionally taken pride in its status as a self-regulating profession. In return for the privileges accorded to it by society and the trust given to its members by their patients, the dental profession has established high standards of behaviour for its members and disciplinary procedures to investigate accusations of misbehaviour and, if necessary, to punish the wrongdoers. This system of self-regulation has sometimes failed, and in recent years steps have been taken to make the profession more

accountable, for example, by appointing lay members to regulatory authorities. The main requirement for self-regulation, however, is wholehearted support by dentists for its principles and their willingness to recognise and deal with unsafe and unethical practices. The increasing use of constructive and mutually supportive peer review groups, where dentists discuss and review their successes and difficulties with local colleagues, is a welcome development, especially in general dental practice where, unlike in hospitals or health clinics, dentists may lack the benefit of working in an environment that naturally fosters peer review.

The obligation to report incompetence, misconduct or impairment on the part of one's colleagues is emphasised in codes of dental ethics. For example, the American Dental Association **Principles of Ethics and Code of Professional Conduct** states that "Dentists shall be obliged to report to the appropriate reviewing agency...instances of gross or continual faulty treatment by other dentists" and "All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society." The application of this principle is seldom easy, however. On the one hand, a dentist may be tempted to attack the reputation of a colleague for unworthy personal motives, such as jealousy, or in retaliation for a perceived insult by the colleague. A dentist may also be reluctant to report a colleague's misbehaviour because of friendship or sympathy ("there but for the grace of God go I"). The consequences of such

reporting can be very detrimental to the one who reports, including almost certain hostility on the part of the accused and possibly other colleagues as well.

Despite these drawbacks to reporting wrongdoing, it is a professional duty of dentists. Not only are they responsible for maintaining the good reputation of the profession, but they are often the only ones who recognise incompetence, impairment or misconduct. However, reporting colleagues to the disciplinary authority should normally be a last resort after other alternatives have been tried and found wanting. The first step might be to approach the colleague and say that you consider his or her behaviour unsafe or unethical. If the matter can be resolved at that level, there may be no need to go further. If not, then it may be necessary to take the next step of informing the disciplinary authority.

### **Relationships with Other Health Professionals**

Chapter Two on relationships with patients began with a discussion of the great importance of respect and equal treatment in the dentist-patient relationship. The principles set forth in that discussion are equally relevant for relationships with co-workers. In particular, the prohibition against discrimination on grounds such as race, creed, colour, sex or national origin (American Dental Association **Principles of Ethics and Code of Professional Conduct**) is applicable in dealings with all those with whom dentists interact in caring for patients and other professional activities.

Non-discrimination is a passive characteristic of a relationship. Respect is something more active and positive. With regard to other healthcare providers,



such as dental hygienists and assistants, laboratory technicians, etc., it entails an appreciation of their skills and experience insofar as these can contribute to the care of patients. The **FDI International Code of Dental Ethics** states that dentists “should behave towards all members of the oral health team in a professional manner and should be willing to assist colleagues professionally and maintain respect for divergence of professional opinion.” All healthcare providers are not equal in terms of their education and training, but they do share a basic human equality as well as similar concern for the well-being of patients.

As with patients, though, there are legitimate grounds for refusing to enter or for terminating a relationship with another health care provider. These include lack of confidence in the ability or integrity of the other person and serious personality clashes. Distinguishing these from less worthy motives can require considerable ethical sensitivity on the dentist’s part.

### **Cooperation**

Dentistry is at the same time a highly individualistic and a highly cooperative profession. On the one hand, dentists are quite possessive of ‘their’ patients. It is claimed, with good reason, that the individual dentist-patient relationship is the best means of attaining the knowledge of the patient and continuity of care that are optimal for the prevention and treatment of oral disease. The retention of patients also benefits the dentist, not least financially. At the same time, as described above, dentistry is highly complex and specialised, thus requiring close cooperation among practitioners with different but

complementary knowledge and skills. This tension between individualism and cooperation has been a recurrent theme in dental ethics.

The weakening of dental paternalism has been accompanied by the disappearance of the belief that dentists 'own' their patients. The traditional right of patients to ask for a second opinion has been expanded to include access to other healthcare providers who may be better able to meet their needs. Dentists should facilitate the exercise of this right although, as noted above, they are not to profit from relationships with other dentists by fee-splitting.

Whereas relationships among dentists are governed by generally well-formulated and understood rules, relationships between dentists and other healthcare professionals are in a state of flux and there is some disagreement about what their respective roles should be. As noted above, many other health professionals favour a team approach to patient care in which the views of all caregivers are given equal consideration, and they consider themselves accountable to the patient, not to the dentist. Many dentists, on the other hand, feel that even if the team approach is adopted, there has to be one person in charge, and dentists are best suited for that role given their education and experience. This view is supported by the FDI **International Principles of Ethics for the Dental Profession** where it states, "The dentist must accept full responsibility for all treatment undertaken..." and the FDI **Statement on Supervision of Auxiliaries within the Dental Team**: "the dentist is also responsible for the support, guidance and supervision of auxiliaries within the dental team."

Although some dentists may resist challenges to their traditional, almost absolute, authority, it seems certain that their role will change in response to claims by both patients and other healthcare providers for greater participation in dental decision-making. Dentists will have to be able to justify their recommendations to others and persuade them to accept these recommendations. In addition to these communication skills, dentists will need to be able to resolve conflicts that arise among the different participants in the care of the patient.

### **Conflict resolution**

Although dentists can experience many different types of conflicts with other dentists and healthcare providers, for example, over office procedures or remuneration, the focus here will be on conflicts about patient care. Ideally, oral health care decisions will reflect agreement among the patient, dentists and all others involved in the patient's care. However, uncertainty and diverse viewpoints can give rise to disagreement about the goals of care or the means of achieving those goals. Limited healthcare resources and organisational policies may also make it difficult to achieve consensus. Dentists are particularly susceptible to such conflicts because of the lack of generally accepted standards of care and because so many patients cannot afford high quality oral health care.

Disagreements among dentists and/or dental auxiliaries about the goals of care and treatment or the means of achieving those goals should be clarified and resolved by the individuals involved so as not to compromise their relationships with the

patient. The following guidelines can be useful for resolving such conflicts:

- Conflicts should be resolved as informally as possible, for example, through direct negotiation between the persons who disagree, moving to more formal procedures only when informal measures have been unsuccessful.
- The opinions of all those directly involved should be elicited and given respectful consideration.
- The informed choice of the patient, or authorised substitute decision-maker, regarding treatment should be the primary consideration in resolving disputes.
- If the dispute is about which options the patient should be offered, a broader rather than a narrower range of options is usually preferable. If a preferred treatment is not available because of resource limitations, the patient should normally be informed of this.
- If, after reasonable effort, agreement or compromise cannot be reached through dialogue, the decision of the person with the right or responsibility for making the decision should be accepted. If it is unclear or disputed who has the right or responsibility to make the decision, mediation, arbitration or adjudication should be sought.

If health care providers cannot support the decision that prevails as a matter of professional judgement or personal morality, they should be allowed to

withdraw from participation in carrying out the decision, after ensuring that the person receiving care is not at risk of harm or abandonment.

### **Back to the Case Study**

Dr. C is right to be alarmed by the treatment results of the referring dentist. She has an ethical duty not to ignore this problem but to do something about it. As a first step, she might try to have a discussion with the referring dentist to communicate her concerns and see whether he might voluntarily take corrective measures. If this does not succeed, she could raise the issue with the other dentists in the community to see whether they share her misgivings and seek their advice on further action. Together they may be able to convince the problem dentist to address the issue. If none of these initiatives has the desired effect, Dr C can approach the appropriate dentist licensing body and ask it to investigate. Dr. C also has to decide whether she should inform the patients about their substandard treatment. On this issue the American Dental Association's **Principles of Ethics and Code of Professional Conduct** advises that "Patients should be informed of their present oral health status without disparaging statements about prior services."

## CHAPTER FIVE – ETHICS AND DENTAL RESEARCH

### Objectives

After working through this chapter you should be able to:

- identify the main principles of research ethics
- know how to balance research and clinical care
- satisfy the requirements of ethics review committees

### Case Study #4

Dr. R, a general practice dentist in a small rural town, is approached by a contract research organisation (C.R.O.) to participate in a clinical trial of a new sealant. He is offered a sum of money for each patient that he enrolls in the trial. The C.R.O. representative assures him that the trial has received all the necessary approvals, including one from an ethics review committee. Dr. R has never participated in a trial before and is pleased to have this opportunity, especially with the extra money. He accepts without inquiring further about the scientific or ethical aspects of the trial.

### Importance of Dental Research

Dentistry is not an exact science in the way that mathematics and physics are. It is evidence based and has many general principles that are valid most of the time, but every patient is different and what is an effective treatment for 90% of the population may not work for the other 10%. Thus, dentistry is inherently experimental. Even the most widely

accepted treatments need to be monitored and evaluated to determine whether they are effective for specific patients and, for that matter, for patients in general. This is one of the functions of dental research.

Another, perhaps better known, function is the development of new dental materials, devices and techniques. Great progress has been made in this area over the past 50 years and today there is more dental research underway than ever before. Nevertheless, there are still many unanswered questions about the causes of oral diseases (both familiar and novel ones) and the best ways to prevent or cure them. Dental research is the only means of answering these questions.

### **Research in Dental Practice**

All dentists make use of the results of dental research in their clinical practice. To maintain their competence, dentists must keep up with the current research in their area of practice through Continuing Dental Education/Continuing Professional Development programs, dentistry journals and interaction with knowledgeable colleagues. Even if they do not engage in research themselves, dentists must know how to interpret the results of research and apply them to their patients. Thus, a basic familiarity with research methods is essential for competent dental practice. The best way to gain this familiarity is to take part in a research project, either as a dental student or following qualification.

Ideally, all aspects of dental practice should be validated by research. Materials such as dental amalgams and pharmaceutical products such as

anaesthetics do require evidence for their safety and efficacy before they are given governmental approval for their distribution and use. However, dental techniques do not require any such approval. Most dentists trust that the techniques they learn in dental school are appropriate but are ready to adopt new ones if these appear to be better. Rather than relying on their own, necessarily limited, experience, dentists need to have recourse to the results of research for determining which materials, drugs and techniques are best for their patients.

The most common method of research for comparing and evaluating drugs is the clinical trial process, which with certain modifications serves for materials and techniques as well. The process usually begins with laboratory studies followed by testing on animals. If these prove promising, the four steps, or phases, of clinical research, are next:

- Phase one research, usually conducted on a relatively small number of healthy volunteers, who are often paid for their participation, is intended to determine what dosage of a drug is required to produce a response in the human body, how the body processes the drug, and whether the drug produces toxic or harmful effects.
- Phase two research is conducted on a group of patients who have the disease that the drug is intended to treat. Its goals are to determine whether the drug has any beneficial effect on the disease and has any harmful side effects.



- Phase three research is the clinical trial, in which the drug is administered to a large number of patients and compared to another drug, if there is one for the condition in question, and/or to a placebo. Where possible, such trials are 'double-blinded', i.e., neither research subjects nor their dentists know who is receiving which drug or placebo.
- Phase four research takes place after the drug is licensed and marketed. For the first few years, a new drug is monitored for side effects that did not show up in the earlier phases. Additionally the pharmaceutical company is usually interested in how well the drug is being received by physicians and dentists who prescribe it and patients who take it.

The rapid increase in recent years in the number of ongoing trials has required finding and enrolling ever-larger numbers of patients to meet the statistical requirements of the trials. For dental research, those in charge of the trials, whether academic researchers or industry, now rely on many dentists, often in different countries, to enrol patients as research subjects.

Although such participation in research is valuable experience for dentists, there are potential problems that must be recognised and avoided. In the first place, the dentist's role in the dentist-patient relationship is different from the researcher's role in the researcher-research subject relationship, even if the dentist and the researcher are the same person. The dentist's primary responsibility is the health and well-being of the patient, whereas the researcher's primary responsibility is the generation of knowledge,

which may or may not contribute to the research subject's health and well-being. Thus, there is a potential for conflict between the two roles. When this occurs, the dentist role must take precedence over the researcher. What this means in practice will be evident below.

Another potential problem in combining these two roles is conflict of interest. Dental research is a well-funded enterprise, and dentists are sometimes offered considerable rewards for participating. These can include cash payments for enrolling research subjects, equipment such as computers to transmit the research data, invitations to conferences to discuss the research findings, and co-authorship of publications on the results of the research. The dentist's interest in obtaining these benefits can sometimes conflict with the duty to provide the patient with the best available treatment. It can also conflict with the right of the patient to receive all the necessary information to make a fully informed decision whether or not to participate in a research study.

These potential problems can be overcome. The ethical values of the dentist – compassion, competence, autonomy – apply to the dental researcher as well. As long as dentists understand and follow the basic rules of research ethics, they can successfully integrate research into their clinical practice.

### **Ethical Requirements**

The basic principles of research ethics are well established. It was not always so, however. Many prominent medical 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. Although there were some statements of research ethics dating from the early 20th century, these did not prevent healthcare professionals in many different countries – and in times of peace and war alike – from performing research on subjects that clearly violated fundamental human rights. Following World War Two, some German physicians were tried and convicted by a special tribunal at Nuremberg, Germany. The basis of the judgment is known as the Nuremberg Code, which has served as one of the foundational documents of modern research ethics. Among the ten principles of this Code is the requirement of voluntary consent if a patient is to serve as a research subject.

The World Medical Association 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 Two, the founders of the WMA immediately took steps to ensure that physicians would at least be aware of their ethical obligations. In 1954, after several years of study, the WMA adopted a set of **Principles for Those in Research and Experimentation**. This document was revised over the next ten years and eventually was adopted as the **Declaration of Helsinki (DoH)** in 1964. It was further revised in 1975, 1983, 1989, 1996 and 2000. 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 organisations of Medical Sciences, **International Ethical Guidelines for Biomedical Research Involving Human Subjects**,

1993, revised in 2002) 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 agree to a very large extent on the basic principles of research ethics. These principles have been incorporated in the laws and/or regulations of many countries and international organisations, including those that deal with the approval of drugs and medical devices. Here is a brief description of the principles, taken primarily from the **DoH**.

Unfortunately, there is no comparable statement of research ethics for dentists. The 2000 **Summary Code of Ethics** of the International and American Associations for Dental Research ([www.dentalresearch.org/about/aadr/ethics.html](http://www.dentalresearch.org/about/aadr/ethics.html)) provides little if any specific guidance for how researchers should deal with ethical issues.

### **Ethics Review Committee Approval**

Paragraphs 13 and 14 of the **DoH** stipulate that every proposal for research on human subjects must be reviewed and approved by an independent ethics committee before it 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 project as presented, require changes before it can start, or refuse approval altogether. Many committees have a further role of monitoring

projects that are underway to ensure that the researchers fulfil their obligations and they can if necessary stop a project because of serious unexpected adverse events.

The reason why ethics committee approval of a project 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.

One unresolved issue regarding ethics committee review is whether a multi-centre project requires committee approval at each centre or whether approval by one committee is sufficient. If the centres are in different countries, review and approval is generally required in each country.

### Scientific Merit

Paragraph 11 of the **DoH** requires that research involving human subjects must be justifiable on scientific grounds. This requirement is meant to eliminate projects that are unlikely to succeed, for example, because they are methodologically inadequate, or that, even if successful, will likely produce trivial results. If patients are being asked to participate in a research project, even where risk of harm is minimal, there should be an expectation that important scientific knowledge will be the result. To ensure scientific merit, paragraph 11 requires that the project be based on a thorough knowledge of the

literature on the topic and on previous laboratory and, where appropriate, animal research that gives good reason to expect that the proposed intervention will be efficacious in human beings. All research on animals must conform to ethical guidelines that minimise the number of animals used and prevent unnecessary pain. Paragraph 15 adds a further requirement – that only scientifically qualified persons should conduct research on human subjects. The ethics review committee needs to be convinced that these conditions are fulfilled before it approves the project.

### Social Value

One of the more controversial requirements of a research project is that it contribute to the well-being of society in general. It used to be widely agreed that advances in scientific knowledge were valuable in themselves and needed no further justification. However, as resources available for health research are increasingly inadequate, social value has emerged as an important criterion for judging whether a project should be funded.

Paragraphs 18 and 19 of the **DoH** clearly favour the consideration of social value in the evaluation of research projects. The importance of the project's objective, understood as both scientific and social importance, should 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.

The social worth of a research project is more difficult to determine than its scientific merit but that is not a good reason for ignoring it. Researchers, and ethics review committees, must ensure that patients are not subjected to tests that are unlikely to serve any useful social purpose. To do otherwise would waste valuable health resources and weaken the reputation of research as a major contributing factor to human health and well-being.

### Risks and Benefits

Once the scientific merit and social worth of the project have 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, which may not even go to the research subjects. A risk is the potential for an adverse outcome (harm) to occur. It has two components: (1) the likelihood of the occurrence of harm (from highly unlikely to very likely), and (2) 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 for a good research project. At the other end of the spectrum, a likely risk of a serious harm would be unacceptable unless the project provided the only hope of treatment for terminally ill research subjects. In between these two extremes, paragraph 17 of the **DoH** requires researchers to adequately assess the risks and be sure that they can be managed. 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.

## Informed Consent

The first principle of the **Nuremberg Code** reads as follows: “The voluntary consent of the human subject is absolutely essential.” The explanatory paragraph attached to this principle requires, among other things, that the research subject “should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.”

The **DoH** goes into some detail about informed consent. Paragraph 22 specifies what the research subject needs to know in order to make an informed decision about participation. Paragraph 23 warns against pressuring individuals to participate in research, since in such circumstances the consent may not be entirely voluntary. Paragraphs 24 to 26 deal with research subjects who are unable to give consent (minor children, severely mentally handicapped individuals, unconscious patients). They can still serve as research subjects but only under restricted conditions.

The **DoH**, like other research ethics documents, recommends that informed consent be demonstrated by having the research subject sign a ‘consent form’ (paragraph 22). Many ethics review committees require the researcher to provide them with the consent form they intend to use for their project. In some countries these forms have become so long and detailed that they no longer serve the purpose of informing the research subject about the project. In any case, the process of obtaining informed consent does not begin and end with the form being signed but must involve a careful oral explanation of the



project and all that participation in it will mean to the research subject. Moreover, research subjects should be informed that they are free to withdraw their consent to participate at any time, even after the project has begun, without any sort of reprisal from the researchers or other dentists and without any compromise of their health care.

### Confidentiality

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 requires the disclosure of personal health information to others, including the wider scientific community and sometimes the general public. In order to protect privacy, researchers must ensure that they obtain the informed consent of research subjects to use their personal health information for research purposes, which requires that the subjects 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 and should be stored and transmitted securely.

### Conflict of Roles

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-research subject relationship, even if the dentist and the researcher are the same person. Paragraph 28 of the **DoH** requires that in such cases, the dentist 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 project requires that patients be

randomised 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.

### Honest Reporting of Results

It should not be necessary to require that research results be reported accurately, but unfortunately there have been numerous recent accounts of dishonest practices in the publication of research results. Problems include *plagiarism*, data fabrication, duplicate publication and 'gift' authorship. Such practices may benefit the researcher, at least until they are discovered, 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.

### Whistle-blowing

In order to prevent unethical research from occurring, or to expose it after the fact, anyone who has knowledge of such behaviour has an obligation to disclose this information to the appropriate authorities. Unfortunately, such whistle-blowing is not always appreciated or even acted on, and whistle-blowers are sometimes punished or avoided for trying to expose wrong-doing. This attitude seems to be changing, however, as both scientists and government regulators are seeing the need to detect and punish unethical research and are beginning to appreciate the role of whistle-blowers in achieving this goal.

Junior members of a research team, such as dental students, may find it especially difficult to act on suspicions of unethical research, since they may feel unqualified to judge the actions of senior researchers and will likely be subject to punishment if they speak out. At the very least, however, they 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 relevant authorities, either directly or anonymously.

### **Unresolved Issues**

Not all aspects of research ethics enjoy general agreement. As the biomedical sciences continue to advance, in areas such as genetics, the neurosciences and tissue transplantation, new questions arise regarding the ethical acceptability of techniques, procedures and treatments for which there are no ready-made answers. Moreover, some older issues are still subjects of continuing ethical controversy, for example, under what conditions should a placebo arm be included in a clinical trial and what continuing care should be provided to participants in dental research. At a global level, the 10/90 gap in health research (only 10% of global research funding is spent on health problems that affect 90% of the world's population) is clearly an unresolved ethical issue. Furthermore when researchers do address issues in resource-poor areas of the world, they often encounter problems due to conflicts between their ethical outlook and that of the communities where they are working. All these topics will require much further analysis and discussion before general agreement is achieved.

Despite all these potential problems, dental research is a valuable and rewarding activity for dentists and dental students as well as for the research subjects themselves. Indeed, dentists and dental students should consider serving as research subjects so that they can appreciate the other side of the researcher-research subject relationship.

### Back to the Case Study

Dr. R should not have accepted so quickly. He should first find out more about the project and ensure that it meets all the requirements for ethical research. In particular, he should ask to see the protocol that was submitted to the ethics review committee and any comments or conditions that the committee put on the project. He should only participate in projects in his area of practice, and he should satisfy himself about the scientific merit and social value of the project. If he is not confident in his ability to evaluate the project, he should seek the advice of colleagues in larger centres. He should ensure that he acts in the best interests of his patients and only enrolls those who will not be harmed by changing their current treatment to the experimental one or to a placebo. He must be able to explain the alternatives to his patients so they can give fully informed consent to participate or not to participate. He should not agree to enrol a fixed number of patients as subjects since this could lead him to pressure patients to agree, perhaps against their best interests. He should carefully monitor the patients in the study for unexpected adverse events and be prepared to adopt rapid corrective action. Finally, he should communicate to his patients the results of the research as they become available.

## CHAPTER SIX – CONCLUSION

### Rights and Privileges of Dentists

This Manual has focused on the duties and responsibilities of dentists, and indeed that is the main substance of dental ethics. However, like all human beings, dentists have rights as well as responsibilities, and dental ethics would be incomplete if it did not consider how dentists should be treated by others, whether patients, society or colleagues. Indeed, there may be difficulty in maintaining professional and ethical standards when dentists' rights are significantly at risk. This perspective on dental ethics has become increasingly important as dentists in many countries are experiencing great frustration in practising their profession, whether because of limited resources, government and/or corporate micro-management of health care delivery, sensationalist media reports of dental errors and unethical dentist conduct, or challenges to their authority and skills by patients and other health care providers.

Dental associations have an important role to play in defending the rights of dentists, given the threats and challenges listed above. However, dentists sometimes need also to be reminded of the privileges they enjoy. Public surveys in many countries have consistently shown that dentists are among the most highly regarded and trusted occupational groups. They generally receive higher than average remuneration (much higher in some countries). They still have a great deal of clinical autonomy, although not as much as previously. Some are engaged in an exciting search for new knowledge through participation in research. Most important, they provide services that are of

great value to individual patients, particularly those who are vulnerable and most in need, and to society in general. Few occupations have the potential to be more satisfying than dentistry, considering the benefits that dentists provide — relief of pain and suffering and cure of illnesses. Fulfilment of their ethical duties may be a small price to pay for all these privileges.

### **Responsibilities to Oneself**

This Manual has classified dentists' ethical responsibilities according to their main beneficiaries: patients, society, and colleagues (including other health professionals). Dentists often forget that they have responsibilities to themselves, and to their families, as well. In many parts of the world, being a dentist has required devoting oneself to the practice of dentistry with little consideration for one's own health and well-being. Working weeks of 60-80 hours are not uncommon and vacations are considered to be unnecessary luxuries. Although many dentists seem to do well in these conditions, their families may be adversely affected. Other dentists clearly suffer from this pace of professional activity, with results ranging from chronic fatigue to substance abuse to suicide. Impaired dentists are a danger to their patients, with fatigue being an important factor in dental mishaps.

The need to ensure patient safety, as well as to promote a healthy lifestyle for dentists, is being addressed in some countries. For example, some dental educational institutions now make it easier for female students to interrupt their training programmes for family reasons. Although measures such as these can contribute to dentist health and

well-being, the primary responsibility for self-care rests with the individual dentist. Besides avoiding such obvious health hazards as smoking, substance abuse and overwork, dentists should protect and enhance their own health and well-being by identifying stress factors in their professional and personal lives and by developing and practising appropriate coping strategies. When these fail, they should seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect their relationships with patients, society or colleagues.

### **The Future of Dental Ethics**

This Manual has focussed on the current state of dental ethics, although with numerous references to its past. However, the present is constantly slipping away and it is necessary to anticipate the future if we are not to be always behind the times. The future of dental ethics will depend in large part on the future of dentistry. In the first decade of the 21st century, dentistry is evolving at a very rapid pace and it is difficult to predict how it will be practised by the time today's first-year dental students complete their training, and impossible to know what further changes will take place before they are ready to retire. The future will not necessarily be better than the present, given widespread political and economic instability, environmental degradation, the continuing spread of HIV/AIDS and other potential epidemics. Although we can hope that the benefits of dental progress will eventually spread to all countries and that the ethical problems they will face will be similar to those currently being discussed in the wealthy countries, the reverse could happen — countries that are wealthy now could deteriorate to the point where

their dentists have to deal with ever larger numbers of patients who cannot afford oral health care and severe shortages of dental supplies.

Given the inherent unpredictability of the future, dental ethics needs to be flexible and open to change and adjustment, as indeed it has been for some time now. However, we can hope that its basic principles will remain in place, especially the values of compassion, competence and autonomy, along with its concern for fundamental human rights and its devotion to professionalism. Whatever changes in dentistry occur as a result of scientific developments and social, political and economic factors, there will always be people needing cure if possible and care always. Dentists have traditionally provided these services along with others such as oral health promotion and disease prevention. Although the balance among these activities may change in the future, dentists will likely continue to play an important role in all of them. Since each activity involves many ethical challenges, dentists will need to keep informed about developments in dental ethics just as they do in other aspects of dentistry.

This is the end of the Manual but for the reader it should be just one step in a life-long immersion in dental ethics. To repeat what was stated in the Introduction, this Manual provides only a basic introduction to dental ethics and some of its central issues. It is intended to give you an appreciation of the need for continual reflection on the ethical dimension of dentistry, and especially on how to deal with the ethical issues that you will encounter in your own practice. The list of resources provided in



Appendix B can help you deepen your knowledge of this field.

## APPENDIX A - GLOSSARY

*Accountable* – answerable to someone for something (e.g., employees are accountable to their employers for the work they do). *Accountability* requires being prepared to provide an explanation for something one has done or has not done.

*Advocate* – (verb) to speak out or take action on behalf of another person or group; (noun) someone who acts in this way. Dentists serve as advocates for their patients when they call on governments or health insurance officials to provide services that their patients need but cannot easily obtain on their own.

*Beneficence* – literally, ‘doing good’. Dentists are expected to act in the best interests of their patients.

*Bioethics* –the study of moral issues that occur in dentistry, health care and the biological sciences. It has four major subdivisions: **clinical ethics**, which deals with issues in patient care (cf. Chapter Two of this Manual); **research ethics**, which deals with the protection of human subjects in health care research (cf. Chapter Five of this Manual); **professional ethics**, which deals with the specific duties and responsibilities that are required of dentists and other health care professions (**dental ethics** is one type of professional ethics); and **public policy ethics**, which deals with the formulation and interpretation of laws and regulations on bioethical issues.

*Consensus* – general, but not necessarily unanimous, agreement.

*Justice* – fair treatment of individuals and groups. As Chapter Three points out, there are different understandings of what constitutes fair treatment in health care.

*Managed health care* – an organisational approach to health care in which governments, corporations or insurance companies decide what services will be provided, who will provide them (dentists, physicians, other health professionals, etc.), where they will be provided (clinics, hospitals, the patient's home, etc.), and other related matters.

*Non-maleficence* – literally, not doing wrong. Dentists and dental researchers are to avoid inflicting harm on patients and research subjects.

*Plagiarism* – a form of dishonest behaviour whereby a person copies the work of someone else, for example, all or part of a published article, and submits it as if it were the person's own work (i.e., without indicating its source).

*Pluralistic* – having several or many different approaches or features: the opposite of singular or uniform.

*Profession* – from the word 'profess' – to state a belief or a promise in public – which is also the basis of the terms 'professional' and 'professionalism'.

*Rational* – based on the human capacity for reasoning, i.e., to be able to consider the arguments for and against a particular action and to make a decision as to which alternative is better.

*Value* – (verb) to consider something to be very important; (noun) something that is considered to be very important.

*Virtue* – a good quality in people, especially in their character and behaviour. Some virtues are particularly important for certain groups of people, for example, compassion for dentists, courage for fire-fighters, truthfulness for witnesses, etc.

*Whistle-blower* – someone who informs people in authority or the public that an individual or an organisation is doing something unethical or illegal. (The expression comes from the world of sport, where a referee or umpire blows a whistle to signal an infraction of the rules.)

## APPENDIX B – DENTAL ETHICS RESOURCES ON THE INTERNET

### General

FDI World Dental Federation:

- International principles of ethics for the dental profession (1997) –  
[www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Principles\\_of\\_Ethics.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Principles_of_Ethics.pdf)
- Guidelines for a code of ethics for dental publications (1998) –  
[www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Code\\_Ethics\\_Publications.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Code_Ethics_Publications.pdf)
- Relationship between the dental profession and third party carriers (1998) –  
[www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Third\\_Party-Carriers.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Third_Party-Carriers.pdf)
- Human Immunodeficiency Virus infection and other blood borne infections (2000) –  
[www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/HIV\\_Infection.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/HIV_Infection.pdf)
- Supervision of auxiliaries within the dental team (2000) –  
[www.fdiworldental.org/federation/assets/statements/ENGLISH/Supervision/Super\\_Auxiliary.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Supervision/Super_Auxiliary.pdf)
- Oral and dental care of people with disabilities (2003) –  
[www.fdiworldental.org/federation/assets/statements/ENGLISH/Disability/Dental\\_Care\\_Disability.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Disability/Dental_Care_Disability.pdf)

- Infection control in dentistry (2003) – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Infection\\_control.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Infection_control.pdf)
- Continuing dental education (2004) – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Dental\\_Education/Continuing\\_Dental\\_Education.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Dental_Education/Continuing_Dental_Education.pdf)
- Code of practice on tobacco control for oral health organisations (2004) – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Code\\_of\\_practice.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Code_of_practice.pdf)
- Guidelines for dental volunteers (2005) – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Guidelines\\_dental\\_volunteers.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Guidelines_dental_volunteers.pdf)
- Nairobi Declaration on Oral Health In Africa (2004) – [www.fdiworldental.org/public\\_health/assets/Activities/Nairobi/NairobiDeclarationEng.pdf](http://www.fdiworldental.org/public_health/assets/Activities/Nairobi/NairobiDeclarationEng.pdf)
- Improving Access to Oral Care (2005) – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Access\\_to\\_oral\\_Health\\_Care/Improving\\_access.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Access_to_oral_Health_Care/Improving_access.pdf)
- Need and Demand for Oral Health Care (2005) – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Demand\\_for\\_Care/Demand\\_for\\_oral\\_care.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Demand_for_Care/Demand_for_oral_care.pdf)
- Ethical International Recruitment of Oral Health Professionals – [www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Ethical\\_Recruitment.pdf](http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Ethical_Recruitment.pdf)

International Dental Ethics and Law Society –  
[www.ideals.ac/](http://www.ideals.ac/) (resources - [www.ideals.ac/links.php](http://www.ideals.ac/links.php))

International Medical and Dental Ethics Commission –  
[www.imdec.org/](http://www.imdec.org/)

E-course - Ethics and Law: International Principles of  
Ethics for the Dental Profession –  
[www.dentistry.bham.ac.uk/ecourse/ethics/p-ethicsfordentists.asp](http://www.dentistry.bham.ac.uk/ecourse/ethics/p-ethicsfordentists.asp)

American College of Dentists: Ethics  
Handbook for Dentists –  
[www.facd.org/acdethics.htm#EthicsHandbook](http://www.facd.org/acdethics.htm#EthicsHandbook) (2004)

American College of Dentists online ethics courses –  
[www.dentaethics.org/](http://www.dentaethics.org/)

American Society for Dental Ethics (formerly PEDNET) –  
<http://societyfordentaethics.org/>

PEDNET - The Professional Ethics in Dentistry  
Network (now ASDE) –  
[www.luc.edu/ethics/032310pednet\\_main.shtml](http://www.luc.edu/ethics/032310pednet_main.shtml)

## Consent and Confidentiality

General Dental Council (U.K.): Patient Consent –  
[www.gdc-uk.org/News+publications+and+events/  
Publications/Guidance+documents/Patient+  
consent.htm](http://www.gdc-uk.org/News+publications+and+events/Publications/Guidance+documents/Patient+consent.htm)

General Dental Council (U.K.): Principles of Patient  
Confidentiality – [www.gdc-  
uk.org/News+publications+and+events/Publications/G  
uidance+documents/Patient+confidentiality.htm](http://www.gdc-uk.org/News+publications+and+events/Publications/Guidance+documents/Patient+confidentiality.htm)

## HIV/AIDS

Resources – [www.wits.ac.za/bioethics/](http://www.wits.ac.za/bioethics/)

UNAIDS –

[www.unaids.org/en/in+focus/hiv\\_aids\\_human\\_rights/un\\_aids+activities+hr.asp](http://www.unaids.org/en/in+focus/hiv_aids_human_rights/un_aids+activities+hr.asp)

## Relations with commercial enterprises

Educational resources – [www.ama-assn.org/ama/pub/category/5689.html](http://www.ama-assn.org/ama/pub/category/5689.html)

Resources – [www.nofreelunch.org/](http://www.nofreelunch.org/)

## Research on human subjects

International Association for Dental Research & American Association for Dental Research: IADR/AADR Code of Ethics – [www.iadr.org/about/iadr/ethics.html](http://www.iadr.org/about/iadr/ethics.html)

Guidelines and resources – [www.who.int/ethics/research/en/](http://www.who.int/ethics/research/en/)

Harvard School of Public Health, ethical issues in international health research course – [www.hsph.harvard.edu/bioethics/](http://www.hsph.harvard.edu/bioethics/)

## APPENDIX C

Association for Dental Education in Europe: *Profile and Competences for the European Dentist* – [adee.dental.tcd.ie/ec/repository/EJDEProfile—final—formatted-for-web-.pdf](http://adee.dental.tcd.ie/ec/repository/EJDEProfile—final—formatted-for-web-.pdf) (2004)

### Domain I: Professionalism

#### MAJOR COMPETENCE: PROFESSIONAL BEHAVIOR

On graduation, a dentist must have contemporary knowledge and understanding of the broader issues of dental practice, be competent in a wide range of skills, including research, investigative, analytical, problem-solving, planning, communication, presentation and team skills and understand their relevance in dental practice.

Specifically, a dentist must:

#### SUPPORTING COMPETENCES:

- 1.1) Be competent to display appropriate caring behaviour towards patients.
- 1.2) Be competent to display appropriate professional behaviour towards all members of the dental team.
- 1.3) Have knowledge of social and psychological issues relevant to the care of patients.
- 1.4) Be competent to seek continuing professional development (CPD) allied to the process of continuing education on an annual basis, in order to ensure that high levels of clinical competence and evidence-based knowledge are maintained. This should be readily demonstrated with the use of a CPD logbook.
- 1.5) Be competent to manage and maintain a safe



working environment with special reference and to all aspects of cross-infection control.

1.6) Have knowledge and awareness of the importance of his/her own health and its impact on the ability to practise as a dentist (ergonomics and occupational diseases).

1.7) Be competent to deal with other members of the dental team with regard to health and safety.

### **MAJOR COMPETENCE: ETHICS AND JURISPRUDENCE**

The graduating dentist must have knowledge and understanding of the moral and ethical responsibilities involved in the provision of care to individual patients and to populations, and have knowledge of current laws applicable to the practice of dentistry. In particular, the graduating dentist must:

#### **SUPPORTING COMPETENCES:**

1.8) Have knowledge of the ethical principles relevant to dentistry and be competent at practising with personal and professional integrity, honesty and trustworthiness.

1.9) Be competent at providing humane and compassionate care to all patients.

1.10) Have knowledge and understanding of patients' rights, particularly with regard to confidentiality and informed consent, and of patients' obligations.

1.11) Have knowledge and awareness that dentists should strive to provide the highest possible quality of patient care at all times.

1.12) Be competent at selecting and prioritising treatment options that are sensitive to each patient's

individual needs, goals and values, compatible with contemporary therapy, and congruent with a comprehensive oral health care philosophy.

1.13) Acknowledge that the patient is the centre of care and that all interactions, including diagnosis, treatment planning and treatment, must have the patient's best interests as the focus of that care.

1.14) Be competent in respecting patients and colleagues without prejudice concerning gender, diversity of background and opportunity, language and culture.

1.15) Be competent at recognising their own limitations and taking appropriate action to help the incompetent, impaired or unethical colleague and their patients.

1.16) Have knowledge of the judicial, legislative and administrative processes and policy that impact all aspects of dentistry.

1.17) Be competent in understanding audit and clinical governance,

## Domain II: Communication and Interpersonal Skills

### MAJOR COMPETENCE: COMPETENT IN COMMUNICATING

The graduating dentist must be competent in communicating effectively with patients, their families and associates, and with other health professionals involved in their care. In particular, he or she must:

**SUPPORTING COMPETENCES:**

2.1) Establish a patient-dentist relationship that allows the effective delivery of dental treatment.

2.2) Have knowledge of behavioural sciences and communication including behavioural factors (incl. factors as ethnicity and gender) that facilitate the delivery of dental care and have knowledge of the role of psychological development in patient management.

2.3) Be competent in identifying patient expectations (needs and demands) and goals for dental care.

2.4) Be competent at identifying the psychological and social factors that initiate and/or perpetuate dental, oral and facial disease and dysfunction and diagnose, treat or refer, as appropriate.

2.5) Be competent at sharing information and professional knowledge with both the patient and other professionals, verbally and in writing, including being able to negotiate and give and receive constructive criticism.

2.6) Be competent at applying principles of stress management to oneself, to patients and to the dental team as appropriate.

2.7) Be competent at working with other members of the dental team.

## Domain VII: Health Promotion

### **MAJOR COMPETENCE: IMPROVING ORAL HEALTH OF INDIVIDUALS, FAMILIES AND GROUPS IN THE COMMUNITY**

The new dentist must be competent at improving the oral health of individuals, families and groups in the community. Specifically, he or she must:

#### **SUPPORTING COMPETENCES:**

7.1) Be competent in applying the principles of health promotion and disease prevention.

7.2) Have knowledge of the organisation and provision of healthcare in the community and in the hospital service.

7.3) Be competent in understanding the complex interactions between oral health, nutrition, general health, drugs and diseases that can have an impact on oral health care and oral diseases.

7.4) Have knowledge of the prevalence of the common dental conditions in the country of training/practice.

7.5) Have knowledge of the importance of community-based preventive measures.

7.6) Have knowledge of the social, cultural and environmental factors which contribute to health or illness.

General Dental Council (U.K.): *The First Five Years: A Framework for Undergraduate Dental Education* – [www.gdc-uk.org/News+publications+and+events/Publications/Guidance+documents/The+First+Five+Years.htm](http://www.gdc-uk.org/News+publications+and+events/Publications/Guidance+documents/The+First+Five+Years.htm)

## LAW, ETHICS AND PROFESSIONALISM

63. Dental students should understand the legal and ethical obligations of registered dental practitioners, the permitted activities of PCDs and the regulatory functions of the GDC. Every student should be aware of the principles and practices involved in dental audit, of the ethical responsibilities of the dental profession in clinical investigation and research and in the development of new therapeutic procedures including the concept of risk assessment and management. The ethical aspects of professional relationships should also be drawn to students' attention, and their reconciliation with personal and public morality. Dental students need to have some familiarity with the specific requirements of contemporary general dental practice, including reference to relevant regulations and the valuable role played by the dental defence organisations. Students should recognise and act upon the obligations of membership of the dental profession, as outlined in the GDC's publication *Maintaining Standards*. The Disability Discrimination Act and the Human Rights Act are examples of how this area is rapidly changing and influencing many facets of professional life. Issues of professionalism such as student behaviour with respect to alcohol and the use of recreational drugs should be addressed.

64. The legal basis under which patients are treated should be discussed and the ethical responsibilities which the student assumes under these circumstances examined. No student should proceed to treat patients without a proper understanding of these matters, especially consent, assault, duty of care and confidentiality. The legal requirement to maintain full, accurate clinical records should also be appreciated by the student.

65. Students should understand the importance of communication between practitioner and patient. This helps to develop attitudes of empathy and insight in the student and provides the opportunity for discussion of contemporary ethical issues. Students should also be encouraged to understand their own responses to work pressures and their management. There may be opportunities for integrated or complementary teaching with other basic sciences on topics such as pain, stress and anxiety, and with clinical specialties on topics such as social class, poverty, and the needs of children and the elderly.

66. There should be guidance on the key ethical and legal dilemmas confronting the contemporary practitioner and on the basics of employment law. Students should also have opportunities to consider the ethical and legal dimensions of day to day practice. For example, students should learn how to:

- handle patient complaints;
- ensure that patients' rights are protected;
- provide appropriate care for vulnerable patients;
- confront issues concerning treatment planning and the practice of dentistry and dentistry within the

context of limited financial resources;

- maintain confidentiality;
- deal with gender and racial issues;
- deal with colleagues failing their professional responsibilities.

67. Students should also understand the practical and ethical considerations that should be taken into account when seeking patients' consent, such as:

- providing sufficient information about conditions and possible treatments;
- responding to questions;
- knowing who is the most appropriate person to give consent;
- gaining consent in emergencies;
- establishing a patient's capacity to give consent;
- statutory requirements that may need to be taken into account;
- gaining valid consent.

68. Ethical and safety issues should form an important part of the 'Introduction to Clinical Dentistry' element of the curriculum. The course material must not ignore the moral and ethical dilemmas which confront the dentist in practice.

69. The ethical approach to patient care will subsequently be reinforced in the clinical dental course, being broadened as time passes to encompass the legal obligations of the practitioner. In that regard, special attention must be paid to the regulatory mechanisms of dentistry, particularly as they apply to general dental practice. Stress should be placed on good record keeping.

Association of Canadian Faculties of Dentistry:  
*Competencies for a Beginning Dental Practitioner in  
Canada* – [www.acfd.ca/en/publications/ACFD-Competencies.htm](http://www.acfd.ca/en/publications/ACFD-Competencies.htm)

**A beginning dental practitioner in  
Canada must be competent to:**

1. recognise the determinants of oral health in individuals and populations and the role of dentists in health promotion, including the disadvantaged.
2. recognise the relationship between general health and oral health.
3. evaluate the scientific literature and justify management recommendations based on the level of evidence available.
4. communicate effectively with patients, parents or guardians, staff, peers, other health professionals and the public.
5. identify the patient's chief complaint/concern and obtain the associated history.
6. obtain and interpret a medical, dental and psychosocial history, including a review of systems as necessary, and evaluate physical or psychosocial conditions that may affect dental management.
7. maintain accurate and complete patient records in a confidential manner.
15. recognise signs of abuse and/or neglect and make appropriate reports.



20. discuss the findings, diagnoses, etiology, risks, benefits and prognoses of the treatment options, with a view to patient participation in oral health management.
22. present and discuss the sequence of treatment, estimated fees, payment arrangements, time requirements and the patient's responsibilities for treatment.
23. obtain informed consent including the patient's written acceptance of the treatment plan and any modifications.
45. apply accepted principles of ethics and jurisprudence to maintain standards and advance knowledge and skills.
47. demonstrate professional behaviour that is ethical, supercedes self-interest, strives for excellence, is committed to continued professional development and is accountable to individual patients, society and the profession.

The (USA) Commission on Dental Accreditation:  
*Standards for Dental Education Programs* –  
[www.ada.org/prof/ed/accred/standards/predoc.pdf](http://www.ada.org/prof/ed/accred/standards/predoc.pdf)

## Ethics and Professionalism

2-20 Graduates must be competent in applying ethical, legal and regulatory concepts to the provision and/or support of oral health care services.

2-21 Graduates must be competent in the application of the principles of ethical reasoning and professional

responsibility as they pertain to patient care and practice management.

2-22 Graduates must recognise the role of lifelong learning and self-assessment in maintaining competency.

## **APPENDIX D - STRENGTHENING ETHICS TEACHING IN DENTAL SCHOOLS**

Some dental schools have very little ethics teaching while others have highly developed programs. Even in the latter ones, however, there is always room for improvement. Here is a process that can be initiated by anyone, whether dental student or faculty member, who wants to strengthen the teaching of dental ethics in his or her institution.

1. Become familiar with the decision-making structure in the institution
  - Dean
  - Curriculum Committee
  - Faculty Council
  - Influential faculty members
2. Seek support from others
  - Students
  - Faculty
  - Key administrators
  - National dental association
  - National dental regulatory body
3. Make a strong case
  - Association for Dental Education in Europe: *Profile and Competences for the European Dentist*

- General Dental Council (U.K.): *The First Five Years: A Framework for Undergraduate Dental Education*
- Association of Canadian Faculties of Dentistry: *Competencies for a Beginning Dental Practitioner in Canada*
- The (USA) Commission on Dental Accreditation *Standards for Dental Education Programs*
- Examples from other dental schools
- Research ethics requirements
- Anticipate objections (e.g., overcrowded curriculum)

#### 4. Offer to help

- Provide suggestions for structure, content, faculty and student resources
- Liaise with other dental ethics programmes, the FDI, etc.

#### 5. Ensure continuity

- Advocate for a permanent dental ethics committee
- Recruit younger students
- Recruit additional faculty
- Engage new faculty and key administrators



## About the FDI World Dental Federation

The FDI World Dental Federation is the worldwide, authoritative and independent voice of dentistry. With more than 130 national dental associations in more than 125 countries around the world, it represents nearly one million dentists internationally.

For more information about the FDI World Dental Federation, please visit [www.fdiworldental.org](http://www.fdiworldental.org)



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