3RD EDITION

Ethics and Law in DENTAL HYGIENE

Phyllis L. Beemsterboer

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This book is dedicated to my husband,
Joseph R. Jedrychowski,
and
the Beemsterboer/Jedrychowski families
who mean everything to me.
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Preface

From its early beginnings in the twentieth century, dental hygiene has enjoyed a rapid growth, as both a profession and a field of health care science. Dental hygiene students no longer have to rely on one textbook to provide all the materials and references from which to study and learn. Today, numerous textbooks and online resources, on a wide variety of subject content, are available to dental hygiene educators and students. As the study of dental hygiene has evolved, so has the world surrounding it. The ongoing development of health care law, the growing awareness of improving access to oral health care, and the emphasis on social justice have interwoven themselves into the processes and procedures of dental hygiene. The complexity of the modern world has increased the challenges of providing ethical care in the daily functioning of the dental hygienist. Advanced education and training in ethics and legal issues has never been more important to help students navigate today's health care realities. Ethics and law now require a dedicated title that addresses the subject in the proper scope and depth for the dental hygiene student. *Ethics and Law in Dental Hygiene* meets this need in both the educational and professional markets, serving as a valuable tool for new and practicing dental hygienists.

Background and Importance to the Profession

Dental ethics as an area of study came into its own in the 1980s as the result of the efforts of a group of scholars at Georgetown University in Washington, DC. From this small visionary group came an ethics study network organization, several workshop and consensus activities, and ultimately three dental ethics textbooks. All three textbooks addressed the role of the dental hygienist in some way in the provision of dental health care to the public. An increased emphasis on and awareness of ethics in the various dental professions has given way to more specialized titles and to groups that work toward increasing the social responsibility and ethical conduct of oral health care professionals. The importance of ethics is also evidenced by the many dental hygiene educators who are active in the American Society for Dental Ethics (ASDE), an association of educators, philosophers, and practitioners who are dedicated to the ongoing study of ethical issues and education with the goal of promoting professional responsibility and conduct for the public we serve. The third edition of *Ethics and Law in Dental Hygiene* provides up-to-date ethics coverage for dental hygiene students and practitioners.

Audience

This text is devoted to the topic of ethics and law for the dental hygienist, a professional who has a unique place in the provision of oral health care services. The book provides information and guidance for entry-level dental hygiene students as well as experienced practitioners looking to continue their professional development.

Organization

This textbook is organized into three sections, with the first two sections focusing on content and the third devoted to application. The first section presents the foundational aspects of ethics and introduces an ethical decision-making tool for the analysis of ethical dilemmas. Legal concepts are discussed in the second section and provide information on state practice acts and risk management.

The third section provides 32 case scenarios authored by various contributors with expertise in dental and dental hygiene ethics for the reader to discuss and analyze. Questions to stimulate thought and discussion are included as well, and the ethical decision-making model can be applied to each of the

cases. Although hypothetical cases, the situations presented are a culmination of many years of experience in dentistry and dental hygiene and provide a variety of material for lively and fruitful discussion sessions.

Ten "testlets" are also included to help prepare students for the National Board Dental Hygiene Examination (NBDHE). A testlet is a short clinical scenario with a series of associated test items that focus on critical thinking and problem-solving skills. Lastly, a listing of suggested activities and projects helps expand upon the topics presented in the textbook and encourages additional thought and discussion.

Key Features

- Coverage of ethics and law is balanced equally throughout and presented in a clear and concise manner to assist in understanding these often complex topics.
- Concepts are discussed in the context of real world relevance to help readers apply the knowledge to everyday situations.
- A six-step decision-making model equips readers with a framework to tackle ethical situations.
- Contributors include educators and practitioners who are renowned leaders in the ethics of dentistry and dental hygiene.
- A wealth of case studies and additional activities cover a wide range of situations and provide readers with opportunities to hone their ability to make sound ethical and legal decisions.
- Chapter key terms and a back-of-book glossary help ensure content mastery of the unique and often challenging language used within ethics and law.

New to This Edition

- Returning chapters are fully revised and expanded, including coverage of key topics such as the Health Insurance Portability and Accountability Act (HIPAA), health disparities, and interprofessionalism.
- Additional case scenarios written by experts within dental and dental hygiene ethics are provide for discussion, analysis, and application.
- Increased number of "Testlets" are available to encourage critical thinking, challenge problem-solving skills, and help prepare students for the case-based National Board Dental Hygiene Examination (NBDHE).
- The most recent editions of the American Dental Hygiene Association (ADHA) and American Dental Association (ADA) codes of ethics are provided in full.
- For instructors, there is a brand new online Evolve website with teaching resources to work in coordination with the book. Chapter-by-chapter PowerPoint slides, case study answers and rationales, and a test bank using NBDHE exam-style questions with answers referencing textbook page numbers.

Whatever point you are at in your dental hygiene career, *Ethics and Law in Dental Hygiene* is an excellent foundation and a valuable reference to guide you through this complex subject matter with ease and understanding.

Acknowledgments

The collaborators for this edition are dental professionals who are devoted to the education of dental hygienists. My deepest appreciation goes to Cheryl Cameron and Pam Zarkowski, dental hygiene educators and administrators who also are attorneys. Bioethics experts David Ozar and Frank Catalanotto were most generous with their time and expertise in chapter revisions.

I am grateful to my colleagues at the Center for Ethics in Health Care at Oregon Health & Science University, especially Susan Tolle MD and members from the American Society for Dental Ethics who work tirelessly to advance the discipline of dental ethics. It is the friends who walk the journey with you that bring joy and inspiration.

Phyllis L. Beemsterboer

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SECTION I

Ethics

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Ethics and Professionalism

PHYLLIS L. BEEMSTERBOER

LEARNING OUTCOMES

- Describe the role of the dental hygienist in health care.
- Explain the relationship between the health care provider and the patient.
- Describe the aspects of a true profession as they apply to dentistry and dental hygiene.
- Explain interprofessionalism and its importance in health care education and practice.
- Discuss the theory of competency and skill acquisition for the dental hygienist.
- Compare educational competencies and practice standards.
- Identify the traits of a professional dental hygienist.

From its inception in the early 1900s, the profession of dental hygiene has been concerned with the public good and with advocating methods of preserving oral health. The first **oath** written for dental hygienists called upon Apollo, the god of health, and Hygeia, the goddess of health, to help each practitioner in performing the "sacred duty of teaching to the public, particularly children and young people, by precept, lecture and every other available mode of instruction, the value of dental health as a priceless possession."[1,2]

The dentists who pioneered this special field of endeavor positioned the dental hygienist as the oral preventive therapist because of their vision of the day when dental disease could be prevented by adhering to a system of treatment and cleanliness.

The original intent of the first oath was preserved in a revised and modernized version adopted by the Board of Trustees of the American Dental Hygienists' Association (ADHA) in 1979 and is still in use today. This oath, which is affirmed by numerous dental hygiene students before or at the time of graduation from their formal education and training program, captures the essence of the public mission of the profession. This oath, reprinted from Steele,[1] recalls that original oath, which has since been updated by the ADHA (www.adha.org/aboutadha/dhoath.htm):

In my practice as a dental hygienist,
I affirm my personal and professional commitment
To improve the oral health of the public,
To advance the art and science of dental hygiene,
And to promote high standards of quality care.
I pledge continually to improve my professional
Knowledge and skills, to render a full measure
Of service to each patient entrusted to my care,
And to uphold the highest standards of professional
Competence and personal conduct in the interest
Of the dental hygiene profession and the public it serves.

Over the years the profession of dental hygiene has evolved and changed with requirements for formalized education, regulation by licensure, and increased scope of practice. In addition, the public served by all health care providers has changed with the advent of new diseases, the development of advanced treatment methods, and a continually increasing human life span. However, dental hygiene retains its original

focus on the public good as well as its primary role in the prevention of dental disease and promotion of oral health.

Society recognizes that health care providers, by virtue of their education and special skills, are appropriately held to a higher standard than can be expressed exclusively by legislative mandate. Thus these higher standards are expressed in professional codes of ethics and are enforced by those within the profession. This is called *self-regulating* or *self-policing behavior* and represents an increased level of trust on the part of the public. In essence the public agrees that it is neither qualified nor in a position to evaluate the adequacy of treatment provided by health care professionals. Therefore the public trusts these professions to perform their own evaluations. Ethical dental hygienists willingly accept the **duty** of self-regulation, both in judging their colleagues and in submitting to **peer review,** to ensure quality care for the public.

Ethics is about character and courage and how we meet the challenge when doing the right thing will cost more than we want to pay.

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The Health Care Provider

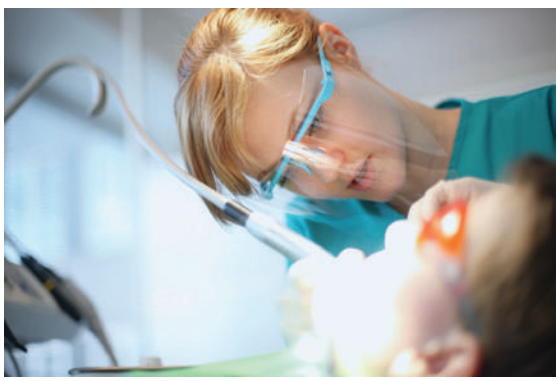
All health care providers are granted special rights and responsibilities when they choose and enter a career in the biomedical fields. In the past, becoming a professional in medicine, dentistry, or the allied disciplines was considered a calling. Once specialized training was completed, the individual became a member of a profession, defined as a limited group of persons who have acquired some special skill and are therefore able to perform that function in society better than the average person (Box 1.1).[2] In the corporate world, success is measured by financial gain. For the health care professional, the patient's welfare is placed ahead of profit. Because of this ideal, society has granted the health care professional a certain status that carries prestige, power, and the right to apply special knowledge and skill.

When patients seek care from any health care provider, they expect to receive the best care from a professional and ethical practitioner. The health care services provided involve technical skill, appropriate knowledge, critical judgment, and, most important, caring. Patients perceive this essence of caring and respond to it. In the delivery of health care, trust is the critical foundation for the relationship that develops between the person seeking services—the patient or client—and the health care provider—the professional. The patient is aware that the health care provider has certain knowledge and skills; the graduation certificate and state license hanging on the wall are proof of that fact. However, the caring that the patient seeks gives the provider of dental hygiene services the greatest opportunity for professional service and satisfaction. An understanding of ethical issues and an awareness of the ethical obligations inherent in the provision of health care enable the dental hygienist to deal effectively with the problems of patients and their communities.

• BOX 1.1 Characteristics of a True Profession

- Specialized body of knowledge of value to society
- Intensive academic course of study
- Standards of practice
- External recognition by society
- Code of ethics
- Organized association
- Service orientation

(From: Motley WE. *Ethics, jurisprudence and history for the dental hygienist,* ed 3. Philadelphia, Lea & Febiger; 1983.)



(From: Shutterstock.com)

The importance of and need for professionalism in all areas of health care have been extensively discussed and written about. Educators in medicine, dentistry, and dental hygiene have shared the importance of fostering professionalism and the fact that students must be immersed in clinical learning environments that model the highest principles.[3]

A number of medical organizations have focused on how to reemphasize the essence of professionalism in health care. The Institute of Medicine has produced several reports on this topic, and a project by a consortium of internal medicine groups led to the publication "Medical Professionalism in the New Millennium: A Physician Charter."[4] The authors advocated that everyone "involved in health care" use the charter to engage in discussions to strengthen the ethical underpinning of professional relationships. The Physician Charter sets out three fundamental principles that are not new but reinforce the foundation of the medical profession as one of service to others. The ethical principles of the primacy of patient welfare (beneficence and nonmaleficence) and patient autonomy are listed first; the principle of social justice is the third main tenet. The desired goal was to reinvigorate the value of professionalism that includes social responsibility: the ethic of care, and access to that care, for all members of society.

Professionalism is rooted in a relationship or contract with society. Ministry, medicine, and law grew from medieval guilds that were established in universities centuries ago. Entrance into these fields was controlled through the awarding of educational credentials. Early dental practitioners were itinerant barbers, and the road to professional status moved from apprenticeship to education through the establishment of professional schools.[5] Developing an educational process gave the members control over entry into the occupation and the size of the labor force. Because of their smaller number and their education, professionals became trustees of the community and took leadership positions in their societies.[6] This role led to the public understanding that the professional person's knowledge is linked with service in the interest of the local community. Ultimately, the professional came to be defined as someone learned, publicly licensed, and supported by a collegial organization of peers committed to an ethic of service to clients and the public.[7] The professions then are much like universities and college in this sense—given a unique charter that grants autonomy and special status for a public purpose.

The Dental Hygienist

The dental hygienist is a professional oral health care provider—an individual who has completed a required higher education accredited program; demonstrated knowledge, skills, and behaviors required by the college or university for graduation; passed a written national board examination; and successfully performed certain clinical skills on a state or regional examination. Because of these accomplishments, the state then grants this individual a license to practice the profession for which he or she completed training and education. By taking this step the state is assuring the public that this licensed individual is competent to practice. That is the reason that a board of dentistry or a dental practice act exists: to protect the public's health and safety.

A dental hygienist provides educational, clinical, and therapeutic services supporting the total health of the patient through the promotion of optimal oral health. Because of these functions, the dental hygienist has been defined as a preventive oral health care professional.

> *An investment in knowledge always pays the best interest.*
>
> **BENJAMIN FRANKLIN**

To be considered a profession, a specific field or area of study traditionally must have several characteristics. These include a specialized body of knowledge and skill of value to society, an intensive academic course of study, set standards of practice determined and regulated by the group, external recognition by society, a code of ethics, an organized association, and a service ethic. What separates the professional from the layperson is this specialized knowledge, which is exclusive to the professional group. Because being a professional is considered desirable, many careers and occupations aspire to this level. Real estate agents,

auto mechanics, and culinary chefs all use the term *professional* to indicate a desired level of competency and quality performance. However, the true professions are still considered to be medicine, dentistry, ministry, and law because they possess all the characteristics previously listed.

Moreover, a profession incurs an obligation by virtue of its relationship with society—something that is affirmed and reaffirmed over time. When an individual enters a course of professional study, learning about the tenets of the profession and its inherent obligations is part of the educational program. The Hippocratic Oath, dentist's pledge, and the dental hygiene oath are examples of outward signs that reflect acceptance of the professional obligation. Professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to and wise application of the principles of professionalism. These principles are excellence, humanism, accountability, and altruism.[8]

Professionalism

The expectations of the public regarding health care have changed and evolved over the years. People have become increasingly knowledgeable, involved, and active in their own health care decisions. This change evolved from a traditional relationship between the practitioner and the patient. Ozar[9] described this evolution in his classic article in which he developed the three models of **professionalism**: the commercial model, the guild model, and the interactive model. These models are not intended to reflect how dental care has been delivered in the past but provide an examination of how the obligations of provider and patient should be established from a moral perspective.

Commercial Model

The commercial model describes a relationship in which dentistry is a commodity, a simple selling and buying of services. The patient is the consumer and the dentist is the producer. The dental needs of the patient are not as important as what the patient is willing to pay for or what gives the dentist the greatest return on time, effort, and materials. The patient, as the consumer, weighs needs and discomfort against the cost of the purchase of dental services. A dentist with a new technique in esthetic dentistry would present it in such a way as to attract patients and build his or her business, thereby keeping it from other dentist competitors. In this model all dentists are in competition, selling the same commodity to the public for the best price, creating a true marketplace. In this commercial model no obligation exists between the dentist, the patient, other dentists, or the community.

Guild Model

The second model, the guild model, presents dentistry as an all-knowing profession. It is called the *guild* model because it resembles the medieval guild of old in which those who were members of the group controlled knowledge, skill, and competency. In this model the patient has dental needs and the dentist, as a member of the profession, provides care to meet the needs of that patient, who is uninformed and passive in the process. This is a paternalistic undertaking in which the obligation to provide care comes from the dentist's membership in his or her chosen profession.

Interactive Model

In the third model, the interactive model, the patient and the dentist are equals and have roles of equal moral status in the process of dental care delivery. According to this model, patients determine their own needs and health care choices on the basis of their personal values and priorities but seek the care of the dentist because of his or her knowledge and skill. Thus the status of the dentist and the patient is essentially equal; however, their equality is based on their distinctive roles. Patients needing services and dentists who are able to provide those services are both bound by the common **values** of health and comfort. The obligation for care in this relationship holds both parties as equals because neither can achieve these values without the other. A delicate balance must be maintained in this model between the expertise of the professional and the choice of the patient based on the

patient's own values and purposes. Ozar[9] describes this subtle partnership in decision making as the dental professional's first responsibility. The fundamental obligations in the interactive model are for the dentist to treat each patient well and to support the profession. This obligation derives from the larger community sanction that is granted upon graduation and licensure and that is voluntarily accepted upon entrance into the profession.

The three Ozar models provide insight into the moral basis of the relationship of patient and provider in dental care. The interactive model is preferable because it presents the patient and provider as partners who make different contributions to the partnership. This equal moral status creates an obligation for equal respect as partners working together toward attaining and maintaining oral health.

Interprofessionalism

As gains in the acknowledgment of the patient as a partner in health and wellness grew, it became clear that building and empowering all members of the health care team could increase safety, efficiency, and patient outcomes. Institution of Medicine reports on quality of care, access to care, and preparation of future health care teams underscored the need to improve collaboration among clinicians.[10,11] Communication skills and the understanding of aging and medically complex populations are among the acknowledged competencies required for highly effective teams. This led to various academic health centers establishing curricula in **interprofessional education** (IPE).

The term *IPE* refers to occasions when students from two or more health professions learn together during all or part of their professional training with the objective of cultivating collaborative practice to improve the quality of patient care at the individual and population level.[12] In 2011, six major health education organizations—the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges, and Association of Schools of Public Health—came together as the Interprofessional Education Collaborative (IPEC) and published core interprofessional competencies that could be embedded in all curricula providing a foundation for interprofessional learning and collaborative practice. These core competencies are expressed in four interprofessional competency domains as recommended by IPEC:[13]

- Values and ethics for interprofessional practice to maintain a climate of mutual respect and shared values
- Roles and responsibilities for assessing and addressing the health care needs of patients and populations
- Interprofessional communication to support a team approach for the maintenance of health and treatment of disease
- Teams and teamwork to apply values and principles of team dynamics for delivery of care that is safe, efficient, and equitable

Various educational programs will choose goals and objectives within these domains as fit their settings and types of professionals that are training together. The idea of training health care team members together has met with great interest by students and faculty alike. Dental and dental hygiene educators have long acknowledged that oral health care is advanced when all members of the dental team are working together collaboratively. The preventive role of the dental hygienist is an excellent foundation for establishing oral and general community public health programs. Communicating with clinicians from all aspects of health care can only improve the outcomes for health, wellness and the treatment of diseases. Ethical issues will be encountered in interprofessional collaboration and all members of health care teams will need to be aware of and trained in the complex dynamics of relationships.

Competency in Dental Hygiene

A basic attribute of professionals is that they have achieved **competency** in the scope of practice that is legally granted to that particular discipline or field. Competencies are essential skills requiring knowledge, skill, and ability that are performed by a health care provider.[14] For a dental hygienist, competencies are skills regularly used in real practice settings to meet the oral health needs of patients. In addition, these

competencies have been examined and endorsed by dental hygienists, dentists, and dental educators as valid and appropriate.

The Commission on Dental Accreditation, which is the authorized agency that accredits all dental hygiene education programs in the United States, publishes standards and competencies that all dental hygiene programs must meet or exceed in their educational programs (Box 1.2).

Accreditation in the United States is a system that has been developed to protect the public welfare and provide standards for the evaluation of educational programs and schools. Regional accrediting agencies examine colleges and universities, whereas specialized accrediting agencies focus on a particular profession or occupation. A specialized accrediting agency recognizes a course of instruction composed of a unique set of skills and knowledge, develops the accreditation standards by which such an educational program is evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards. Accreditation

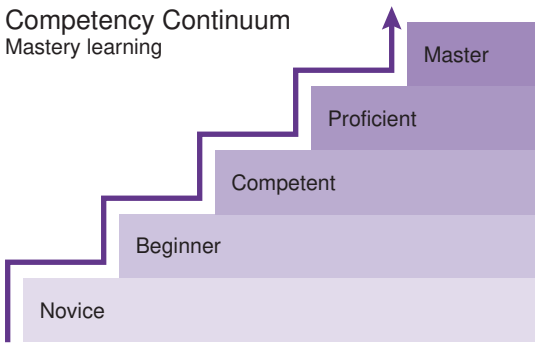
• BOX 1.2 Patient Care Competencies: *Accreditation Standards for Dental Hygiene Education Programs*

The Commission on Dental Accreditation is the agency that conducts the accreditation program for all dental education programs. The Commission is the nationally recognized accrediting body for dentally related fields and receives its authority from acceptance by the dental community and by being recognized by the U.S. Department of Education (USDE). The standards for dental hygiene are reviewed and revised periodically through an open and contributory process that includes representatives from the discipline of dental hygiene. The standards listed may change because of this ongoing cycle of review but will include competencies in:

1. Providing dental hygiene care for the child, adolescent, adult, and geriatric patient including assessing the treatment needs of special needs patients
2. Providing the dental hygiene process of care, which includes:
   - Comprehensive collection of patient data to identify the physical and oral health status.
   - Analysis of assessment findings and the use of critical thinking in order to address the patient's dental hygiene treatment needs.
   - Establishment of a dental hygiene care plan that reflects the realistic goals and treatment strategies to facilitate optimal oral health.
   - Provision of patient-centered treatment and evidence-based care in a manner minimizing risk and optimizing oral health.
   - Measurement of the extent to which goals identified in the dental hygiene care plan are achieved.
   - Complete and accurate recording of all documentation relevant to patient care.
3. Providing dental hygiene care for all types of classifications periodontal disease, including patients who exhibit moderate to severe periodontal disease.
4. Interpersonal and communication skills to effectively interact with diverse population groups and other members of the health care team.
5. Assessing, planning, implementing, and evaluating the health promotion activities of community-based health promotion and disease prevention programs.
6. Providing appropriate life support measures for medical emergencies that may be encountered in dental hygiene practice.
7. Applying the principles of ethical reasoning, ethical decision making, and professional responsibility as they pertain to the academic environment, research, patient care, and practice management.
8. Applying legal and regulatory concepts to the provision and/or support of oral health care services.
9. Applying self-assessment skills to prepare them for lifelong learning.
10. Evaluating current scientific literature.
11. Problem-solving strategies related to comprehensive patient care and management of patients.

(From: Commission on Dental Accreditation. *Accreditation standards for dental hygiene education programs.* Chicago: American Dental Association. Effective January 1, 2013.)

standards are developed in consultation with those affected by the standards and those who represent the communities of interest. The Commission on Dental Accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure in dentistry, dental hygiene, and all related dental disciplines.[15] The commission consists of 30 members and includes a representative of the ADHA. The commission uses a peer-review process to ensure that the dental hygiene standards are met in each program and a formal, on-site review is conducted every 7 years.



• **Fig. 1.1** Competency continuum.

Education is not the filling of a bucket, but the lighting of a fire.

W.B. YEATS

Patient care competencies, sometimes called *graduation competencies,* are standards that must be met by graduates of any educational program accredited by the Commission on Dental Accreditation. In states in which mastery of additional skills is mandated by the dental practice act, accredited programs also offer training opportunities in those competencies. An example of such a skill or function is the administration of local anesthesia or nitrous oxide analgesia.

Acquisition of dental hygiene skills is a process guided by educational theory and experienced dental hygiene educators. General education, biomedical science, dental science, and dental hygiene science content areas provide the core of knowledge in a dental hygiene program. Educational theory categorizes the process of skill performance into five stages of competency, also termed *the expert learning continuum* (Figure 1.1). The five stages are novice, beginner, competent, proficient, and master.[16,17]

When a student begins preclinical activities and progresses to caring for clinical patients under the supervision of faculty, this stage of learning is called *novice* or *advanced beginner.* At or even before graduation the student will have achieved competency, that is, the ability to perform skills without faculty supervision and with confidence. After graduation, the dental hygienist works toward proficiency and continues working, throughout his or her professional life, toward becoming an expert. Becoming an expert is not an end point; rather it is something a true professional constantly strives for in practice. An analogy is the professional athlete who constantly practices a sport, seeking improvement and even greater ability. Perhaps that is why the term *practice* is used, as in the practice of dental hygiene or the practice of dentistry. Professionals constantly seek to perform at increasingly higher levels, perfecting the art and science of dental hygiene for every patient treated.

Standards for Clinical Dental Hygiene Practice

The ADHA established **standards** for clinical dental hygiene practice in 1985 to outline the expectations for the practicing dental hygienist.[18] In its role as the organized voice for dental hygiene, the ADHA advocates quality care, health promotion, and enhanced oral health, with the ultimate goal of improving overall health for all individuals and groups. The revised Standards for Clinical Dental Hygiene Practice were validated in 2008 and reaffirmed in 2014 to lay out a framework for clinical practice that focuses on the provision of patient-centered comprehensive care.[16] The six standards of practice are assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation (Box 1.3). Establishing, reviewing, revising, and publishing these standards are professional responsibilities that the ADHA

• BOX 1.3 Highlights of the Standards for Clinical Dental Hygiene Practice

Standard 1: Assessment

Assessment is the systematic collection, analysis, and documentation of oral and general health status and patient needs. It is comprised of patient history collection, performing a comprehensive clinical evaluation, and measuring risk assessment.

Standard 2: Dental Hygiene Diagnosis

The dental hygiene diagnosis is the identification of an individual's health behaviors, attitudes, and oral health care needs for which the hygienist is educationally qualified and licensed to treat. This aspect of practice requires evidenced-based critical analysis and interpretation of assessments in order to reach conclusions about the dental hygiene treatment needs.

Standard 3: Planning

Planning is the establishment of goals and outcomes based on patient needs, expectations, values, and current scientific evidence. The dental hygiene plan of care is based on the assessment and dental hygiene diagnosis within the context of ethical and legal principles and the overall dental treatment plan.

Standard 4: Implementation

Implementation is the delivery of dental hygiene services minimizing risk and optimizing oral health. Communication with patient/caregiver is critical and must be appropriate for age, language, culture, and learning style.

Standard 5: Evaluation

Evaluation is the measurement of the extent to which the goals have been achieved in the dental hygiene care plan. Evidenced-based criteria are used to continue, discontinue, or modify the care plan based on ongoing reassessments and diagnoses.

Standard 6: Documentation

Documentation is the complete and accurate recording of all collected data, treatments planned and provided, recommendations, and other relevant information. This information is recorded appropriately and should meet all state regulations and ethical guidelines.

(From: American Dental Hygienists' Association. *Standards for clinical dental hygiene practice.* Chicago; 2014. Standards are currently in the process of being updated.)

assumes for its members to ensure that professional practice is based on the best and most scientifically accurate evidence and practice approaches.

Professional Traits for the Dental Hygienist

The **professional traits** or attributes of a successful dental hygienist are found in the basics of professionalism. These traits are nurtured in the dental hygiene student and then carried into clinical practice or other practice settings.

The attributes that have been identified as those of a health care professional are the same whether that individual is a physician, nurse, dentist, dental hygienist, or other allied health care provider. All these traits are rooted in beneficence: the core of health care that places the needs of the patient or client ahead of those of the provider. Society expects and demands this behavior from individuals who choose to pursue a career in the health fields. From the perspective of the general population, the term *professional* has evolved to mean an individual who demonstrates certain attributes, **traits**, and behaviors that embrace the best qualities of care and service.

The ethicist Laurence McCullough has stated that two virtues are required in a professional person. The first is self-effacement, which means putting aside all notions of self as better educated, socially superior, or more economically well off and focusing on the needs of the patient. The second is self-sacrifice, or putting aside or giving up one's own interests and concerns.

The professional traits that a dental hygienist must demonstrate and a dental hygiene student should strive to develop are listed in Box 1.4 and discussed in the following section. Dental hygienists who demonstrate these traits will experience a positive level of satisfaction in the practice of dental hygiene and will

• BOX 1.4 Professional Traits of the Dental Hygienist

- Honesty and integrity
- Caring and compassion
- Reliability and responsibility
- Maturity and self-analysis
- Loyalty
- Interpersonal communication
- Respect for others
- Respect for self

be able to recognize their contributions to the overall benefit of society.

Honesty and Integrity

A relationship of trust is essential to providing care when personal health information is shared. The patient should be confident that information given in written and verbal form is held in confidence and handled appropriately.

I've learned that making a "living" is not the same as making a "life."

MAYA ANGELOU

Patients and colleagues must be able to depend on the words and actions of individuals who treat and work with them. Professional integrity is a commitment to upholding the Code of Ethics and the standards of care.

Caring and Compassion

The ability to care for and be compassionate to each and every patient is a critical trait expected of all individuals who seek a career in a health care profession. Caring means demonstrating the empathy necessary to comfort and guide the patient in the health promotion process. Persons who are compassionate are merciful to all patients, including those who are unlike themselves or who are possibly difficult to understand and treat.

Reliability and Responsibility

The dental hygienist must accept responsibility for performing all services to the best standard of care. Sound judgment must be applied in every patient encounter, keeping in mind the technical, scientific, and ethical dimensions of the case. Maintaining current knowledge of dental hygiene theory and technique is part of that responsibility. Most states have a legal requirement for continuing education for those who hold a dental hygiene or dental license. The goal of mandated continuing education is to ensure optimal health services to the public by fostering continued competence. A reliable individual meets the obligations of time and duty, keeping appointments and meeting established schedules.

I believe that every right implies a responsibility; every opportunity, an obligation; every possession, a duty.

JOHN D. ROCKEFELLER

Maturity and Self-Analysis

A mature individual works efficiently and effectively toward the goals of attaining and maintaining oral health for each patient. The dental hygienist often seeks employment in solo or group dental practices in which a small number of individuals must work as a team, relying on each person to perform his or her assigned role and to always keep the needs of the patient primary to all activities. Self-analysis is the trait in which the dental hygienist assesses his or her skills and takes responsibility for changing and improving those skills when necessary.

Loyalty

Protecting and promoting the interests of a person, group, or organization is the definition of loyalty. Any relationship between a health care provider and a patient is a special affiliation; all professional decisions must be unencumbered by conflicting personal interests. Promises should be carefully made and kept.

Interpersonal Communication

The foundation of trust lies in communication and the ability of the patient to speak and be heard. Listening to the overt and subtle cues provided by patients allows the dental hygienist to develop a relationship that fosters an open exchange of information. Patients expect that personal, intimate facts and impressions about them will be kept in confidence by the dental hygienist.

Tolerance for Others

To treat all patients without discrimination is a basic ethical and legal requirement. This behavior goes beyond the legal warning to not discriminate based on race, creed, color, age, sex, ethnicity, or disabilities to include occupation, financial status, personality, and oral conditions. It means caring for all individuals who seek treatment whether or not they are likeable. Patients occasionally will prove difficult and hostile during the course of treatment, but the dental hygienist must still treat them to the best of his or her ability.

The only person who is educated is the one who has learned how to learn and change.

CARL ROGERS

What you are thunders so loudly that I cannot hear what you say to the contrary.

RALPH WALDO EMERSON

Respect for Self

Dental hygienists should maintain their own physical and mental health so that the needs of the patient can remain the primary focus. Working while under the influence of alcohol, drugs, lack of sleep, or emotional distress does not allow the health care provider to focus on the needs of the patient. Each patient deserves the complete attention of the dental hygienist when being treated.

Legal Requirements for the Dental Hygienist

Dental hygienists are subject to the rules and regulations of the jurisdiction in which they practice dental hygiene. When a license is granted to an individual, that person becomes responsible for knowing and upholding all the statutes and laws set down in the legal document, usually called the *state dental practice act* or the *code of dental practice.* Ignorance of a portion of the law or code is no excuse for noncompliance by a dental hygienist or any other health care provider. The responsibility and power for legislative protection of the public rest with each individual state or territory. **Licensure** is designed to enforce practice codes, establish standards, and sanction incompetent practitioners, all for the purpose of protecting the health and safety of the public.

The scope of practice of a dental hygienist was first established by law in Connecticut in 1915 at the urging of Dr. A.C. Fones, the father of dental hygiene.[2] The Connecticut dental law delineated the practice parameters of the dental hygienist and subsequently served as a model for the states that later adopted similar legislation. All state boards, as well as those in the Virgin Islands and Puerto Rico, grant a license to practice to the dental hygienist. An unlicensed person may not provide dental hygiene care.

Legal statutes periodically change in response to many factors, both to protect the public and advance the interests of the health professions. The process for any legal change is arduous, complicated, and costly in time and effort. Most legislative changes related to dental health care are driven by individuals in the dental and dental hygiene professions. For the most part the public remains unaware of the intricacies of the process or its effect on their dental health care delivery. Some of the factors that influence legislative changes in a state include the following:

- Need and demand for dental care
- Distribution of dental health care providers
- Federal health legislation
- Goals of organized dental and dental hygiene associations advocacy groups

Increases in the scope of practice for the dental hygienist have occurred over the years but usually have been accompanied by a great deal of controversy and

consternation. The services performed by the dental hygienist usually are classified as either traditional duties, such as scaling, root planing, and education of the patient, or expanded functions, such as the administration of local anesthesia and placement of restorative materials. Some states have implemented an additional practice level for dental hygienists, termed an *expanded-* or *extended-duty dental hygienist*. Individuals pursuing this level of practice must complete additional training in periodontal or restorative functions and be sanctioned to perform these skills by the particular state in which they practice. The specific duties of the dental hygienist in a given state are detailed in the dental statutes or dental practice act. Only duties or functions allowed in a particular state may be performed by the licensed dental hygienist, even if that individual is trained and licensed in another state in which the practice act is more expansive. The exact duties and services that may be performed by the dental hygienist in a particular state are based on customary parameters of practice and the state dental practice act.

The legal mandates in each state use terms that differentiate the level of supervision set out by that particular body. Some states are more liberal in their dental practice acts than others. Several states have adopted mechanisms to allow a dental hygienist to practice without the supervision of a dentist after gaining a special license or credential. These allowances are granted after additional training or testing, often with the goal of improving public access to appropriate care.

Summary

The profession of dental hygiene was established with the goal of providing oral health education and services to the public so that dental disease could be prevented. As a health care professional, the dental hygienist is given the trust of society; with that special trust come rights and responsibilities. Attaining and maintaining competency in dental hygiene are among the obligations that the dental hygienist accepts in completing a formal education program and passing the state licensure examination. The traits that characterize a successful dental hygienist are the same traits found in any successful health care professional: placing the needs of the patient first and aiming to provide the best care to every patient as well as society at large.

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2

Ethical Theory and Philosophy

PHYLLIS L. BEEMSTERBOER AND DAVID OZAR

LEARNING OUTCOMES

- Explain the main components of moral growth.
- Describe the theories of moral development and the role of cognitive growth.
- Discuss character and the contribution of character development to ethical conduct for the health care provider.
- Compare the three theories of ethical thinking and give examples of each from oral health care.

The dental hygienist will be faced with numerous professional and personal problems in everyday life. Many of these problems are familiar situations in which we easily determine what we ought to do, but in others determining what is the ethical action takes careful reflection. For both situations, an introduction to the foundation of ethical theory is important to guide ethical decision making as well as assist in understanding the process by which such decisions are made. Ethical decision making is behavior and, as a behavior, is something that can be done well or done poorly and something that can be taught and learned. Thus this chapter begins with an overview of moral development and then examines three broad approaches from moral philosophy that should enhance the understanding of how **ethical theory** lays the foundation for ethical decision making. Chapter 3 builds on ethical theory by introducing conceptual tools that can be applied in real-life situations.

The key to your universe is that you can choose.

CARL FREDERICK

Moral Development

How do individuals become moral? Are we born moral, or do we learn to be moral? If **morality** is something that must be learned, how is it learned? Do all persons learn morality at the same rate and to the same degree? If human beings are born capable of becoming moral and therefore must learn to be moral, how do individuals learn to differentiate right from wrong and how do they incorporate this skill in life?

Several authors have focused on moral development as a process. Just as each individual develops physically and intellectually, moral development also has been shown to typically occur in progressive steps or stages. Some researchers have related age, maturation of components of personality, and increased experience with moral development, whereas others have stressed that moral development has a cognitive component as well. That is why differentiating right from wrong, which is a cognitive matter, is different from incorporating right and wrong into life—that is, moral development overall. The examples of saints and heroes, including highly admirable members of one's own profession, as well as moral growth by ordinary people every day, can give clues about the causes or mechanisms of moral development. As psychological research on moral development is a fairly new field,

from a scientific point of view, much of what is involved remains unclear.

What has become clear is that a strong relationship exists between education and development of moral judgment, the cognitive aspect of moral development. One of the strongest and most consistent correlates with development of moral judgment, even stronger than chronologic age, is years of formal education.[1,2] For many people moral development continues as long as the person is in a formal education environment but then plateaus upon leaving school. This is an important lesson. If you want to keep growing as a moral human being, keep learning, though not necessarily in school. Instead, never stop observing and reflecting on what is going on around you and people's reasons for their actions. Keep asking questions, read, and discuss with others to keep your learning vital, and, most important, do so in aspects of your life in which moral matters are at stake. Professional life obviously is one of those aspects.

(From: Shutterstock.com.)

Various educational programs and interventions have been used to facilitate development of moral judgment by providing enriched and stimulating educational experiences. A review of moral education programs revealed that almost half were effective in promoting moral development, especially if the program lasted longer than a few weeks and if the program involved the participants in discussions of controversial moral dilemmas.[3] Adults also seemed to gain more from such programs than did younger children, most likely because a wider range of life experiences typically enriches a person's awareness of the moral aspects of situations.

These findings have implications for persons preparing for a career in dental hygiene because they emphasize several things about learning to make moral decisions. First, findings suggest that the capacity for moral judgment is not as rigid as some have argued. That is, neither a person's cognitive moral development nor their ability to employ what they understand in actual decisions is frozen at some specified age. Rather, individuals can continue to learn, and research has supported the idea that adults make greater gains than children. Second, individuals who are still in formal education programs will likely benefit from advanced training, especially when expected to exercise their ethical decision-making ability by considering a variety of dental hygiene case scenarios. Third, these findings suggest that participation in continuing **ethics** education courses after graduation may reinforce an individual's ability to make sound ethics judgments and also have a positive influence on the person's commitment to practicing in an ethical manner.

Theories of Cognitive Moral Development

One View: Male Justice Orientation

Moral development has been studied a great deal by psychologists, who have provided some knowledge of the process and how it influences our actions in adulthood. The most famous developmental psychologists, Piaget[4] and Kohlberg,[5] categorized stages in the moral development of male children. Piaget and Kohlberg both stated that moral development is sequential and depends on an individual's level of cognitive development. Piaget's[4] model consisted of four stages (Table 2.1), whereas Kohlberg[5] defined moral development according to both levels and stages (Table 2.2).

Each stage in the process of cognitive moral development involves judgment skills that are more

complex, comprehensive, and differentiated from the preceding stage. The process also is sequential, with an individual moving from simple to more complex stages. Kohlberg's stages follow the Piagetian view that justice is the core of morality; however, because this was first demonstrated empirically only in male subjects, it is important not to generalize more broadly at this point. Kohlberg's theory focuses primarily on cognitive processes, which is consistent with his belief that understanding guides behavior. He asserts the moral superiority of his stage 6, in which what he considers to be genuine moral judgments are made and in which genuine moral judgments are defined as judgments about the good and right of actions based on objective, impersonal, or ideal grounds.[6] Thus cognitive moral development for Kohlberg is a progression toward increasingly valid or universal moral thought. However, there are other accounts of genuine moral judgments besides Kohlberg's, so the health care provider should consider what more there is to cognitive moral development than Kohlberg has discussed and what else besides the cognitive aspects goes into moral development more broadly.

TABLE 2.1 Piaget's Four-Stage Model of Moral Development

Stage	Characteristics of Moral Development
1	**Amoral** stage (ages 0–2 years)
2	Egocentric stage (ages 2–7 years); bends rules and reacts to environment instinctively
3	Heteronomous stage (ages 7–12 years); accepts the moral authority of others
4	**Autonomous** stage (ages 12 and older); a morality of self based on cooperation; rules tested and become internalized

An Alternate View: Female Ethic of Care

Among the criticisms of Kohlberg's work is the challenge that his model reflects a male-oriented perspective of morality. Gilligan,[7] in her classic book, states that women tend to see morality in the context of a relationship she calls the *ethic of care*. She proposes that feminine moral reasoning is typically different from masculine moral reasoning. To survive evolutionarily and practically, female individuals have had to develop a sense of responsibility based on the universal principle of caring, which Gilligan sees as quite different from universal justice. Like Kohlberg's model, Gilligan's model also has three levels (Table 2.3); unlike Kohlberg's model, Gilligan includes noncognitive growth in her model of moral development.

Gilligan believes that complete moral development occurs in the context of two moral orientations—a

TABLE 2.2 Kohlberg's Three-Level Model of Moral Development

Level	Level of Reasoning	Stage
1	Preconventional reasoning (stages 1 and 2), in which externally established rules determine right and wrong action	Stage 1: punishment and obedience orientation Stage 2: instrumental relativist orientation
2	Conventional reasoning (stages 3 and 4), in which expectations of family and groups are maintained and where loyalty and conformity are considered important	Stage 3: interpersonal concordance orientation Stage 4: law and order orientation
3	Postconventional or principled (stages 5 and 6), in which the person autonomously examines and defines moral values with decisions of conscience dictating the right action	Stage 5: social contract legalistic orientation Stage 6: universal ethical principle orientation

TABLE 2.3 Gilligan's Model of Moral Development

Level	Care Orientation
1	Orientation to individual survival and being moral is surviving by being submissive to society
2	Goodness as self-sacrifice, in which being moral is first not hurting others with no thought of hurt to self
3	Morality of nonviolence; avoiding hurt becomes the moral guide governing all moral reasoning

male justice orientation and a female ethic of care—and therefore that Kohlberg's measurement of moral development *only* in a justice-oriented scoring system is biased toward the male. Gilligan's work, which focuses on gender differences within the study of moral judgment development, has received much interest and support.[8] As a much oversimplified example of her model, the male health care provider, when discovering a case of suspected child abuse, would acknowledge his duty to report, report the suspicious case, and move on. For the female health care provider, however, even if her actions turned out to be identical with those of the male, the basis of those actions being ethically required would be different; the duty to report—and her actually reporting if she determines this is her most important duty—is derived from the relationships surrounding the child and the need to protect the interests of the child. One reason for this difference in Gilligan's theory of moral development is that it is based on the way girls are raised. The care orientation is a parallel path of moral development and perhaps one that will provide further insight into justice orientation. But in any case, in Gilligan's description of moral development, both perspectives are accepted as crucial to the understanding of moral development.

Cognitive Development Theory

The basic tenet of cognitive development theory is that people operate on their experiences to make sense of them, and those experiences, as we make sense of them, in turn change the basic conceptual structures by which people construct meanings. Researchers studying the relation between moral judgment and behavior can see that many factors determine behavior. For example, studies link moral perception with actual, real-life behavior as well as moral judgment. In addition, the literature suggests that students pursuing professional education are "in an important formative period of ethical development and that formal schooling is a powerful catalyst to ethical development,"[9] as is the motivation to become an excellent member of the profession. Rest[10] and his co-workers have explained this by saying that people who develop in moral judgment are those who love to learn, who seek challenges, and who are reflective, set goals, take risks, and profit from stimulating and challenging environments. These are characteristics frequently found in professional students who are working hard to become excellent professionals.

> *Nurture your mind with great thoughts, for you will never go any higher than you think.*
>
> **BENJAMIN DISRAELI**

Character

The issue of **character** in an individual and the process of character education are topics that have gained significant attention in recent years, primarily because of a perceived lack of emphasis on character development in today's society. Character usually is defined as qualities or dispositions that are consistently practiced. The term comes from a Greek term meaning a constellation of strengths and weaknesses that form the person. Many times when we act "without having to think about it," our actions are the product of the habits of perception, valuing, and judgment (some of them excellent, some of them less so) that make up our character.

Some colleges and several philanthropic foundations have established character development or a character focus as their mission. One such example is the Josephson Institute of Ethics, based in Marina

Del Rey, California. This nonprofit group supports character-based decision making using consequentialist and virtue philosophy. Their basic program is called the "Character Counts Coalition," and it includes six core ethical values: (1) trustworthiness; (2) respect; (3) responsibility; (4) fairness; (5) caring; and (6) citizenship. The mission of the Josephson Institute is to improve the ethical quality of society by teaching principled reasoning and ethical decision making. Programs are targeted at children in schools, legislators, lawyers, journalists, and leaders in the corporate, public, and nonprofit sectors. Another example is the Templeton Foundation, in Radnor, Pennsylvania, which sponsors character education programs. All these efforts are grounded in the belief that positive traits of character can be forged through educational experiences, whether in elementary or high school or professional school. They also presume that character can be shaped and influenced by good example at every level of learning.

The reason for mentioning character here is twofold. First, as stressed previously, the cognitive aspects of moral development are only part of the story. Incorporating the skill of differentiating right from wrong into life is a matter of building habits—habits of carefully perceiving, carefully judging, and consistently acting in accordance with one's moral judgments. One of the best ways to appreciate the value of a habit is to see how it operates in someone we admire, which is why living human examples of good habits are so important to moral development. Second, on the cognitive side, which is the focus of this chapter, much can be learned. Focusing on the different ways in which moral thinking can be done and the conceptual tools that one has to make well-reasoned, moral judgments is an important first step. In the academic world, examining the different ways in which moral thinking can be done is called a *study of moral or ethical theory.* To keep matters simple, an "ethical" or "moral" question (compared with a question that has nothing to do with ethics or morality) is a question in which a person's well-being or rights or duties are at issue or at stake. In addition, because the meanings of "ethical" and "moral" are not carefully distinguished in a manner that is widely and consistently used, these terms often are treated as synonyms and used interchangeably.

Pride is concerned with who is right. Humility is concerned with what is right.

EZRA TAFT BENSON

Be more concerned with your character than your reputation, because your character is what you really are, while your reputation is merely what others think you are.

JOHN WOODEN

Overview of Ethical Theories

The role of ethical theories is to lay a cognitive foundation for ethical decision making. A system of **moral reasoning** or moral thinking is important because it provides a frame of reference that will help the individual make morally appropriate responses to moral dilemmas.

Although multiple theories have been proposed to explain how people direct their actions when faced with a moral dilemma, three broad-based classical views or philosophies of moral reasoning will be reviewed here; they are known in the academic literature as consequentialism, deontology or nonconsequentialism, and virtue ethics.[11]

Consequentialism or Utilitarian Ethics

CONSEQUENTIALIST ETHICS

An action or rule is right insofar as it produces or leads to the maximization of good consequences.

Consequentialism refers to the kind of moral thinking that is predicated on the idea that the rightness or wrongness of any action is determined and justified by the consequences of the act being considered, judged in comparison with the consequences of the other possible acts that might be performed in the situation. Consequentialist thinking is always comparative because it aims at maximizing good

consequences (and minimizing harmful ones). Thus consequentialists consider the consequences of each important alternative course of action available to them in the situation before deciding on a right action. Doing moral thinking in this way means considering all relevant consequences (potential outcomes) of potential actions in the situation, identifying and evaluating them in terms of benefit and harm in order to determine the action(s) that, compared with the alternatives, yield the best outcomes, before making a choice about which action to take.

For example, a dental hygienist may observe that her employer routinely leaves overhangs on restored teeth. Because overhangs may negatively affect the patient's periodontal health, the hygienist must determine what, if any, action to take. She begins by identifying her alternatives and examining the benefit or harm that will most likely result from each one. First, the hygienist could take no action. One consequence of inaction might result in some patients developing severe periodontal disease and/or losing teeth. Second, the hygienist could remove the overhangs. One consequence of this action would be enhanced oral health for the patient. However, in some states removal of overhangs may be illegal for a hygienist, and doing so could put her professional reputation in jeopardy or make employer communication difficult. Third, the hygienist could discuss with the employer the fact that overhangs are frequently present. The consequences could be that the dentist would restore teeth more carefully. However, another consequence might be that the dentist simply tells the hygienist to mind her own business and do her job. If the hygienist persists, the employer may decide to terminate employment. All these are consequences to consider because they are important alternatives for the dental hygienist in this situation. However, notice that the consequential reasoning approach would require the hygienist to do what is the best action even when it might not be in the hygienist's own best interest. Being ethical is not always easy; most versions of consequentialism stress that in good moral reasoning the effects of the alternative actions for everyone affected, not just oneself, must be taken into account.

John Stuart Mill was one of the most famous proponents of **utilitarianism**, a version of the consequentialist approach to moral decision making, who stressed that, in consequentialist reasoning, every person affected by an action should be considered.[11] Mill often is described as saying that an action should be judged to be moral on its capacity to provide the greatest good for the largest number of people. However, his teacher Bentham said that, not Mill, and Bentham himself eventually repudiated the phrase because it misled people into thinking that, for a utilitarian, whatever benefitted the *majority* was the right thing to do. Both men did teach that the moral action is the one (of the alternative actions available) that maximizes good and minimizes harm when the consequences for every affected person are considered. Obviously, one place in which utilitarian reasoning might be appropriate is when ethical matters must be decided (e.g., by a legislator or officer of government) that affect large social systems, a community, or even a nation. A public health dentist or a hygienist with a master's degree in public health would be more likely to use this approach in public health thinking than would others. Thus one of the best examples of utilitarianism in dentistry is the application of fluoride to community water systems. The consequence was a benefit through caries reduction, provided at a relatively low cost and available to all members of a community regardless of social status or income, and with almost no possibility of causing harm. The alternative, going on without fluoride, was a situation in which many people would have had many more carious lesions and other dental problems because their oral hygiene was typically not dependable enough to prevent these harms.

Deontology or Nonconsequentialism

NONCONSEQUENTIALIST ETHICS

The central claim of deontological or nonconsequentialist ethics is that an action is right when it conforms to a principle or rule of conduct that meets a requirement of some overriding duty.

The expression *deontological ethics* is derived from the Greek word *deon,* meaning duty. Deontologists state that some actions are required by the rightness or wrongness of the action, regardless of the consequences of the action. Whereas consequentialists focus

on the consequences of an act, deontologists argue that some acts are right or wrong independent of their consequences (thus the term **nonconsequentialism**). Some acts are right because they have a direct relation to some overriding duty, or they are wrong because they directly violate some overriding duty, but not because of consequences. For example, a deontologist might believe that a health care provider, as a moral person, has a duty to tell the truth in all circumstances and therefore has a specific duty to tell the truth to patients. With this view, a professional's duty to tell the truth to a patient is not founded on the consequences of telling the patient the truth, but on the belief either that an absolute duty exists never to lie or that the patient is entitled by reason of a fundamental right to receive the truth. According to deontology then, moral standards exist independently of the particular circumstances of an action and do not depend on consequences. Duty and the relation of a person's actions to duty are the only relevant considerations.

Immanuel Kant[12] is credited for establishing one of the most detailed nonconsequentialist or deontological theories of ethical thinking. Kant held that the test of any rule of conduct is whether it can be a duty for all human beings to act on—what he called a *universal law.* That test is, according to Kant, what tells us whether an action is directly related to an overriding duty. Kant also stressed that all human beings (as adults) are free, are worthy of respect, and are their own choosers of their purposes and actions. Many deontological theories of human rights have been built by later thinkers on this basis.[12] This school of thought has had a significant effect on biomedical ethics. It places primacy on the right of the individual to act autonomously—that is, to make his or her own decisions on the basis of his or her own values, goals, principles, and ideals. Autonomy as an important principle of health care ethics is further explored in Chapter 3.

Kant's test for correct moral reasoning was called the *categorical imperative,* which means a rule or standard of conduct that is absolutely binding for all human beings under all circumstances in which the rule or standard applies. Kant held that some of the moral rules we are familiar with (e.g., do not lie) have this character of overriding duty. Most of the rules


Immanuel Kant.

(From: Shutterstock.com.)

with this character are negative, in that they tell a person what *not* to do. For example, one must not lie, cheat, or steal. Borrowing an old Latin word, *perfectum,* which meant "binding unconditionally," Kant categorized the negative rules having this character as "perfect duties." Perfect duties are always binding. Kant also talked about "imperfect duties," which refer to moral obligations to act in certain ways during our lives but leave it to each person to judge when and in what situation to fulfill the obligation (*imperfect* here meaning "conditionally binding," that is, depending on the actor's judgment to determine when to fulfill the obligation). Thus a perfect duty requires one not to kill an innocent human being. The prohibition against murder is binding because it is right and directly connected to an overriding duty, not because of the consequences. An example of an imperfect duty is an obligation to help another person in need or to be compassionate. We all have an overriding duty to pay attention to people's needs, but we are not obligated to try to meet them in every situation in which someone is in need. It is a matter of moral judgment that a person must carefully make to determine for whom and in which situations to fulfill this duty.[12]

Sometimes Kant's Categorical Imperative is compared with the Golden Rule, which cautions individuals to "do unto others as you would have others do

unto you." As Kant stated it: "Act that you can will the maxim of your action to be a universal law binding upon the will of every other rational person."[12]

An example of the deontological approach as it applies to dental hygiene is that a hygienist has a duty to maintain patient confidentiality in the provision of oral health care for his or her patient. Other than sharing information appropriately with other health care providers, information acquired while providing patient care must remain private unless the patient's express permission has been granted. If an adult patient's relative or a representative of a finance company asks questions regarding the patient, confidentiality must be maintained. It is right because respect for others' autonomy is an overriding duty, and a patient's revelation of personal information to the hygienist for purposes of oral health care does not include permission to use it for any other purpose. If this philosophy were strictly held in health care, public health reporting of communicable disease would seem to not be permitted. However, Kant expanded his moral theory to cover societal rules in ways that could make such reporting morally acceptable if one could reasonably argue that any rational person would want such information communicated to avoid harm to others. Just as consequentialist thinking can get quite complex when many alternative actions must be compared, when consequences are hard to predict, and when different kinds of benefits and harms affect different persons as a consequence of an action, so deontological thinking—though it may appear simple at the start—can be complex when trying to determine what social standards could reasonably be willed by rational people to be universal standards to live by. No moral philosopher has ever claimed that moral thinking is like solving a simple equation in mathematics. One reason theories have been offered is to help us understand how complex making good moral decisions can be, and then to try to help us think about them more clearly.

Let us have faith that right makes might, and in that faith let us in the end dare to do our duty as we understand it.

ABRAHAM LINCOLN

Virtue Ethics

VIRTUE ETHICS

Character or virtue and the goodness of the person in living a good life, acquired by a person through learning and reflection and repetition (based on Greek tradition of Plato and Aristotle).

Character, or virtue, refers to stable patterns of perceiving, thinking, and acting rightly. A person cannot stop and carefully weigh possible actions in terms of ethical standards hundreds of times a day even though hundreds of opportunities for action each day are ethically significant. Therefore most of our actions are the product of our character, or the stable patterns perceiving, thinking, and acting that are part of us. If those patterns are perceiving, thinking, and acting rightly, we call them *virtues,* and we say the person has a "good character" or is a "good person." Likewise, when we speak of professionalism in any profession, we are talking about stable patterns of perceiving, thinking, and acting in accord with the profession's ethical standards. Character and virtue therefore are central themes in any discussion of ethics for professionals.

Virtue ethics was first articulated as a moral theory in the Greek tradition of Plato and Aristotle, who emphasized that the cultivation of virtuous traits of character is the primary function of morality. Aristotle wrote that virtue is a stable state of character and is the result of practice—that virtue is something acquired by a person through learning, reflection, and repetition. When trying to describe the virtues of good persons, he looked for a balance between intellect and commitment in action (just as moral development is understood today to involve both cognitive and noncognitive components). He also stressed that the person who is virtuous has developed the ability to perceive, judge, and act rightly as a dependable habit; the ideal is stability in these patterns so that the virtuous person would act in a virtuous manner in all situations. Aristotle also recognized that we are all fallible in achieving this ideal and stressed the value for each of us to identify role models whom we can learn from in order to become more virtuous and do the right thing in each situation more easily and regularly.

Each of the virtues is a habitual disposition to perceive, judge, and act rightly. Virtue ethics focuses not so much on the rightness or wrongness of a given act or whether it conforms to duty, but rather on the goodness of the person who habitually chooses to act in that way or see such acts as proper responses to duty.[13] Rather than focusing first on consequences or nonconsequentialist factors such as duty or rights, philosophers of the virtue ethics tradition urge us to reflect on what kind of person we *ought* to be (and *ought not* be) and not the ethical characteristics of the acts we ought to do. A dental hygienist could treat a hostile and unhappy patient with extra kindness and caring to maximize good and reduce harm or because she considers it her duty. However, in the rush of daily professional life, a dental hygienist will more likely do this in order to be a good professional and a good caring person. When this is her ethical perspective, she clearly is striving to be virtuous and is doing her day-in day-out ethical thinking according to the virtue ethics approach.

Thus virtue ethicists believe that individuals make most of their choices on the basis of virtue and character. The focus is on the character of the person. If a person has good character, that person will make choices that produce good. In an ideal world, of course, all people would be of good character and would make good choices easily and habitually in every situation. But we know that few, if any, of us have completely arrived at that point. Even if, speaking ideally, all people of good character have good ethical decision-making abilities, in the real world, we have to work to develop these abilities first and then make them into habitual patterns of perceiving, judging, and acting in our lives.[14]

> *Many people say that it is the intellect which makes a great scientist. They are wrong: it is character.*
>
> **ALBERT EINSTEIN**

Summary

Rarely does a person embrace one ethical philosophy exclusively. More than likely an individual is influenced by more than one ethical system as well as by a number of other factors, including religion, culture, and environment. However, knowledge of these philosophic frameworks for ethical thinking helps health care providers understand their professional commitments more clearly and understand their patients and co-workers better, as well as understand their own personal philosophy when dealing with problems and dilemmas in the delivery of health care. The profession of dental hygiene needs people of good character who can, as a result of education, experience, and careful reflection, acquire more skill in making ethical decisions and acting according to them.

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3

Ethical Principles and Values

PHYLLIS L. BEEMSTERBOER

LEARNING OUTCOMES

- Identify the normative ethical principles.
- List the ethical principles used in dentistry and dental hygiene.
- Describe the difference between a choice and an ethical dilemma.
- Explain the role of principles in the decision-making process of the dental hygienist.
- Compare the values and ethical concepts that support the principles of ethics.

Ethical principles guide the conduct of health care providers by helping to identify, clarify, and justify moral choices. Principles help address the moral question: What ought I do in the situation I now face? More specifically, what is good, right, or proper for a person to do in this situation? Normative principles provide a cognitive framework for analyzing moral questions and problems. These principles are linked to commonly expected behaviors because they are based on shared standards of thinking and behaving. In health care the main normative principles are nonmaleficence, beneficence, autonomy, and justice. These principles are associated with expectations for behavior, and they provide guidelines in dealing with right and wrong actions. These principles provide direction about what should and should not be done in specific situations.

Integrity is never a given, but always a quest that must be renewed and reshaped over time.

WILLIAM SULLIVAN

Ethical Dilemmas

A difference exists between addressing everyday problems and addressing ethical dilemmas. What is an ethical dilemma? An ethical dilemma occurs when one or more ethical principles are in conflict. An example of a true ethical dilemma is one in which the principle of nonmaleficence is in conflict with the principle of autonomy in a specific situation. Such a dilemma might occur, for example, when a patient who has undergone heart valve replacement and who requires premedication tells the dental hygienist he does not want to take any antibiotics and urges the dental hygienist to go ahead with scaling and root planing. The patient is expressing his autonomy by stating he does not wish to be premedicated. The dental hygienist, however, has taken an oath to do no harm (nonmaleficence). This is a genuine ethical dilemma because two ethical principles (patient autonomy and nonmaleficence) are in conflict. Resolving an ethical dilemma is certainly a very different enterprise from solving daily problems, such as which automobile to purchase or which instrument to choose for scaling. It also is different from a situation in which a dentist is knowingly and intentionally charging an insurance company for procedures not performed. That action clearly involves unethical and unlawful behavior, but

it is not a true ethical dilemma because principles are not in conflict. The dentist is wrong and committing fraud. A discussion of which ethical principle takes precedence over another is not necessary. The dentist's behavior is wrong, unjust, and unlawful.

In a perfect world the needs and wants of the patient would always come first, and no conflicts, disputes, or dilemmas would exist for the dental hygienist or any health care provider to resolve. However, that is not the case in the real world, where what is in the patient's best interest may be open to question depending on whose perspective—that of the clinician, the patient, the patient's family, or other health care professional—is being considered. Principles, values, and rules in health care will help guide decision making in the process of providing the best dental health care for the patient. Weighing and balancing ethical principles are the major tasks involved in ethical decision making.

A Principle

A **principle** is a general normative standard of conduct, holding that a particular decision or action is true or right or good for all people in all times and all places. Principles derive from common morality and the traditions of health care, specifically from some of the role obligations of practicing medical clinicians. These principles provide the comprehensive norms used in biomedical ethical framework analysis.[1]

Principle of Nonmaleficence

The founding principle of all the health professions is **nonmaleficence**. This principle declares that a health care provider's first obligation to the patient is to do no harm (in Latin, **primum non nocere**). Patients place themselves in the care of another person and, at a minimum, should expect that no additional harm will result from that act. The patient grants another person the privilege of access to a portion of his or her body for an explicit purpose, a privilege founded in trust. Fundamental to that trust is that the health care provider will do no harm to the patient.

The Hippocratic Oath requires that the health care provider promise to keep the sick from harm and injustice. In reference to nonmaleficence, the American Dental Association's (ADA) publication, *Principles of Ethics and Code of Professional Conduct,* states that "the principle expresses the concept that professionals have a duty to protect the patient from harm". Under this principle the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate."[2] For example, practitioners are required to maintain their level of knowledge and skill through participation in appropriate continuing education programs. Thus a dentist who has not performed an endodontic procedure since graduation from dental school 25 years ago would be expected to refer patients to a colleague for root canal therapy. Likewise, a dental hygienist also has an obligation to stay up to date with the changing standards of care in the profession. A hygienist who is unfamiliar with sealant placement procedures or anesthesia techniques should defer performing that service until achieving competency.

Although nonmaleficence primarily is concerned with doing no harm, over time it has evolved to include preventing and removing harm. Therefore health care providers have an obligation to do no harm as well as to prevent harm. Prevention of harm clearly is a domain of dental hygienists. Hygienists are concerned with preventing harm when standard precautions are observed, when scaling and root planing are performed to preserve teeth and periodontal tissues, and when educating patients in home health care. Similarly, dental hygienists remove harm when they treat patients who have active periodontal disease.

Application of Nonmaleficence

Does prevention of harm mean all possible harm? A narrow interpretation of this principle would hold that complete avoidance of any pain and suffering in patient care must be maintained. Such strict interpretation would mean that invasive diagnostic tests to locate disease, as well as intraoral injections to allow scaling and root planing, could never be performed. Consequently patients could never benefit from

treatment that would alleviate current pain, and they could not benefit from the prevention of future pain and suffering. This would seem to be an unrealistic application of nonmaleficence. A health care provider may not always be able to avoid harm. In fact, causing some degree of harm when that harm will lead to a greater good—restoring a patient to health—may be desirable as well as necessary. This conflict is referred to as the *principle of double effect,* and it requires the health care provider to consider the risks and benefits whenever treatment is provided.[1] What comprises harm and good can be delineated by the following classification system:[3]

1. One ought not to inflict harm.
2. One ought to prevent harm.
3. One ought to remove harm.
4. One ought to do or promote good.

The first entry refers to avoidance of harm (nonmaleficence), which takes precedence over the second, third, and fourth entries, which define beneficence, or the promotion of good. This hierarchy of nonmaleficence and beneficence provides the clinician with a guideline to follow in sorting out dilemmas in practice. Not inflicting harm takes precedence over preventing harm, and removing harm is a higher priority than promoting good. Ideally, the dental hygienist would be able to implement all four parts of this hierarchical relationship; however, when faced with constraints and conflict, prioritization would be necessary. Avoiding harm and promoting good in the practice of dental hygiene and dentistry are not always possible.

Principle of Beneficence

Whereas nonmaleficence is concerned with doing no harm to a patient, **beneficence** requires that existing harm be removed. Beneficence focuses on "doing good" for the patient. Doing good requires taking all appropriate actions to restore patients to good health. Health care providers, based on their knowledge and skill, use all reasonable means to benefit the patient. Dentists and hygienists have acquired a body of knowledge and corresponding skills that make them uniquely qualified to help identify patient needs and recommend and provide actions to address those needs. Thus their unique qualifications allow them to benefit the patient by removing existing harm and assisting in the prevention of future harm.

Beneficence and nonmaleficence often are linked because they are both founded in the Hippocratic tradition, which requires the physician to do what will best benefit the patient. This is a consequentialist approach. Meeting the requirement to do what the physician believes will best benefit the patient implies the need to conduct a consequence analysis to determine the best possible outcome for the patient. Beneficence is found in all health care codes. By choosing to become a dental hygienist, an individual assumes a responsibility to help others and professes to be a part of a profession. This means that the hygienist's actions, behaviors, and attitudes must be consistent with a commitment to public service, which is a commitment to benefit others. This commitment to help and benefit others morally defines the healing professions and sets them apart from other occupations, such as architecture or engineering.[4]

Application of Beneficence

For dental hygienists, whose primary focus is preventing oral diseases, promoting good is a daily purpose and goal. Indeed, for any person who is in a position to promote good for the benefit of others, as health care providers are, failure to increase the good of others is morally wrong. The purpose and existence of biomedical research, public health policies and programs, and preventive medicine are the formalized aspects of this part of health care. Society—through various federal, state, and community-based activities—attempts to meet this need for the good of the public. The promotion of good becomes difficult, however, when good is defined according to differing values and belief systems. The teaching of careful oral hygiene self-care to maintain health and function is an example of promotion of good to many people. However, the removal of all carious teeth to eliminate pain and suffering may be considered promoting good to other individuals. In public health programs the appropriation of limited resources to meet the medical and dental needs of a given population can be a challenging and frustrating exercise but also part of being a health care professional who advocates for the betterment of society.

Principle of Autonomy

Autonomy is self-determination and the ability to be self-governing and self-directing. An autonomous person chooses thoughts and actions relevant to his or her needs, independent from the will of others. In health care autonomy gives rise to the concept of permitting individuals to make decisions about their own health, which is the heart of many ethical dilemmas that occur in dentistry.[5] All health care providers must respect the autonomy of patients and properly inform them about all aspects of the diagnosis, prognosis, and the care being provided. Because dental hygienists have a wide range of knowledge and skills, they must fully and adequately explain the parameters of the services that can be performed as well as the consequences of performing or not performing those services.

Application of Autonomy

The application of autonomy is founded in deontology and is based on respect for persons. The deontologist holds that the health care provider has a duty to allow patients to make decisions about actions that will affect their bodies. The health care provider also has a duty to provide patients with all the unbiased information they would need to make a decision about treatment options. This is an area in which potential for conflict exists between what the dentist and/or hygienist believes is in the best interest of the patient and what the patient believes is in his or her best interest. Sometimes what the professional believes is best for the patient is not what the patient elects to do. As long as the patient selects from treatment options that are consistent with accepted standards of care, the professional may ethically act on the patient's choice. However, the professional practitioner also has the autonomy to not provide a service requested by the patient if that service is in conflict with the standards of patient care. For example, refusing a patient's request to extract all healthy teeth would be ethical even though that decision would conflict with the patient's autonomy. Dentists and hygienists will avoid doing harm to a patient even if the patient is exercising autonomy by asking to receive a potentially harmful treatment or service.

Principle of Justice

> *All virtue is summed up in dealing justly.*
>
> **ARISTOTLE**

The principle of **justice** is concerned with providing individuals or groups with what is owed, due, or deserved. Nonconsequentialists view justice as a duty for health care providers. The foundation of justice has frequently been described as the principle of equality; likes should be treated alike, equals should be treated as equals, and unequals should be treated as unequals. The obvious problem in this approach is that some mechanism or criteria must determine who is equal or unequal. If one is unequal, is he or she entitled to the same type and quality of health care as the "equals"? Would that be just? Fundamental to the principle of justice is an effort to treat people who have similar needs in a similar or identical manner. All patients who seek treatment for the prevention of periodontal disease should receive the same level of care and attention from the dental hygienist regardless of personal or social characteristics. For example, consider the case of a large city in the state of Iowa with 3500 people who need the same extensive treatment for periodontal disease. Hypothetically, all have the same oral health needs. Those who have money can, with both professional and home care, save all their teeth. Those without money may lose all their teeth in the next 4 years. Of those who have money, only those who are younger than 60 years are encouraged to participate in complete therapeutic activities to save all their teeth; those who are "foreign" are assumed to not care whether their teeth are saved or lost. Is this just? Regardless of age, gender, social status, religion, or other distinguishing factors, each person should be entitled to the same oral health care options when a similar health care need exists. That would be just.

Justice in dentistry, most often discussed in terms of public policy issues, is further referred to as *distributive justice.* Every society must address the problem of how its resources will be distributed because every society has a scarcity of resources. Resources are scarce whether referring to materials, specially trained individuals, money, or time. **Distributive justice** is

(From: Shutterstock.com.)

concerned with the allocation of resources in large social systems. Policymakers must confront the issue of how society distributes its resources. Who gets what and why? This has implications for national health care policy. Should the United States have a national health care policy? If so, should dentistry be included in any proposed national health care policy? If so, what kind of treatment will be offered, who will provide the treatment, and who will be eligible to receive the treatment?

Justice consists not in being neutral between right and wrong, but in finding out the right and upholding it, wherever found, against the wrong.

THEODORE ROOSEVELT

Application of Justice

If resources were unlimited, the problem of just allocation would be minimal. Unfortunately, that is not the reality of the world in which we live. Choices must be made, benefits and burdens must be balanced, and resources justly distributed. A lofty goal for most organized societies would be the just application of health care. However, no legal mandate exists for medical and dental care to be available to all persons, and decisions are made daily according to the ability of the patient to pay for the services rendered. Thus the provision of dental care is applied unequally. People who present for treatment are, for the most part, granted access to care based on their economic ability and not their dental needs.

The question of who should provide dental care when an economically impoverished individual is in need of treatment is difficult to answer. Many dental hygienists and dentists provide charitable services on a regular basis, either in a private practice office or through participation in a community-based service clinic, because of their recognition of their obligation to serve society. Unfortunately, although this is a lauded practice, it does not come close to meeting the needs of those who cannot access dental care. Many dental public health practitioners and leaders consistently call for the profession to make oral health a much higher priority for federal and state decision makers.

If you tell the truth *you don't have to remember anything.*

MARK TWAIN

Values and Concepts

Several values and rules support the principles of ethics and add clarity to attempts to make ethical decisions. Many of the concepts are related to the discussion of consequentialism and nonconsequentialism presented in Chapter 2. Remember that an ethical dilemma occurs when one or more ethical principles are in conflict. Thus values and concepts discussed in this section are founded in ethical principles and the theory upon which those principles are based. Conflict between or among some of these values and concepts are to be expected. They do, however, add clarity to attempts to identify ethical issues and resolve conflicts. These new terms and concepts are paternalism, veracity, informed consent, capacity, and confidentiality and are rooted in the health care principles.

Paternalism

Paternalism arises from the Hippocratic tradition and is closely related to the principles of nonmaleficence and beneficence. The Hippocratic approach is based

on the physician (interpreted as including all health care providers in modern times) doing what he or she believes is best for the patient according to his or her ability and judgment. After all, who knows more about oral health and disease than the dentist and hygienist? This approach requires the dentist or hygienist to undertake a role similar to that of a parent. Paternalism means that the health care professional acts as a parent and makes decisions for the patient on the basis of what the professional believes is in the best interest of the patient. Paternalism should never be applied primarily to benefit the professional at the expense of the patient. In fact, many would argue that paternalism should never be applied because it subverts the autonomous wishes of the patient. Thus paternalism and autonomy are in conflict. A dentist or hygienist cannot unilaterally act on behalf of the patient without denying the patient's right to exercise autonomy.

Application of Paternalism

In general, patients today are well informed about health, treatments, and their rights as patients and want to participate in the decision-making process. In years past, however, paternalism (now commonly called *parentalism*) was a common practice partly because the health care provider had superior knowledge and skills and partly because patients expected the health care provider to make decisions in their best interests. Patients often had no knowledge that alternative care options were available. Furthermore, even if patients did know other options existed, many placed the professional in a parental role by asking the professional what they should do. Patients frequently had so much trust in the provider that they would do whatever was suggested. Such paternalistic acts were carried out with good intentions to benefit the patient and often became second nature to the clinician. The historic benchmark for refuting paternalism was a political philosophy essay written in the mid-1800s. Mill's essay remains one of the hallmarks of liberal political theory and is the basis for the societal presumption that individuals are free to act as they see fit.[6]

The responsibility of the dental hygienist is to educate the patient about the balance of benefits and risks of treatment, which often creates a conflict between autonomy and beneficence. This aspect of providing ethical care is most important and requires the dental hygienist to take the time and effort to ensure that the patient has all the knowledge required to make health decisions. A dental hygienist or dentist also can refuse to perform a procedure that he or she considers to not be in the best interest of the patient. Such a decision, which is based on the autonomy of the health care provider, often is done in practice. For example, many dentists have been asked by a patient—and have refused—to remove healthy dentition merely because the patient believes that taking care of dentures would be easier than caring for their natural teeth.

Veracity

> *If your mouth turns into a knife it will cut off your lips.*
>
> **AFRICAN PROVERB**

Veracity is defined as being honest and telling the truth. It is the basis of the trust relationship established between a patient and a health care provider. Veracity binds the patient and the clinician as they seek to establish mutual treatment goals. Patients are expected to be truthful about their medical history, treatment expectations, and other relevant facts. Clinicians, for their part, must be truthful about the diagnosis, treatment options, benefits and disadvantages of each treatment option, cost of treatment, and the longevity afforded by the various treatment options. This allows patients to use their autonomy to make decisions in their own best interest. The obligation of veracity, based on respect for patients and autonomy, is acknowledged in most codes of ethics, including the codes of the American Dental Hygienists' Association (ADHA) and the American Dental Association (ADA).

Application of Veracity

Lying to a patient does not respect the autonomy of the patient and can compromise any future relationships the patient may have with health care providers. Because relationships are built on trust, lying, even little "white lies," easily erodes trust. *Benevolent*

deception is the name given to the practice of withholding information from a patient because of the clinician's belief that the information may harm the individual. This practice is in the tradition of the Hippocratic Oath but is not supported by most codes of ethics and then only in extraordinary circumstances. Only a rare case would justify deceit in the dental setting. The interactive health care relationship between patient and clinician functions most effectively when both parties are truthful and adhere to all promises made in the process.

Informed Consent

Informed consent has both ethical and legal implications in medicine and dentistry and is based on the patient exercising autonomy in decision making. Informed consent is two pronged. First, it requires that the professional provide the patient with all relevant information needed to make a decision. Second, it allows the patient to make the decision on the basis of the information provided. Informed consent could be viewed as a process of providing appropriate information to the patient, the process of understanding and assimilating the information, and making the decision. Thus informed consent involves explaining all aspects of health and treatment and ensuring that the patient comprehends what is being explained.

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Application of Informed Consent

As previously noted in the discussion of autonomy, accepting the decision of the patient when it is in conflict with what the health care provider would most likely recommend is extremely difficult for dental professionals. Dentists and hygienists must recognize that the patient has a right to informed consent as well as a right to make an informed refusal. Respecting the autonomy of individuals as self-determining agents recognizes their right to make their own choices and determine their own destiny. This autonomy includes the right for a patient to assess all the information provided by the professional yet still make a choice that is not the one most valued by the professional. This is known as *informed refusal.* The media frequently provide details of medical dilemmas when a "wrong" or questionable decision is made for another person. For example, parents in some religious groups refuse to allow life-saving treatments for their sick children or for themselves. Although less dramatic than a life and death decision, dental decisions may involve choices that are potentially harmful to the patient. An example of this was provided in the discussion of the principle of autonomy and obedience to the standards of care.

When patients give their authorization for a procedure or a comprehensive treatment plan, they grant the health care provider informed consent for that treatment. Faden and colleagues[7] state that two kinds of informed consent exist. The first is the set of rules that health care providers must serve to obtain and document information and disclosure; the second is the process of interaction and communication, which produces a truly informed decision.

Not all individuals have the ability to make informed decisions about their dental health. Children and people who are mentally disabled typically have a parent or caregiver who assumes that function. Depending on the age and capacity of the child, certain choices can and should be discussed with the younger patient, but actual decisions regarding what types of services are rendered must remain the purview of the legal guardian. Informed consent when the patient does not understand because of a language barrier is not possible, and steps must be taken to remedy the situation. The use of a translator, family member, or other communication option must be pursued to ensure that the patient fully understands the choices and consequences. To do any less is unethical and illegal. The only exception to this would be

if the patient's life were in danger and an immediate procedure were required to save that life.

Capacity

An issue related to autonomy and informed consent is the determination of decision-making capacity. **Capacity** is a clinical term used to describe a person's ability to understand their health care conditions, treatment options and ability to make their own decisions. For an individual to make informed consent, capacity or competence is a prerequisite. This is a growing concern with an aging population as older adults can exhibit a wide range of cognitive function. Older individuals are not only becoming a larger percentage of the population, but they are also living longer. The Census Bureau predicts that one of every five Americans will be 65 years of age or older by the year 2030.[8]

The elements of capacity include understanding, appreciation, and reasoning. These elements are measured by a person's ability to express their wishes, understand information, reason, and arrive at a decision. Questioning the patient as to how he or she is understanding the risks to treatment or why they are declining treatment are among the ways to explore the capacity of a patient. There are objective assessment instruments that can be utilized to help with this determination and routinely used by primary health care providers.[9] Treating a person with a cognitive impairment can present a range of ethical dilemmas.

In the dental setting, assuring that a patient has capacity may often require reaching out to the family, the primary care physician, or surrogate decision maker. It is not uncommon for an individual to have transient or diminished capacity, which is the ability to express his or her wishes on one day and not the next. Awareness of the issues of capacity will assist the dental hygienist in providing ethical and legal oral health treatment to geriatric populations.

Confidentiality

Confidentiality is a critical aspect of trust and has a long history of use in the healing arts. Confidentiality is related to respect for persons and involves the patient exercising his or her autonomy in providing information to the professional. The requirement for confidentiality is mentioned in all codes of ethics as well as the Hippocratic Oath. Trust is necessary for the exchange of personal and intimate information from the patient to the clinician. A patient has a right to privacy concerning his or her medical and dental history, examination findings, discussion of treatment options and treatment choices, and all records pertaining to dental and dental hygiene care. This privacy extends to the way in which information is gathered, stored, and communicated to other health care professionals. Discussion about a patient's history or treatment is not to be shared with spouses, family, or friends; to do so is a violation of confidentiality. Information about a patient can be given to other health care professionals with the patient's permission. When a case is discussed in an educational setting or a second opinion is sought, the clinician who first saw the patient in question should protect the privacy of the patient.

Application of Confidentiality

Conflicts and exceptions will arise surrounding the principle of confidentiality. In certain situations, legal requirements exist to report diseases that can have an effect on the health of the public, such as sexually transmitted diseases. Reporting suspected child abuse, which is required in most states, is a violation of confidentiality. In dealing with minor children, divulging confidential information to the parents may be necessary to protect the child from harm. This is especially difficult with adolescents, who may or may not be adults according to the legal system. The patient's right to confidentiality often must be balanced against the rights of other individuals. In any situation the health care provider must communicate to the patient the professional and legal responsibilities that exist for disclosure and work toward helping the patient as much as possible.

Fidelity is the belief that it is right to keep promises and fulfill commitments. Some philosophers consider this value as stemming from autonomy and the basic idea of respect for persons. Others denote it as a framework of confidentiality. For the health care provider, it includes the duty to fulfill all portions of expressed or **implied promises** made to the patient in