Issues in Dental Ethics

Professional Ethics in Dentistry Network

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A Call for Ethics Committees in Dental Organizations and in Dental Education

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Abstract

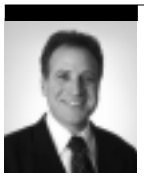
It is argued that dental organizations need ethics committees to address growing concerns among the public regarding ethical conduct. Such committees could provide education, help formulate policy and guidelines, and develop case review and consultation, as well as create useful networks. The results of a survey of Canadian faculties of dentistry regarding ethics resources are presented.

Introduction

The public has been bombarded of late with stories relating to ethics in politics, business, and professional practice. The issues surrounding corporate misdeeds may have violated statutes, but ethical obligations are often greater than legislated duties and these appear to have been violated even more. In Canadian politics, it seems that as soon as one ethical crisis is placated, another surfaces in the federal cabinet and things are little different in the United States. Insider trading issues seem commonplace, as do unethical accounting practices. Consequently, the public has lost confidence in the stock markets as a direct result of such fiscal impropriety, not to mention the shredding of documents and "creative" accounting practices on financial statements.

For its part, dentistry is facing increased public scrutiny after stories of waterline contamination were aired on "60 Minutes" and "W5." As a result, some patients have begun questioning whether dentists are putting cost-control issues ahead of patient safety. Stories of insurance fraud and unnecessary treatment also surface in the press and cause the public to question the ethics of the dentists whom they used to trust implicitly. A *Readers Digest* article (Ecenberger, 1997) entitled "How Honest is Your Dentist?" raised national awareness on dental ethics. A recently aired program on the Canadian Broadcasting Corporation, entitled "Dental Boot Kamp," (Walsh, 2003) and a Canadian newspaper article in the *National Post,* "Dentists' Fraud Growing" (Blackwell, 2002), were quickly responded to by the president of the Ontario Dental Association. However, the question becomes: Is damage control the most effective method of regaining the public trust?

Medicine and biomedical research have faced similar situations in their history, and have moved to deal with conflicting value judgments, cost containment restructuring, and patient concerns with the development of ethics committees, ethics networks, and ethics educational programs. This



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article proposes a similar move for professional dentistry.

Ethics Infrastructure

Organizations, such as dental associations and faculties of dentistry, are faced with an onerous task of self-governance and the monitoring of organizational values. In order to have an effective organizational strategy, it is not enough to have peer review and other dentist-dominated committees. It is essential to have an independent ethics infrastructure. A dental ethics committee should be independent of the parent organization; otherwise there is a risk of the committee being captured by the organization that it professes to direct. Such an ethics infrastructure would link organizational processes and practices to the core values and/or mission statement of that particular organization. It would also put in place the means to assess and provide discussion and feedback on ethical performance. More importantly, such an ethics committee should be involved in the early decision making process of changes so that ethical concerns are dealt with prior to action being taken. Taking a proactive position makes changing proposals easier, less expensive, and less embarrassing than waiting until unnoticed ethical considerations surface down the road. The net result could be effective integration of clinical and administrative decisions (Goodstein, 1999).

History

In medicine and biomedical research prior to 1975 or so, there existed some special committees assigned to specific situations such as abortions, dialysis selection, and medical-morals with respect to Catholic doctrine in Catholic hospitals. The development of hospital ethics committees and research ethics committees occurred in the late 1970s and 1980s as a means to ensure that physicians and biomedical researchers had the patient's and the research subject's best interests in mind when making treatment or research decisions. Some of these hospital committees dealt with the legitimate ethical goal of optimization of resources. Resources often have to be rationed, creating the need of an ethical review model. Thus the first dialysis committees, which were often composed of non-experts, made life and death rationing decisions. Some of them used middle-class values and were criticized for not being ethically knowledgeable enough to carry out their decisions. In the development of ethics committees, it became clear that they should not be about making decisions, but rather about the process of helping decision-makers think about decisions more carefully, assisting, not doing the ranking and prioritizing among competing ethical values (Ross, 1993). Ethical expertise is an essential ingredient in making good decisions; but the process of sharing knowledge from a variety of points of view is equally important.

In the U.S. in 1983, less than 1% of hospitals had ethics committees. In Canada at that time, 29% had ethics committees (Levine, 1984). By 1985, 50% of hospitals in the U.S. had ethics committees. By 1993, 85% of hospitals in the U.S. indicated in surveys that they had or were in the process of developing them. Although ethics committees were born to deal with crisis issues such as transplants, end-of-life decisions etc., other ethical issues (such as doctor patient communications, hierarchy of provider relationships, and administrative decisions) had to be dealt with as equally important. The complex and crisis issues are often resolved at some point in time; but systemic ethical issues, such as evaluating the way a clinic is run and whether patient's needs are being met, go on and on (Warren, 1989).

Ethics Committee Functions

Before any committee can function, it has to have clearly defined goals and a clear relationship to other elements of the organization and profession. If it does not have credibility with other parts of the organization and its various other constituencies, there would exist a hostile and doubtful environment that would impede the committee's effectiveness. Once established, a dental ethics committee should have three main functions.

1. Education. Dental ethics education involves the development of tools for teaching ethical values and the dissemination of cases for discussion so that practitioners and students can learn from them. In this way, others can learn decision-making skills to apply when faced with ethically similar situations. Currently, if a dentist is faced with an ethical concern, the answer might vary according to the background of the person asked. For example, a dentist with a background in dental public health would have a higher priority on social justice than a periodontist who works more with individual cases and deals more directly with patient autonomy.

With ethics committees functioning in organizations such as dental associations, members would be better educated and operate from something closer to an ethical consensus regarding changing dentist-patient relationships (e.g., capitation plans), billing practices (e.g., assignment of benefits), and new treatment options (e.g., implants, cosmetic procedures, bone and tooth transplants, periodontal plastics, etc.). The public would have input and access to these findings as well, which would lead to a greater level of transparency on how ethical decisions are made and to improved accountability of practitioners to their patients.

2. Policy Recommendations and Guidelines. The committees should also develop policy recommendations and guidelines. For example, in the clinic setting, patient confidentiality is a constant concern. This concern is even greater in the dental school clinic, where close proximity of treatment among patients and students provides even greater challenges. Guidance from an ethics committee and recommendations about relevant policies could be very helpful. Decisions that educational institutions face regarding patient's rights and ethical protection should have the same degree of organizational support as infection control, where committees have been routinely established to deal with patient and operator safety. Thus, in infection control, guidelines are developed in a committee setting and passed on to the various departments for implementation. Then, testing and feedback from staff, patients and students ensures both compliance and effectiveness of the regimen. A dental ethics committee could adopt a similar process of feedback and could obtain a similar measure of influence in the institution. Input could be sought on important issues, such as resource allocation and staffing. Ethics committees overseeing research ethics and integrity of reporting research have proven very effective and important. Recommendations from a dental ethics committee could develop into formal guidelines that would raise the ethical standards of practice throughout specific institutions and throughout the profession.

3. Case Review and Consultation. In addition, such a committee could offer the assistance of retrospective case review and consultation on ongoing cases. Reviewing recent cases would enable organizations and institutions to address changing structures more effectively and avoid the negative consequences

Survey of Canadian Dental Schools Regarding Ethics

10% teach formal ethics in only one of the four years, the last year.

40% teach ethics in two years and of those: 50% in first and last year; 25% in first and second year; 25% in first and third year.

30% teach ethics in three years; all in the final three years.

20% teach ethics in all four years.

None of the dental schools in Canada have a chair in ethics.

Ethics committees exist currently in 50% of the schools. But they deal exclusively with issues of research ethics in 40% of these cases. That is, only 30% of the schools have ethics committees of the sort discussed in this proposal.

As for advisors to the faculties on ethics dilemmas:

- Ethics professors: 70%
- Deans and associate deans: 70%
- Department heads: 60%
- Other staff: 10%
- Ethics committees: 30%
- Lay persons: 10%
- Outside ethics consultants: 60%

Of the three faculties that have clinical dental ethics committees, they are made up of:

- Ethics professors: 66%
- Department heads: 33%
- Deans and associate deans: 66%
- Staff: 33%
- Other: 33%

The faculties that are affiliated or collaborative with any joint bioethics centers: 40%.

The faculties that offer students graduate studies in dental ethics: 10%.

The faculties were asked how they viewed the current level of ethics education that they provide for their undergraduate students:

- More than adequate: 20%
- Adequate: 50%
- Could be improved: 30%

Those that stated that they could be improved cited the lack of the following as reasons: time (100%), adequately trained educators (66%), funding (30%).

The faculties that offer continuing education for graduates: 40%.

The faculties that expressed an interest in being part of an ethics network to share ideas and dilemmas with other dental faculties: 80%.

of poor practice. They could also seek feedback from patients, especially when their level of satisfaction could be quite different from the level of success as determined by clinicians alone. For example, cases that may be biologically sound could be esthetically compromised or may leave the patient with uncomfortable sensitivity that should beg the question as to the value of the procedure. There is often a disparity in assessing positive or negative outcomes from the perspective of the clinician versus the patient. An ethics committee could provide retrospective review of such decisions so all involved could learn from them. Another example would be the situation in which patients have not received complete disclosure in order to direct the patient, in a paternalistic manner, towards the care that the dentist may wish to render.

Additional Structures and Networking

In addition to ethics committees that perform these three functions, every dental school should ideally have a chair in ethics so that ethical considerations could receive the multidisciplinary support and funding that other disciplines in the curriculum enjoy. Wherever such committees are established, financial support is necessary for the establishment of an ethics resource library, administrative support, as well as workshops and ethics-related conferences. Affiliations with graduate programs in ethics nearby would enable graduate students to study, expand knowledge, and ensure continuity in dental ethics. Since ethical values have some fluidity and change with society—as evidenced in the historical evolution of codes of ethics, for example—collaboration with existing bioethics programs, such as the Joint Centre for Bioethics in Toronto, would allow students to expand their knowledge in ethics, while concentrating their focus and its relevance to dentistry. Thus, as a true discipline within dental scholarship, dental ethics could carry out forward-looking research to help shape what constitutes ethical norms and societal values in oral health care and more broadly. Graduates of such MHSc Bioethics courses could be the committee chairmen of future dental ethics committees. In addition, such networking could provide educational programs for the dental ethicists' constituents, opportunity to carry out surveys, and even provide public access to on-line forums with current subjects of interest. For example, the state of Michigan has a network of hospital ethics committees with nationwide web access to an electronic bulletin board for medical ethics. The focus of such networks would be to develop a sense of community among institutional ethics committees.

It is not the mandate of an ethics committee to resolve all the ethical issues that arise in the institution or organizations. As indicated in the

Challenges that Might Be Taken Up by Ethics Committees

1. What is it like to be a patient here at the dental clinic?
2. What mechanisms are in place to assess patient satisfaction?
3. What is it like to be an employee here?
4. What is it like to teach here?
5. How knowledgeable and sensitive is the staff with regard to cultural and religious background of the patients, students and other employees of the institution?
6. How effective as communicators and conflict managers are the employees of this institution?
7. There is a constant conflict of the principles of beneficence and the respect for patient autonomy in dentistry. Patients' judgments of harm/good are unavoidably subjective, with the patient becoming the judge if the treatment rendered to them was in his/her best interest. How are these competing values to be prioritized in various practice situations?
8. The principle of justice has competing values as well. Justice means that we treat everyone fairly, and that everyone receives what he/she needs and deserves. But a choice might seem unfair to an individual when in terms of social values it could be just. What should guide dentists' judgment of fairness in individual cases?
9. Distributive justice is concerned with how resources are allocated socially, especially among those in need. What should be the status of "the greatest good for the greatest number" as a guideline for dental public health and how should conflicts about individual needs in a clinical case be dealt with?
10. Cultures, religions, professions, institutions, and individuals may each have a unique idea as to the good that is to be pursued by the right action. But many individuals can and do accept the goals of more than one system. How should dentists deal with culturally-based conflicting values?
11. The right of privacy and the informed consent doctrine are based on the principle of patient autonomy. There are times when respecting a patient's autonomy via confidentiality can cause great hardship to others, giving rise to other questions of beneficence, nonmaleficence and justice. An example of this would be the mandatory reporting of child abuse or communicable diseases. What guidelines should dentistry follow on these issues?

discussion of proper roles above, what it should do is raise the level of awareness of issues and their implications, and assist decision-makers in evaluating alternatives carefully in the light of relevant ethical standards. It can also issue briefs outlining concerns on issues and recommendations for policy. As already indicated, because professional groups may hold unique positions on the ethics of professional obligation that are not shared by the laypeople with whom the profession is interacting, an effective ethics committee must have active participation from both laypeople and health professionals (Veach, 1984).

Discussion of Characteristics of Canadian Dental Faculties

A survey was completed by Canadian faculties of dentistry (Schwartz, 2004) (see sidebar). Dental faculties find themselves in a conundrum. Many recognize that there is a need for increased ethics education, however they lack adequately trained personnel to expand their teaching. Only one dental school in Canada offers advanced studies in dental ethics for graduate dentists. There are no ethics chairs at any schools currently, as there are in the other disciplines, such as; radiology, periodontics, endodontics, prosthodontics, etc. Ethics committees exist in half of the dental faculties, however only three discuss clinical dental ethics, whereas the others deal exclusively with research ethics on human subjects. There is a wide variation on the emphasis that is placed on dental ethics education as can be seen by the number of years that it is included in the curriculum. Most of the faculties (80%) are interested in being a part of an ethics network to share knowledge and advance education in dental ethics, however only 40% are currently collaborative with any joint centers for bioethics, where ideas can be shared and developed with the other health disciplines, and where graduate students could collaborate studies in dentistry and bioethics together. These graduates could become part of the dental ethics development process by chairing ethics committees and by offering dental ethics training to dental students by dentists who are trained in ethical principles. Currently, 60% of the faculties bring in outside ethics consultants to fill that void.

The dental schools, even though they are typically much more close-knit organizations than professional societies, clearly find it difficult to be responsive to the ethics needs of their students, faculty, and staffs. It is therefore reasonable to propose that enhancing ethics work within the professional societies will take a similarly monumental shift of focus and redirection of effort and resources to bring ethics to the prominence it ought to have in them.

Conclusion

According to a recent survey by the Royal College of Dental Surgeons of Ontario, dentists have identified ethics as the number one issue that is important to them. By following the example of other health disciplines in establishing ethics committees and ethics networks for our professional organizations and in similar structures in our dental schools, as well as the foundation of ethics chairs in our teaching institutions, we can meet the challenges to our profession that lie ahead of us. Dental ethics ought to become a discipline that is given the same priority as other aspects of clinical dentistry in both dental education and in dental practice (Schwartz, 2004). When it is, we will have solid evidence that as a profession we are preserving the public trust in dentists and we can be confident that we will be giving our students appropriate direction into the future. ■

Ethics committees overseeing research ethics and integrity of reporting research have proven very effective and important.

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