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Ethics of Charity Dental Care—International

Manuscript

Issues in Dental Ethics

Departments

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From the Editor

Can We Have Web Conversations about Dental Ethics?

It is clear that the Internet has opened wide the opportunity for folks to express themselves on the ethical character of the profession. It is not so clear that this has elevated the level of conversation. Even though more people can now talk at the same time, the problem is that the computer has done little to improving listening.

The county where I live is unfluoridated and the council is considering the issue. The scaries are out in force, but the profession has remained silent. I did get an op-ed published in our local newspaper and assumed it went to dead letter heaven since not even my friends said anything about having seen it. By chance I discovered that citizens can post comments about such material on the newspaper's Web site, and I had been commented on. Imagine my surprise when I read "From what he wrote, we can assume the author also supports drone bombing of children in Pakistan."

No self-respecting public or private organization and not many dental practices would ever consider having a Web presence without at least placing the Facebook, Twitter, and other logos where we used to put the Good Housekeeping or the ADA seals. Many professional journals are experimenting with interactive media. A commonly expressed concern is that "younger" dentists live in a social media world, and we need to go where their eyeballs are. A virtual cottage industry has emerged that is financially dependent on our believing that.

Out of curiosity I have been looking at whether electronic communities promote reasoned dialogue on issues such as dental ethics. I started with the American Philosophical Association because I recalled it had announced two years ago that it was sponsoring an interactive ethics site. It has been taken down due to lack of interest with only 12 posts.

At the urging of some of my young colleagues, I went to DrBicuspid. I find this site very useful. The staff writes well-crafted and balanced posts and provides copious links to original source material. With the handy keyword search function on the term "ethics," I found just over 50 posts going back to 2009. Here is a glimpse into how the practicing profession defines the important issues in dental ethics.

The dominant category was reporting ethical "got-ya's." Research might be tainted, New York dentists suspended, dentist sued for suppressing use of Internet, Kentucky board president under investigation, state looks into corporate dentistry practices, Medicaid fraud, legislation against DMSOs, students cheat in dental school, dentist fined for prescribing for friends. Another common type of posting could be called breast-beating—"dentists as victims." Examples of this type included dentists' incomes declining, public trust in the profession dipping, dentists embezzled, and a summary of a general presenta-tion of declining ethics in the profession given at the 2011 ADA annual meeting. There were also a few soapbox orations ("the world would be better if everyone did things my way") and three announce-ments: one soliciting nominations for the ADA's Golden Apple service award, one offering suggests for better office automation, and one explaining what the Student Professionalism and Ethics Society does. There were no posts about how dentists could become more ethical or how oral health could be improved.

But my interest was in the ways this electronic forum would be used by practitioners to build constructive dialogue. Half of the postings stimulated no comments. None of the positive postings, such as the student ethics group or the service award were answered. For the most part, advertising others' missteps passed without comment. But professional hand-wringing in public did generate interest, as did the "editorials." Rehearsing the woes in the profession was the best way to work up interest. It seems that

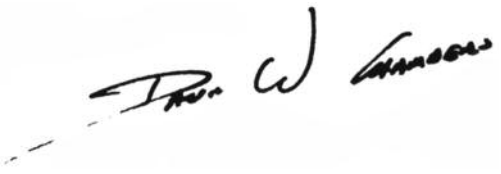
dentists in America are under siege. The comments were generally of two types. "You don't have the facts right, or at least these are not the facts as I understand them" and "I agree that the sky is falling, but you are wrong to attribute it to the insurance companies; the real villain is foreign-trained dentists."

In this small sample, I think I might have detected the key to participation in online chats. I call it the "generalization pivot." It works like this: somewhere in each posting (original or comment) there is a generalization that matches a hot button in potential respondents' thinking. The next comment in line is built on that generalization only (not the intent of the original message), and the pivot can be positive or negative. The comment on my op-ed about bombing Pakistani children hinged on my use of the phrase "public policy decisions." That was enough to justify a logical arabesque of awe-inspiring proportions. It is difficult to explain otherwise how good DrBicuspid journalism could lead to comments about cosmetic dentistry being part of the Obamacare conspiracy or the poor in this country deserving bad teeth or the slip in Gallup ratings of dentists by the public being the result of the president's drug habit.

The most common practice was to comment on the previous comment. The final posting often bore no relationship to the original message. "Going viral" may not mean that a message is seen by a large number of people. It may mean that a message mutated as it was passed along.

Comments in the blogosphere serve more as opportunities for self-expression than for discussion. The 46 comments posted in the sample came from 30 individuals. This is nothing close to being a random sample of the dentists in America and is probably a small fraction of the subscribers to DrBicuspid. One of the opinionated commenters on ethics had a total of 396 posts (all subjects considered), one had 175, and three had made more than 50. DrBicuspid promotes comments by recognizing contributors on frequency (not content) of comments.

Almost 50 years ago the Canadian communications thinker Marshall McLuhan said "the medium is the message." I have no comment to add.



"Going viral" may not mean that a message is seen by a large number of people. It may mean that a message mutated as it was passed along.

Letters to the Editor

The dental insurance industry's primary interest is profit for shareholders not patient care.

To the Editor,

Dr. Ten Pas has very interesting viewpoints regarding dental insurance. Accepting PPOs, I do not consider myself an insurance company "employee." If so, where is my vacation pay? I work for my patients, my staff, and my family. I suggest all parties involved in the dental healthcare field are stakeholders not "employees," each with different priorities.

Dr. Ten Pas states the "freezing or decreasing fees...with little or no notice" is a tactic used in unilateral nonnegotiable agreements such as dental provider agreements. Another component that affects the dentist's survival is increasing costs of dental supplies forcing dentists to pay more for overhead while getting less money due to unreasonable fee schedules. Understandably, dentists do not consider insurance companies a partner. Passing this reduction of fees without due notice onto the "constraints caused by employers being less munificent," shows insurance companies' profits are more important than responsible coverage or fair payments. Let the dentist take the financial loss. The insurance companies may need to charge employers more rather than maintain their profits at the dentist's expense.

The bundling of procedures is another tactic to reduce the reimbursement. Bundling pins with build-ups then bundled with crowns is an example of gaining profits. In the 1970s, there was no bundling. The expertise of placing a pin and a build-up are different. Theoretically and ideally, treatment rendered should be unbundled and billed properly for every service rendered. Let the insurance company bundle it. Let's not do it to ourselves.

In the 1970s, the $1500 yearly maximum allowed the dentist to provide treatment in a timely manner to the patient. Now, we must work within the "crown-a-year club," delaying needed treatment. Insurance companies, please increase the yearly maximum to at least keep up with your fee schedules. You cannot sell "Cadillac" dental plans for "Chevy" prices and not expect problems.

The sharing or leasing of fee schedules is never told by insurance companies. Dr. Ten Pas is correct, "most dentists do not understand the demographics of business, of different networks"; but, I do believe dentists are fully aware of the "demographics.....of patients that make up their practice." Questioning a contract clause is referred to their attorneys emphatically stating it is a "take it or leave it" contract which is nonnegotiable. This frustrates dentists when the largest employers in the area select an unreasonable insurance plan due to its cheapness. The dentist must either sign it or perish.

I do not agree that the dentists and the dental insurance industry are "in

the same boat." The dental insurance industry's primary interest is profit for shareholders not patient care. We have a Code of Ethics.

Calling dentists "employees" of an insurance company is not a good start. All must be willing to have patient care be held most important. To do otherwise would be a continuation of the current situation.

Joseph Graskemper, DDS, JD, FACD
Bellport, NY

Author Response

Dr. Chambers,

I appreciate the policy of *JACD* which offers those whose papers have generated letters to the editor the opportunity to comment.

My article in the last issue of last year's journal, "Can Power Be Shared?", was meant to call attention to my concerns that the dental profession, which has always viewed the loose assembly of independent practitioners as a strength, needs to find common ground and fashion unified approaches to enhancing oral health care. The world of health benefits is changing due to government policies and consolidated power among purchasers.

I had hoped to draw attention to the need for all parties to work together to improve the value proposition we can offer the public. For too long, we have fought over how to share the rewards of providing the best dental care that has ever existed, without realizing that the size of that reward has begun to shrink in recent years.

If the practicing profession and insurers sat on the same side of the table we could accomplish much. That is the conversation I had intended to start.

For the record, my article did not refer to dentists as "employees" (of insurance companies) and I certainly do not regard them as such.

Bill Ten Pas, DMD, FACD
Portland, OR

If the practicing profession and insurers sat on the same side of the table we could accomplish much. That is the conversation I had intended to start.

Correction

On page 43 of the Winter 2013 issue, in the article by Dr. Gary Stafford on "Dental Student Indebtedness," it is stated that "In fact, with an unemployment rate of 0.7%, dentistry is one of ten occupations that has the lowest overall rates across all U.S. occupations." That statement is correct. Unfortunately, Figure 6, on page 47, contains an error of scale. The 0.7% rate in the text is correct.

The Ethics of Charity: International Perspective

An Introduction to the Issue

Anthony T. Vernillo, DDS, PhD, MBE
Alexander J. Schloss, DDS, MSB

For of the most high cometh healing
—The Book of Ecclesiasticus 38:2

Non nobis solum nati sumus (Not for ourselves alone are we born)
—Marcus Tullius Cicero

The interplay between these two quotes constitutes the quintessential ethical mission of 21st century dentistry—promoting oral health across the globe. The necessity for carrying out this mission was identified by the 2010 Global Burden of Disease (GBD) study, funded by the Bill and Melinda Gates Foundation. This study, in examining the health of the world's population, found that oral conditions, excluding oral cancer, affected 3.9 billion people, with untreated dental caries in permanent teeth being the most prevalent of the 291 diseases studied (Marcenes et al, 2013). Commitment to addressing this condition was voiced by the International Association for Dental Research (IADR), when it declared that promoting global oral health must be a high-priority goal of the profession, and that a particular focus should be placed on the reduction of global health inequality. (Sgan-Cohen et al, 2013).

Interest in global health is on the rise among healthcare professionals and trainees. A 2009 survey showed that half of all dental schools offer international volunteer opportunities to their students (Cohen & Valachovic, 2012). The nature of short-term global health experiences abroad varies in length, purpose, and participants. This heterogeneity of short-term experiences presents challenges in distinguishing between voluntourism (combined volunteering and tourism) and responsible engagement in global health (Seymour et al, 2012; Snyder et al, 2011). When conducted in an appropriate manner, these volunteer experiences are important instruments in promoting global oral health (DeCamp, 2011). However, a misguided outreach program can cause harm both to the communities and to the individuals they purport to serve, in addition to risk wasting the resources invested (Holmgren & Benzian, 2011).

Various short-term international experiences have provided valuable help and promote beneficence for many individuals. What has been lacking, however, has been a centrally organized, unifying strategy aimed at establishing a minimum standard of care to be available to all communities of the world, that is, global health equality. The IADR has set forth this high priority goal for the profession.

This quarter's theme issue of the *Journal of the American College of*

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Appreciation is extended to both of them for their work as guest editors.

Dentists has gathered an esteemed group of committed professionals, from the United States and abroad, to discuss conducting these international experiences. Friedman et al. present an ethical framework for short-term international dental and medical activities. Roucka discusses the necessity of conducting these outreach experiences in a manner consistent with the five principles of ethics identified in the ADA's *Principles of Ethics and Code of Professional Conduct*. Bohnert describes her volunteer experience in the Dominican Republic while a dental student. Schloss and colleagues highlight the ethical principle of respect for communities in providing ongoing, sustainable care to communities after the volunteers depart the community. Naidoo presents a rights-based case for reducing disparities in oral health care in the historical context of the South African apartheid experience. Keller and colleagues discuss the importance of having dental and medical students treat refugees to the United States who have survived torture abroad. And finally, Bergman and Vernillo discuss the important role played by corporations, like Henry Schein, Inc., in providing the leadership necessary to carry out these international outreach experiences. The common thread in all of these discussions is the need for the public-private partners to collaborate with the communities in transforming short-term experiences into long-term sustainable solutions in the manner specified by the communities themselves. ■

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What has been lacking, however, has been a centrally organized, unifying strategy aimed at establishing a minimum standard of care to be available to all communities of the world, that is, global health equality.

Developing an Ethical Framework for Short-Term International Dental and Medical Activities

Alexandra Friedman
Lawrence Loh, MD, MPH
Jessica Evert, MD

Abstract

The popularity of volunteering to provide charity health care in third-world countries has increased dramatically in recent years. While there are advantages to both those being helped and to volunteers, there are also ethical issues that need to be addressed. A framework for analyzing the ethical impact of such service is presented which continues 27 principles that should be addressed.

In an interview, Peter Singer, moral philosopher and Professor of Bioethics at Princeton, observed, "More often there is a compromise between ethics and expediency." To avoid this compromise when considering or undertaking engagement in short-term international medical and dental activities, it is prudent to develop and operationalize an ethical framework—both on a program and an individual level. It is recognized that embarking on clinical volunteerism without first considering alternative or supplemental activities that may have a greater benefit on community health is potentially harmful (Wilson et al, 2012). Similarly, embarking on such activities without considering the ethical framework guiding the activity represents the compromising haste alluded to by Singer. The utility of short-term medical and dental activities has been increasingly scrutinized (Seymour, 2012). By developing an ethical framework and consciousness for these activities, participants and programs have the potential to evolve from engaging in short-term "band-aids" toward structuring programs that prioritize sustainability, local health systems integration, and facilitation of alignment with the goals of global health (Mouradian, 2006; Seymour, 2012; Vaduganathan 2014).

The Rise and Impacts of Short-Term International Dental and Medical Activities

Interest in global health is on the rise among healthcare professionals and trainees, driven by the globalization of multiple sectors (Crump & Sugarman, 2008). Short-term participation, in particular, has grown in popularity. In 1978 only 6% of medical students participated in health-related activities abroad, with recent data showing 32% participating in global health education and service activities during medical school (AAMC, 1978; 2013). A 2009 survey similarly showed that half of all dental schools offer international volunteer opportunities to their students (Cohen & Valachovic, 2012).

The nature of short-term global health experiences abroad varies in length, purpose, and participants. Trips may range in length from two days to four weeks (Maki, 2008). Teams are often multidisciplinary and activities during such trips may include research,

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service, education, and public health projects (Crump & Sugarman, 2010). This heterogeneity of short-term experiences presents challenges in distinguishing between voluntourism (combined volunteering and tourism) and "responsible engagement in global health" (Seymour, 2013; Snyder, 2011). What is increasingly clear, however, is that poorly planned short-term international medical and dental activities that do not consider ethical implications run the risk of falling under the former designation, with numerous unintended consequences. For example, there is a growing recognition that the provision of service by visitors from high-income countries often competes with and further weakens existing host community health systems (Seymour, 2013). International activities that are short-term and sporadic are often accused of being a band-aid approach that do not attend to underlying causes of ill health (Mouradian, 2006).

Despite these concerns, the motivations and benefits attributed to visiting participants of short-term international experiences are well documented in literature. These include improved clinical knowledge and skills, enhanced global perspective, fostering of international career intentions, increased dedication to underserved care domestically, and an increased appreciation of public health (Dowell & Merrylees, 2009; Drain et al, 2007; McBride et al, 2010). Institutions also benefit from experiences in healthcare provision abroad by competing for desired candidates, drawing needed funding, and building international reach and prestige (Dowell & Merrylees, 2009).

For hosting institutions and communities, however, the benefits of short-term trips are far less clearly defined. While their receptiveness to such trips can link them to future aid, knowledge exchange, and resources (Crump & Sugarman 2008; Dowell & Merrylees 2009; McBride et al, 2010), receiving communities also bear numerous potential harms. Local patients may be at risk of being treated by inexperienced, foreign trainees; the magnitude of potential harm is further increased by language and cultural barriers (Crump & Sugarman 2008). At the same time, host institutions use great time and resources to accommodate short-term volunteers, faculty and trainees, orient them, and provide logistic support (Dowell & Merrylees 2009). A lack of resources limits the ability of these institutions to evaluate and inform their decisions to host such endeavors (Provenzano et al, 2010).

These tensions, coupled with increasing interest in global health participation by dental and medical professionals, highlight the need for comprehensive ethical approaches to short-term experiences abroad (Crump & Sugarman, 2008; Machin, 2008; McBride et al, 2010; Sherraden et al, 2008). The World Dental Federation (FDI) Guidelines for Dental Volunteers provide directives to mitigate risks and set best-practice standards for dental volunteering worldwide. These

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guidelines include the recommendation that volunteers join a project that is integrated into the host community and recognized by host government, as well as one that conforms to legal requirements for the practice of dentistry (FDI 2005). These guidelines are commensurate with the ethical tenets of prioritizing sustainability, common good, and respect for persons. A 2011 American Dental Association (ADA) resolution, issued in response to concerns about untrained students performing dental procedures abroad, called on both dental and predental students taking part in international volunteer activities to adhere to the ADA *Principles of Ethics and Code of Professional Conduct* and to only perform procedures for which the volunteer has received proper education and training (ADA, 2011).

Ethical Analysis of Short-Term Medical and Dental Activities

The first, critical step in developing an ethical framework for short-term medical and dental activities requires a broader understanding of ethical analysis. Ethical analysis generally evaluates four central components (Jennings, 2010):

- Character and intentions of the agent: what virtues and vices does the agent exemplify?
- Inherent properties of an action: what rights and duties does the action fulfill or violate?
- Consequences (most often understood as causal effects) of an action: what benefits or harms are brought by the action?
- Context in which the action takes place: does the action support or undermine the system or context which makes the action possible or meaningful in the first place?

By applying these questions to international short-term medical and dental work in a generic sense we begin to foster a dialogue about the ideals, tensions, realities, and consequences of such activities. Using this analytical framework to consider each short-term project or international engagement effort lays the foundation of inquiry necessary for developing an ethical framework.

Ethical Principles to Consider When Developing an Ethical Framework

The ethical principles that may apply to short-term international service activities are many. The accompanying table represents an array of principles, ranging from foundational bioethical tenets to those specific to international activities and the power dynamics therein. While the traditional bioethical principles of justice, beneficence, nonmaleficence, and autonomy do apply, they are often interpreted or valued differently in a global setting (Pinto & Upshur, 2013). Foundational bioethical principles alone are insufficient to provide a comprehensive ethical evaluation of the potential pitfalls of short-term international activities. Thus, a more robust framework is necessary, preferably one that challenges and prevents the usual shortcomings of such activities from being manifested.

Literature has described six domains of ethics for international global health activities and programs, including social ethics, professional ethics, clinical ethics, business ethics, organizational ethics, and decision ethics (Evert et al, 2014; Porter, 2004). Four ethical commitments and considerations suggested by Wilson and others (2012) for short-term international service activities include: (1) *service* that is in the best interest and addresses the needs of each patient; (2) *sustainability* through training of

the trainer models, use of locally available medications and astute outcomes assessments; (3) *professionalism* that ensures that community and existing health systems are not left worse off by short-term efforts and that ethical patient care standards practiced in visitor's home country are upheld when visiting an international, underserved community; and (4) *safety* that includes appropriate approvals from local health organizations to be involved in patient care, pre-travel medical clearance, and in-country security measures. Others have suggested the centrality of collaboration between often disparate, parallel short-term international activities and with local partners as being an ethical imperative (Loh et al, 2012). An ethical framework for global health aimed at students suggests the importance of tenets of humility, introspection, solidarity, and social justice (Pinto & Upshur, 2009), while other frameworks include distributive justice, respect for persons, and sustainability (Evert et al, 2014).

Crump, Sugarman and the Working Group on Ethical Guidelines for Global Health Training (WEIGHT) proposed guidelines for establishing trips; preparing for visits; ensuring open communication before, during and after the trip; monitoring impact; and soliciting feedback (Crump & Sugarman, 2010). These and other ethical guidelines inform program structure, impact measurements, and operations of short-term global activities. Ethical guidelines and frameworks that fail to penetrate the execution of programs from planning to delivery stages may actually be more harmful as they can serve as a deceptive veil for ethically unsound activities.

The next step, considering the principles described, is to identify a process by which an ethical framework can be created for each unique short-term healthcare activities abroad. This process should ideally occur at the individual, organizational, or project level and be consistent between levels. An ethical framework is as important as the project framework in permitting program leaders and stakeholders to reflect on their activities and goals through an ethical lens and to outline ethical priorities and integration of tenets into projects or programs. However, it is often a choice of which principles will be prioritized in program development and operations, as it is difficult to prioritize all ethical principles simultaneously. In addition, certain ethical principles can potentially conflict with one another. For example, focusing on the principle of need and addressing needs of patients or a community in an immediate, time-limited sense, may be in conflict with prioritizing sustainability if perpetuation of the intervention is not possible, or in conflict with professionalism if addressing the immediate need requires someone to act beyond his or her level of training. In the table below we list and define key ethical principles that might be included in the development of short-term international service activities' ethical frameworks. Programmatic ethics governs clinical care selection, design, implementation, and follow-up, ensuring that activities are ethically sound before, during, and after the trip, while individual (participant) ethics govern thought, communication, and behavior before, during, and after the short-term activity. Relationship ethics governs the partnerships that are an ideal component of any international effort between high-income country entities and those in low and middle income countries.

Similarly, an ethical framework is useful in program evaluation. Programs and individual participants alike should consider the ethical guidelines upon trip completion, critically assessing the principles that were upheld and those that were challenging to accomplish. Open conversations about potential improvements should be a part of the discussion. Where possible, the host community or institutions therein should be included in reflection and evaluation process.

Avoiding Harms of Band-Aids: Compulsory Ethical Principles for Short-term International Activities

In order to avoid the pitfalls often associated with short-term international medical and dental service activities, we suggest that six ethical principles be compulsory for any framework applied to short-term international activities. These are sustainability, transparency, humility, professionalism, collaboration, and nonmaleficence. By embracing these tenets, projects will have to be thoughtful to collaborate with local health systems, as well as other short-term visiting teams (Vaduganathan, 2014). Ensuring professionalism and not doing harm, either on individual patient or community-levels, will require projects to contemplate potential harms and distractions from health systems strengthening. Prioritizing transparency requires a degree of humility that translates into efforts being clear with regard to their reach, capacity, and limitations both with patients and with community-based stakeholders. Finally, by emphasizing sustainability over tempting transient quick-fix efforts, projects can begin to integrate long-term impacts into short-term programmatic operations.

Discussion

Developing an ethical framework is essential for any short-term medical or dental activity abroad. The use of such frameworks allows participants,

program leaders, and institutions to determine if the nature of the activities, their impact, and their sustainability are optimal. A realization that this is not the case may dissuade further participation short-term activities or encourage pursuit of alternative models of engagement in the global health arena.

We have presented ethical principles that can be incorporated into a framework for the selection of, preparation for, and implementation of international short-term medical and dental activities. We believe that by examining ethical considerations repeatedly from project conception to execution and evaluation, all stakeholders are more likely to benefit. In addition, viewing the short-term activity through a variety of perspectives, including those of locally-based native health providers, host community members who are pulled from their usual duties to support visitors, as well as that of the visiting volunteer can, lead to valuable insights (White & Evert, 2012).

Foundational bioethical principles alone are insufficient to provide a comprehensive ethical evaluation of the potential pitfalls of short-term international activities.

Due to the diverse nature of short-term medical and dental international activities, the application of ethical principles to develop a framework will not result in a uniform framework for all projects. The universality lies in the need and responsibility to develop a framework. Effective implementation of ethically sound short-term international activities will increase the likelihood of critical assessment of impacts. It may also lead to a decision to not take part in short-term international volunteer efforts in favor of other activities that contribute to global health, such as advocacy, fundraising, and research, to name a few. Using ethical frameworks, with a prioritization of transparency, humility, sustainability, professionalism, collaboration, and nonmaleficence will be a crucial piece of the next generation of short-term medical and dental international activities.

While the imposition of an ethical framework may make it more difficult for ad hoc, organic, short-term global health experiences to develop, it is important to note that many of the tenets described here call for greater involvement of local stakeholders and critical examination of the work being conducted. Indeed, applying any ethical framework to a stand-alone, "one-off" trips will likely result in a clear message that participation in such experiences may not necessarily be impactful, nor in line with accepted ethical tenets. Greater advocacy work, arising from this framework and in line with the guidance of other organizations, will encourage a generation of interested young health-care professionals and trainees to critically assess any short-term volunteer work they might take on abroad. ■

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Ethical Tenets for Developing an Ethical Framework in Short-term International Dental and Medical Activities

	Principle Definition	*Guiding Questions*
Solidarity	Alignment of goals and values of yourself with the community you are working in and with (Pinto & Upshur, 2009)	How are my goals and values aligned with the goals and values of the community I am working with?
Humility	Unpretentious openness, honest self disclosure, avoidance of arrogance, and modulations of self-interest (Coulehan, 2011)	What are my limitations to impacting the host community? How can I delegate or turn over power to those traditionally less powerful?
Introspection	Looking inward, honest self-reflection (Pinto & Upshur, 2009)	What contributions have I made? What potential harms/costs has my activities had?
Authenticity	The degree to which one is true to one's self	How transparent are my motivations? How authentic am I being in what I am claiming to do and what I am actually doing? How do my actions abroad compare to how I act at home?
Veracity	The duty to tell the truth	How honest have I been with those around me?
Openness	Being open to people, ideas, and criticism (Gill, 1999)	How open am I to people who are different from me? How am I listening to my hosts? How am I accepting divergent views from my own?
Social Justice	View that everyone deserves equal economic, political, and social rights and opportunities. Recognizing the historically deep and geographically broad understanding of gross inequities, power imbalances, and other underlying causes of ill health	What broad determinants of health exist? How is disempowerment bred and sustained? How is my project contributing to equity?
Principle of Double Effect	An action that is good in itself has two effects: an intended and otherwise not reasonably attainable good effect, and an unintended yet foreseen evil effect (Ashley & O'Rourke, 1997)	What problem does this program hope to address? What other unintended effects might it have?
Distributive Justice	Basic good should be distributed so that the least advantaged members of society are benefited	How can our program ensure resources reach those in most need of them?
Principle of Need	Each person is guaranteed the primary social goods that are necessary to meet the basic needs in the society in which one lives, assuming there are sufficient social and economic resources in the society to maintain the guaranteed minimums	What basic needs can this population not meet because of lack of resources, how can we address these? How is the guaranteed minimums in the community abroad different than your reference community?
Equality	Regardless of their inputs, all group members should be given an equal share of a societal benefit	How are the benefits of the project distributed among the population? How is this project tied to addressing inequalities?
Sustainability	Behaving in a way that can be continued or sustained. The ability to continue a project or effort long-term is valued over other efforts that may have a more immediate, but finite, impact	How will the impacts of this project be maintained? What lasting effect is the project having after short-term visitors and volunteers left?

Ethical Tenets for Developing an Ethical Framework in Short-term International Dental and Medical Activities Cont.

	Principle Definition	*Guiding Questions*
Respect for Persons	The duty to honor others, their rights and their responsibilities. Showing respect for persons implies we do not treat them as a mere means to our ends	How are people in this project treated: as means or ends? How are local health practitioners, professional standards being respected?
Liberty	Each person has an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for all	What basic rights are absent for this group and how can our project work to resolve this?
Common Good	Having the social systems, institutions, and environments on which we all depend work in a manner that benefits all people (Velasquez et al, 1992)	How does this project contribute to the community and systems created to serve the entire community?
Beneficence	All forms of activities intended to promote the good of others	How are the welfare of the host community and patients prioritized?
Nonmaleficence	Avoiding harm to others	What are the potential harms caused by our project? Do we have the proper skills to carry it out? How will we recognize and mitigate harms?
Informed Consent	The right and responsibility of every competent individual to advance his or her own welfare. The right and responsibility are exercised by freely and voluntarily consenting or refusing after being given the most information available from which to base a decision	How can people related to this work be fully aware of what their participation means? How can patients consent to care in an informed fashion in the context of short-term activities?
Human Dignity	The intrinsic worth inherent to every human	How can this work respect the worth being of every individual? How about the dignity of native healthcare workers? Community leaders?
Stewardship	The responsible planning and management of resources	How can this work best be planned and organized? How can resources be maximized?
Subsidiarity	Requires that those in positions of authority recognize that individuals have a right to participate in decisions that affect them	How can the voice of the people this work involves best be accounted for? How can the power be decentralized to those at the most fundamental levels of the community?
Conflict of Interest	When an individual or organization is involved in multiple interests, one of which could possibly corrupt the motivation for an act in another	What prior connections could affect his work? How could my [the project's] allegiance to one entity or goal corrupt another of my [the project's] interests?
Transparency	Acting in such a way that it is easy for others to see what your actions are and the motivations for your actions	How am I ensuring my motivations and activities are transparent to the host community?
Altruism	Living for the sake of others actions are right if they are more favorable for others rather than for the agent (Comte, 1852)	Are my actions beneficial only to the host community at my own expense?

	Principle Definition	*Guiding Questions*
Mutual Altruism	Altruistic activities are bilaterally beneficial and represent enlightened self-interest (Mendonca, 2001)	Are my actions beneficial to both the host community and myself? If so, how are we both benefiting? How am I acknowledging this self-interest?
Professional Ethics Professionalism	A group of ethical tenets laid out by professional bodies; generally includes acting consistent with professional ideals and stature required by a professional skills set	Are the tasks assigned to volunteers commiserate with their professional level and formal training? Am I providing a standard of care that is similar to that I would expect for myself or provide in my home context?
Collaboration	A cooperative approach to working together and problem-solvi common values include joint decision-making, open communication, respect among group members (Stevens and Bhardwaj, unpublished)	Are all the important stakeholders acting in partnership and able to provide their input into joint activities for the betterment of the receiving community? Are these partnerships fair and equal, free of coercion?

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Health and Human Rights

A South African Perspective

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Abstract

General statements of basic entitlements are established as a guide for potential laws and regulations protecting human rights. Human rights are those claimed to belong to every individual regardless of nationality or position within society. The historical evolution of human rights relative to health in the Republic of South Africa is discussed.

Human rights are universal benchmarks that reflect consensus to hold governments and the private sector accountable for the fulfilment of the fundamental needs of individuals. They also constitute the foundation on which both international and national laws and guidelines are based for conducting human research. There has been a reawakening of the need for human rights around the world as overt human rights violations affecting the health of both individuals and populations continue unabated. Such violations can sometimes be engineered or endorsed by governments, institutions of power, and individuals (Gruskin, 2007). While this concern is often misconstrued to be a misguided sense of paternalism by wealthy nations for the poorer developing nations, it is important to reiterate to health professionals—including dental professionals and dental students—that human rights should be imperative to the delivery of care and the for the implementation of public health programs. In this regard, one needs to consider the empirical values on which the notion of human rights are founded. Human rights are universally applicable social or material entitlements that are essential to fulfil fundamental needs that individuals can claim from society on the basis of their humanity. They are a core element of professional obligations for healthcare workers.

Human rights and health are intertwined by the positive and negative effects on health promotion, neglect, or violation of human rights; the effect of health on the delivery of human rights and the effects of public health policies and programmes on human rights (Mann, 1994). Furthermore, the preface of the WHO constitution states that health is the "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" and "the highest attainable level of health is the fundamental right of every human being." The importance of incorporating human rights into ethical and professional standards for health professionals have been recognized by most national and international bodies.

This paper discusses why it is important for dental students to be familiar with the human rights of patients and the fundamental link between the notion of rights and the ethical principles required to ensure that patients get effective and appropriate health care. It provides an overview of the content that dental students in South Africa receive during their undergraduate training. It provides a brief historical perspective from a global setting and explores the South African experience of health and human rights by examining material generated by the

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South African Truth and Reconciliation Commission in terms of public health and human rights before discussing some of the ways South Africa has addressed these issues in the Bill of Rights and Children's Rights.

A Historical Perspective

The human rights movement originated from the devastation of World War II and the concerns for crimes against humanity, such as state-sanctioned genocide, torture, and slavery. Following the Nuremberg Trials, human rights were incorporated into international law by the Universal Declaration of Human Rights that was signed in 1948. It highlighted the importance of the promotion and protection of human rights as a prerequisite for health and well-being. Although not legally binding, it was designed to inspire a culture of respect for human rights, and as a document it has had a powerful influence on the human rights movement as a whole. Over the past 50 years the international community has endorsed key agreements that establish guiding principles and specify standards that define universal human rights. More recently, the emergence of the HIV/AIDS pandemic, its infectious nature, associated stigma, and discrimination challenged the traditional ethical values of the healthcare profession and reinforced the links between health and human rights.

The Universal Declaration of Human Rights

Human rights are primarily rights individuals have in relation to governments. Human rights require governments to refrain from doing certain things, such as torturing persons or limiting freedom of religion. It is also required of governments that they take action to make people's lives better, such as providing education and nutrition programs.

Nondiscrimination is the overarching principle of the document. It is based on the premise that "all human beings are born free and equal in dignity and rights, and are endowed with reason and conscience." Other issues covered include the prohibition of slavery, torture, and arbitrary detention. Freedom of expression, assembly, and religion are protected. The right to own property and the right to work and receive an education are also covered. All rights are interdependent and interrelated and as a result individuals rarely suffer neglect or violation of one right in isolation.

Health and Human Rights in South Africa

Violations of human rights can occur across the spectrum of health care and affect peoples' health and well-being. Health professionals, including dentists, have a role to play in the reduction and prevention of these violations and to ensure that health-related policies and practices promote rights. But they need to be educated about how to do this and

> The TRC concluded that "the health sector, through apathy, acceptance of the status quo and acts of omission…allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights."

therefore it is crucial that a culture of human rights be fostered within the dental profession, be incorporated into their work, and become an integral part of dental training curriculum. This has been particularly pertinent for South Africa, where there is still much anger and resentment from the past injustices of apartheid.

In 1998, the South African Truth and Reconciliation Commission (TRC) made history by holding "health sector" hearings that looked at the role the health sector played in human rights abuses during the apartheid era and demonstrated that the health profession in South Africa had a reputation of complicity in the violation of human rights. The TRC concluded that "the health sector, through apathy, acceptance of the status quo, and acts of omission... allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights." Human rights abuses committed by "agents of the state" were often assisted by healthcare professionals who, through either passive or active collaboration, failed to defend the human rights of vulnerable patients. Rights violations in the health sector affected black medical and dental students, black doctors and dentists, and most importantly, patients of color—in hospitals, in private practices, in police custody, and in prisons.

The enquiry to investigate racism in the Faculty of Medicine, University of Witwatersrand between 1940 and 1994 revealed some disturbing facts. This enquiry was prompted by "anger and resentment" within the faculty and associated hospital services, relating to past discrimination that had been "neither acknowledged nor resolved." According to the report, when the National Party came into power in 1948, it pressured universities to observe apartheid laws. Social segregation was tightened and the intake of black students into health sciences was limited (Shear, 1996). The Faculty of Dentistry, although prepared to accept black students for *preclinical* training, consistently refused to admit them in the *clinical* years on the grounds that there were inadequate facilities available for their training. In August 1944 the Board of Dentistry adopted a recommendation that the faculty agree in principle to the provision of facilities for the training of black dental students and that every endeavour be made to provide such facilities, however, in its representations to the Minister of Education and Native Affairs in this matter, the university expressed the view "that the number of non-Europeans likely to qualify for admission to the clinical years of study would not justify the establishment by the university of a separate non-European dental hospital" (Shear, 1996).

In August 1946 a government Committee of Inquiry recommended "that the training of non-European dentists not be regarded as a matter of urgency since, for some years to come, very few non-Europeans are likely to present themselves for training and consequently it will be necessary, and probably best, that the dental health of the non-European community be catered for through the medium of European dentists" (Shear, 1996). This was consistent with the representations that had previously been made to responsible ministers, but it contradicted the evidence presented to the Government Committee by the faculty that there was "a considerable need for dental services for non–Europeans," that bursaries should be provided for the recruitment of non-European dental students, and that facilities for their training should be provided. It was only much later, in the mid-1960s, that the first black students were admitted to study dentistry, and then only in very small numbers (Shear, 1996).

Black dental students endured a host of discriminatory and humiliating acts from the 1960s onward and these included the following:

- Students were not to come into contact with nor perform any clinical procedures on white patients.
- They were reprimanded for passing through a surgery for whites or having a quick look at a rare and interesting case involving a white patient.
- They were allocated black cadavers only for anatomy.
- They were not admitted to the main student's residences, were not free to use the sport facilities, and were excluded from formal student social functions.

In the early 1970s, the Wits SRC insisted that black students be allowed to sit on the stands during the annual intervarsity rugby match against the University of Pretoria. The university did not agree to it, relations were broken off and there were no intervarsity matches for the ensuing 20 years.

These issues serve to illustrate the unhealthy and unethical context in which black dentists in South Africa have been trained in the past. How have

these experiences influenced the personal value systems and self-esteem of these dentists? Even today, in post-apartheid South Africa, most dentists of colour are hesitant to open private practices in "predominantly white" areas. In South Africa, black dentists have a predominantly black patient base and tend to practice in "black areas" and townships. In State Health Facilities today, however, black dentists examine and treat white patients.

The Present Scenario in South Africa

In South Africa, health is recognised as one of the socioeconomic rights and the language of human rights highlights basic needs such as equality, housing, education, nutrition, and sanitation. Article 25 of the Universal Declaration is of special importance to healthcare professionals: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services." Improvement in each of these areas and creating opportunities for people to reach their full health potential (for example through the right of access to health care) can have a major role in improving health. These sentiments are echoed in Chapter 2 of the Constitution of the Republic of South Africa (adopted in 1996)—the Bill of Rights. The Patients' Rights Charter is also based on a culture of human rights. Healthcare workers at the very least carry obligations to ensure that they are not responsible for violations of human rights and they can act positively as advocates to promote and fulfill human rights.

The Bill of Rights in the South African Constitution

The Bill of Rights in the South Africa Constitution was ratified in 1996, and it categorized a range of health rights: the specific right to receive healthcare services; rights related to the underlying conditions needed for health, which through their fulfillment, enhance health; rights for vulnerable groups and foundational rights that acknowledge our common humanity and principles of equality (see Table 1). Section 27 addresses the right of access to health care, food, water, and social security. The legislature grouped these rights together and recognized that such rights are linked and contribute to the overall wellbeing of an individual.

The main right to health in South Africa affords people the right of access to health care on the basis that the government will progressively realize this right. Healthcare providers cannot act to obstruct patients' rights to access health care, nor refuse to provide treatment for emergencies. Rationing of health care can be compatible with human rights provided it is conducted in a transparent manner and the criteria used are reasonable and nondiscriminatory. Human rights may be limited, but only if it is done to protect others' rights, or in the public interest, subject to fair procedures. All rights in the South African constitution are enforceable and binding to the State and since 1994, the country has introduced many new policies including: free primary health care services for all citizens; free health care for children under six years, pregnant women, and disabled people, and a patient's rights charter. The Bill of Rights has not only inspired substantial reforms in social security and health policies, but it has also given South Africans a way to accomplish such reforms.

Rationing of health care can be compatible with human rights provided it is conducted in a transparent manner and the criteria used are reasonable and nondiscriminatory.

Table 1. Health Rights in the South African Constitution

Category	*Provision*	*Section*
Health Care Services	To have access to health care services, including reproductive health	Section 27.1 (a)
	Access to emergency health care	Section 27.3
Underlying Conditions Needed for Health	To access information	Article 32
	Access to an environment that is not harmful to health or well-being	Article 24
	Access to freedom and security of person, including freedom from all forms of violence	Article 12
	Freedom of religion, belief, and opinion	Article 15
	Be free from medical experimentation without informed consent	Article 12.2 (c)
	To have access to adequate housing	Article 26
	Access to a basic education, including basic adult education and further education	Article 29
	Access to sufficient food and water	Article 27.1 (b)
	Access to social security	Article 27.1 (c)
Vulnerable Groups	Children have the right to basic nutrition, shelter, basic health care and social services	Article 28
	Prisoners have the right to conditions of dentition consistent with human dignity, including the provision of nutrition and medical treatment	Article 35
Foundational Rights Affecting Health	To dignity	Article 10
	To equality (nondiscrimination)	Article 9
	To life	Article 11
	To lawful, reasonable and procedurally fair administrative actions	Article 33

Concluding Remarks

While discriminatory practices as described in this paper have thankfully become rare in South Africa, the potential for human rights abuse is always present in one form or another. Therefore, we need to strengthen and build upon the available information and continued education of health professionals about human rights, as well as mechanisms to prevent abuse and protect vulnerable communities against such abuse. Only when health professionals take responsibility for their past actions and practices, and link human rights to professional accountability, can we shape behaviours to promote and protect human rights in the health sector.

Integration of human rights into international health systems is increasingly driven by the recognition that the respect, protection, and fulfillment of human, civil, political, economic, social, and cultural rights is necessary—not because they are legally binding obligations of governments, but because they are essential for improvements of the health status of individuals and populations. ■

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A Look at International, Short-Term Service Trips

Challenges from a Dental Ethical Perspective

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Abstract

Although professionals helping those in need in other countries is a noble endeavor, it is not without its ethical challenges. Those in the medical field are just beginning to explore these issues. In this paper, the five-principle structure of the ADA Code is used to explore some of the not-so-obvious problems that may come in the wake of charity care in international contexts. Issues surrounding respect for autonomy include informed consent, adequate health history, and cultural sensitivity. Sometimes the difficulty of working conditions increases the possibility of causing harm, and follow-up care may be lacking or inadequate. The duty for beneficence may have different meanings in other cultures than it does in the United States. Standards for justice or fairness may not be the same in other countries, and bringing American benefits to a segment of a local population may disrupt indigenous standards. Issues can also arise around veracity due to communication problems and alternative ways of counting benefits and harms.

"He set up a little folding chair in the middle of the room and put a spittoon next to it. Because there was no electricity, he would flick on the miner's light he wore and begin practicing dentistry. That's how it's done in Nepal, at the top of the world in the Himalayan Mountains." (Catrambone, 1995)

What ensues beyond this vignette is purposely left to the imagination. You may envision a patient with a painfully swollen jaw obtaining immediate relief once a much-needed dental extraction is performed. Maybe you see a child on his mother's lap, receiving sealants that will prevent tooth decay for years to come. Perhaps you imagine a dental student providing the treatment and performing his or her first dental extraction under the watchful eye of a volunteer dentist. Whatever may come into your mind when you read this scenario, rest assured, it occurs in countless places around the world everyday. Physicians, dentists, and allied health professionals alike are participating in short-term service trips (STSTs) in astounding numbers and the numbers appear to be increasing (Chapin & Doocy, 2010). A quick Web search reveals countless organizations whose mission is just this. On the American Dental Association's Web site alone, there are links to more than 140 organizations where dentists may get involved. This care comes at no small expense either. A conservative expenditure appraisal of 250 million dollars is estimated for all such trips originating from the United States annually (Chapin & Doocy, 2010; Maki et al, 2008).

Great need exists for health care in developing countries. As health care advances in first-world countries, the disparity between rich and poor nations continues to grow. According to Walsh (2004), 90% of global health resources are concentrated on 10% of the world's populations. Short-term service trips provide some level of health care where none may exist. (Gynecologists ACoOa & Physicians WsHC, 2010; Roucka, 2011). In their review article, Chapin and Doocy (2010) defined "short-term" as trips of less than two months' duration.

Undoubtedly, helping those in need is a very personally rewarding experience (Catrambone, 1995; Chase, 2003; FDI, 1996; Magee, 2010; Suchdev et al, 2007; Welling et al, 2010). In dentistry, volunteering time and using professional skills and knowledge to help others is noble; and in fact, under the ADA's *Principles of Ethics and Code of Professional Conduct* Section 3, Beneficence, it is a professional obligation. Oftentimes these trips offer

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On the American Dental Association's Web site alone, there are links to more than 140 organizations where dentists may get involved.

healthcare providers the opportunity to visit exotic places while serving others. Just looking at the ADA's International Volunteer Web page, a dentist may choose to go almost anywhere in the world.

As rewarding and intriguing as STSTs may be, such programs present dentists, and all health professionals, with a unique set of practical and ethical challenges. The medical literature in particular has addressed these concerns in depth. (Crump & Sugarman, 2008; DeCamp, 2007; Garbern, 2010; Gynecologists ACoOa & Physicians WsHC, 2010; Hardcastle, 2008; Isaacson, et al, 2010; Morgan 2007; Pinto & Upshur, 2009; Ramsey & Weijer, 2009; Snyder et al, 2011; Suchdev et al, 2007; Wall, 2007; Wall et al, 2006; 2008; 2009; Walsh, 2004; Welling et al, 2010). As healthcare providers, dentists experience the same ethical challenges as their medical colleagues. It is important to note upfront that this article is not meant to demean those who choose to participate in such work; in fact the contrary is true. This author, having participated in STSTs on many occasions in many places, understands the sacrifices made to engage in these endeavors. Time, money, and sometimes even personal safety are sacrificed in the name of helping others. I have a great deal of respect for those who choose to go forward and serve. However, despite good intentions, ethical lapses do occur (Bezruchka, 2000; DeCamp, 2007; Garbern, 2010; Ramsey & Weijer, 2007; Suchdev et al, 2007; Welling et al, 2010).

With many of the health professions participating in STSTs, it is important to note that there are no ADA or American Medical Association "best practices" guidelines in place to advise those who participate in such trips and protect those they serve (Chapin & Doocy, 2010; Maki et al, 2008). On its International Volunteer Opportunity Web page, the ADA does offer a link to the World Dental Federation which has a short policy statement document (www.fdiworldental.org/media/11247/Guidelines-for-dental-volunteers-2005.pdf). This one-page document, though listing some basic guidelines for providers, does not fully address the ethical perils and implications of international short-term service work. Another tool lacking is a standardized set of criteria to evaluate the effectiveness of such programs, thus making it even more difficult to develop guidelines (Maki et al, 2008; Roucka, 2011).

Our ethical obligations when participating in such trips often go unrecognized. Dentists have been trained from early on in dental school that they have a social responsibility to help those who cannot help themselves. Section 3.A. of the ADA Code under Community Service states, "Since dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in a manner to maintain or elevate the esteem of the profession." This author argues that the ethical obligations that go along with being a "leader in their community" are much different from the ethical obligations that apply to service provided in countries besides our own. Situations become very complex when providing services abroad and the guidance of the ADA Code becomes less clear.

In order to really "do good when doing good," STSTs abroad need to take an ethical step beyond what is required when doing community service work at home. Many dentists in the United States provide pro bono services in their own offices or participate in such programs as Mission of Mercy. For instance, the

Wisconsin Dental Association's Web site reports that in 2013 alone the Mission of Mercy program engaged 1,224 volunteers, treated over 2,000 needy patients, and provided dental services valued at $1.8 million. This scenario is repeated annually in many states around the country. In such endeavors, facilities used are transformed into state-of-the-art temporary clinics. Language, communication, and the securing of informed consent is generally not any more of an issue than an average day in any dental office. Infection control standards are maintained, and follow-up care is arranged if necessary. Though some may argue that triage is difficult and some compromises in care are made, i.e., the performance of an extraction instead of a root canal, post-and-core and crown, treatments are still performed within the standard of care. This is in stark contrast to the opening scenario of the Himalayan "dental clinic" provided at the beginning of this paper.

Throughout the literature on this subject, there are common themes that emerge regarding the moral pitfalls that participants of such trips may encounter. When providing dental care abroad, particularly on a short-term basis, it is important that we be aware of these risks and try to avoid them. We need to aim to provide the highest quality, ethically prudent care possible, even under the most difficult circumstances. Welling (2010) describes the "Seven Sins of Humanitarian Medicine." These are:

1. *Leaving a mess behind* (causing more harm than good). For instance, tackling procedures beyond what provider training or facilities can safely handle.
2. *Failing to match technology to local needs and abilities.* Taking the latest and greatest equipment to impoverished areas that they will have no ability to use after the team departs.
3. *Failing of nongovernmental organizations (NGOs) to cooperate with each other or expecting help from military organizations.* The wasting of resources for the sake of competition between NGOs happens. Also, military organizations can be very helpful resources in the field and are often underutilized.
4. *Failing to have a follow-up plan.* Providing services and then making no arrangements for follow-up care. "It is better to pick one country and continue to serve it well than to hopscotch all over the globe."
5. *Allowing politics, training, or teaching goals to trump service while representing the mission as service.* Having ulterior motives for participation, such as obtaining surgical training on a vulnerable population, is wrong.
6. *Going where we are not wanted or needed and being poor guests.* Not engaging local officials in the humanitarian effort and not respecting local customs and culture.
7. *Doing the right thing for the wrong reason.* For example, the desire to go to an exotic place as the first reason for choosing a particular STST or to gain additional training or bragging rights over the number of procedures performed at the local population's expense are not pure motives for participating in such trips.

In the FDI policy statement "Guidelines for Dental Volunteers" mentioned above, many of these "sins" are validated.

For the benefit of dental professionals in particular who have participated or may choose to participate in STST activities abroad, I would like to shed further light on the moral pitfalls associated with such trips with guidance from the literature and in the context of the ADA Code. My intent is to bring to consciousness those issues and to help participants reflect on their past experiences or make ethically sound choices regarding STSTs in the future. We are accountable to the patients we serve in myriad ways.

Principle: Respect for Autonomy

In western culture, respect for patient autonomy is at the heart of modern medical and dental practice. Our patients are our partners in health care. They are presented with treatment options, informed of the pros and cons of each and allowed to make treatment decisions based on this information. This is a crucial aspect of obtaining a valid informed consent. Oftentimes in the context of STSTs, informed consent does not happen (Isaacson, et al, 2010; Wall, 2007). In a country where the volunteer providers of care may not speak the native language, this alone poses a significant challenge. Patients are usually impoverished and vulnerable. They may have no frame of reference to weigh the pros and cons of treatment choices even when language barriers are overcome. Oftentimes it is impossible to obtain an adequate health history. Patients may never have had access to medical care previously. Cultural beliefs and mores may be significantly different from those of the provider. They may also feel compelled to comply with

treatment, fearing retribution if they refuse. All of these things put patients at an extreme disadvantage and make respecting patient autonomy inherently difficult.

Respecting the culture of individual patients and of the host community is paramount. Taking the time to become familiar with local customs and beliefs will give providers a better understanding of their patients. Team members should receive appropriate orientation to the culture, geographic location, community's dental problems, and the work facilities prior to departure to enable them to understand their patients more fully. At least some team members should speak the native language in order to facilitate the informed consent process. Providers should never treat patients as a means to an end; using them to practice procedures, or experimenting on them with new procedures. Medical and human rights abuses of the 20th century have led to clear standards on informed consent. These should be observed in STST settings as well (Isaacson, et al, 2010). Students should only provide care in the context of their ability and with adequate supervision for a number of reasons; not the least of which is that patients may not fully appreciate the difference in skill level between professor and student and could be misled into believing that a student is equally experienced. This distinction should be explained to patients to the best of the team's ability if students are involved in providing care. Patients who seek care at dental schools in the United States are fully informed and accept the risks and benefits of receiving care from novice providers; STST patients should be extended the same consideration.

Principle: Nonmaleficence

Dentists have the duty to refrain from harming patients. In everyday practice, patients are referred to specialists if treatment requirements exceed the qualifications of a treating dentist. Auxiliary personnel are used to assist the practitioner within the legal boundaries of the appropriate state dental practice act. Patients are provided with follow-up care and patient abandonment is prohibited, even when dismissing a patient from a dental practice. Oftentimes practitioners who participate in STSTs push the boundaries. Out of compassion for the people they are serving, they strive to provide good treatment and help as many patients as they can. Most often, facilities are poor and resources scarce. Sterilization services may be substandard. Providers often work extremely long hours with poor lighting and other disadvantages. All of these circumstances make practicing under these conditions inherently more risky to patients. Providers should be cognizant of these disadvantages and their personal limitations and stop providing treatment if patient safety is in jeopardy.

Another important consideration is follow-up care. Teams may visit a STST sight for a week or two and then leave with no plan for patient follow-up care; essentially abandoning the very patients they went to serve. In STST settings, it is important to follow the same principles adhered to in the United States regarding patient safety; some would even argue that it is more important in STST settings. "Cutting and running" is a dangerous practice (Isaacson et al, 2010). To minimize the possibility of patient abandonment issues, arrangements should always be in place for follow-up care once a team has departed. Partnering with local health care providers is imperative. Even if there is no local dentist to manage complications when the team departs, there should be a local physician or hospital accessible in case follow-up care is needed. If this is not arranged in advance, the first sin of "leaving a mess behind" is committed. If follow-up care cannot be arranged, invasive procedures should not be performed.

The laws of dental practice for any host country should be known and obeyed by STST teams, as FDI guidelines remind us, and proper credentialing obtained prior to departure. So as to minimize harm to patients, practitioners should not engage in any activities that exceed their clinical expertise. Risks and benefits for the performance of any procedure should be weighed, and only those that are expected to provide clear advantages should be performed. The desire to do good may cause providers to push the limits and attempt to provide care where they are not fully qualified; however, second-class care is not better than no care. Although a team may be able to treat more patients if under-qualified personnel are allowed to provide care, the consequences must be considered. Humanitarian sin five described above will become a reality if the team crosses these boundaries.

Another consideration under this principle is the management of medical waste; it must be disposed of properly. This is often not considered prior to embarking on these trips, as teams are usually armed with a multitude of instruments, supplies, and equipment. This problem will become imminently clear once the team commences work, however. Teams should have a plan in place to deal with medical waste disposal in accordance with local requirements so as to prevent environmental and health hazards to the local community upon departure (Suchdev et al, 2007).

Principle: Beneficence

The duty of beneficence asks us to act always in our patient's best interest (Isaacson, et al, 2010). Our obligation to community service in dentistry is well accepted. In the context of STSTs, the line between beneficence and benevolence becomes blurred. What does service to community really mean in an international STST context? I argue that it takes on a much deeper and broader meaning. The "community" in this context is often a small, remote village or municipality in a foreign land, alien in culture and language to the dental team. The team arrives with the benevolent motive to willingly donate needed time and care to the local people. But how is the "good" actually measured? Can it really ever be?

In order to adhere to the ethical principle of beneficence in such settings, STST communities should be engaged, not just served. Official dental site assessments should occur prior to any intervention (Eberlin et al, 2008; Roucka, 2011; Suchdev, et al, 2007). In order to fully understand the needs of a particular population, this is imperative. As an example, if the most pressing dental problem in a particular community is the extreme mottling from fluorosis that occurs due to the local water supply being naturally high in fluoride (as was the case in one area of Tanzania that I visited), the community intervention will be vastly different from one in which the water supply completely lacks fluoride and the natives consume a diet high in sugar cane. In fact, doing a thorough site assessment may determine that no community dental intervention is necessary at all.

In addition to obeying local laws and customs, teams have the ethical obligation to create sustainability. Engaging local healthcare providers, if available, in the process not only provides for some level of follow-up care, but also will promote lasting relationships that have the potential to flourish (Suchdev, et al, 2007). Local officials welcoming an STST team into their community are doing so to better the health and well-being of the local population. By taking the time to educate community leaders and local healthcare providers about the importance of oral health, more of a lasting impact may follow (Suchdev, et al, 2007; Isaacson et al, 2010). Going to one location for successive STST visits allows providers to assess program successes and failures and may help to improve the quality of care provided by allowing the team to adjust services accordingly.

Teaching the teachers or "teaching them how to fish" is another way to build relationships and program sustainability. The ADA has been involved with such programs for many years in partnership with Health Volunteers Overseas (HVO, see their Web site at www.hvousa.org). HVO's mission states that it is "a private, nonprofit organization dedicated to improving the availability and quality of healthcare in developing countries through the training and education of local healthcare providers." HVO is recognized as a global leader in the development and implementation of educational programs designed to empower healthcare providers in developing countries. Programs vary in accordance with the needs of the populations served and the educational priorities identified, however, there are certain valuable principles that HVO employs with all of its programs:

- Training focuses on local diseases and health conditions

Ninety percent of global health resources are concentrated on 10% of the world's populations.

- Practices, procedures, and skills taught are both relevant and realistic, and include, when appropriate, a focus on prevention
- Programs are designed to promote lifelong learning
- Whenever possible, programs focus on training local personnel who will assume the roles of both educator and provider

Not all participants in STSTs are necessarily qualified to teach, but nonetheless it is important for them to recognize the importance and benefit of this type of program to a community in need.

Principle: Justice

Through this principle, the ADA Code expresses the concept of fairness in all of our professional relationships: with colleagues, patients, and society. The dental provider's primary responsibility is to treat all patients fairly and without prejudice. In a bigger context, it addresses our obligation to promote oral health by actively working to improve access to dental care for all. Oftentimes on STSTs, the number of patients that seek care exceed the team's ability to provide it. Teams are confronted with the difficult task of triage and patient selection. Providers must be cognizant of the allocation of limited resources in such settings and distribute care as evenly and fairly as possible within that context (Wall, 2007). Heart wrenching decisions must often be made. For example, is it fair to occupy three hours of a provider's time and expend clinic resources to perform a complicated third molar extraction for one patient when five other patients with simpler needs could have been treated with the same resources and time? These choices must be carefully weighed.

Providers working in impoverished areas may also encounter patients with serious infectious diseases. The ADA Code clearly states that the decision not to treat a patient solely on the basis that the individual has an infectious disease is morally wrong. In STST settings, dental providers must weigh the choice to treat or not to treat when conditions are not ideal and infection control, lighting, and other such basic healthcare provision standards are compromised. The noble desire to do good may cloud judgment and expose providers to undue risk. When students are providing care, the danger is even greater and more concerning on many levels.

Choosing locations for STSTs can also put the principle of justice to the test. No one can argue that traveling to the Caribbean in December for a service trip is much more appealing than traveling to Siberia in January. Populations selected to be the recipients of STST care should first and foremost be chosen based on community need and not the provider's personal travel goals (Eberlin et al, 2008). With good planning, both needs can be satisfied.

Principle: Veracity

The principle of veracity in the ADA Code expresses the concept that dental professionals have a duty to be honest and trustworthy in their dealings with patients at all times. This trust in an essential component of the traditional dentist-patient relationship. In the context of STSTs, this relationship is inherently different, and some would argue, nonexistent. As Garbern (2010) eloquently states, "Realistically, how can a physician-patient relationship based on trust and mutual respect, the ideal we hold in the U.S., form in the span of a few months, let alone a single week?" Introduce a language barrier and this becomes even more difficult. The fact of the matter is STST patients are vulnerable. As discussed in the section on respect for autonomy, they are disadvantaged from the beginning. Providers must strive to build patient trust in the limited time they have with patients. Patients may have unrealistic expectations of what the "foreign doctor from the United States" can actually accomplish. Not meeting patient expectations, or worse, performing procedures with questionable long-term benefits may not only damage individual provider-patient relationships but could potentially have long-term detrimental effects on community relations and program sustainability.

Another aspect of veracity that providers must consider is their own motivation for trip participation. The desire to travel to an exotic place with the added benefit of getting a tax deduction, or the quest for students to build clinical skills on is morally wrong if that is the primary motivation. Participants should be honest with themselves and evaluate their reasons for considering participation in STSTs (Ramsey & Weijer, 2009; Wall et al, 2009; Welling et al, 2010).

Program evaluation is another aspect that at first glance, may not seem appropriate to be discussed under the principle of veracity. However, if successive visits to a STST site reveals an ineffective intervention strategy or other serious impediment to the program, STST leaders should in all conscience reassess the program and make adjustments or withdraw.

While the opening scenario of the Himalayan dental clinic may conjure a mental picture of adventure and beneficence, the reality is that the

potential to fall into an ethical "pit" is likely without the proper forethought and planning of any STST program. Having walked the walk myself many times, I can honestly say, I have been in and out of that pit. I am keenly aware that while participating in these trips is the experience of a lifetime, so is it for the patients who receive our care. As opposed to community service programs in the United States, dental providers must literally maintain a "global perspective" when choosing to engage in service activities overseas. A focus on ethics, cultural sensitivity, sustainability, and accountability will help illuminate the way. In this author's opinion, short-term service trips can be rewarding and successful if planned and executed with the aforementioned ethical considerations in mind. ■

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A Student's Perspective on The Ethics of International Charity Dental Care

Malorie Bohnert

Abstract

A senior dental student describes the deep sense of personal satisfaction from participating in a weeklong charity dental care trips to the Dominican Republic. Care, primarily consisting of extractions, was provided to individuals living in conditions that encourage dental disease at the same time the availability of oral healthcare services are essentially nonexistent.

My first exposure to the idea of participating in an international charity organization began after reading an article—"The Heart Feels What the Eyes See" by John Savard—that was given to me by one of the dentists leading the trip. It was a touching article that discussed what we, as volunteers and healthcare providers, can gain from participating in charity care. The article discusses the growth of compassion and spirituality and the change that occurs in a person after seeing what other people go through in other countries. After reading that article, I began to be filled with excitement in anticipation for what I could experience myself while on my weeklong service trip to the remote villages in the Dominican Republic.

After returning from my service trip, I can say that that article was exactly right about the changes that occur in a person after experiencing a service trip. I grew as a person during that one-week adventure. I felt a compassion inside of me that I did not know I could experience, I grew in my spirituality and I realized how much I truly have to be thankful for. That experience planted a seed in my heart that made me want to help as many people as I possibly could in the future.

My expectations for the trip were to not only experience a different culture, learn how to provide dental care in a different setting, and to grow as a person, but also to help the people in the remote villages that had no other access to dental care. Most of our patients had never seen a dentist due to lack of dental facilities near their village or financial inability to access the care. Many of the people in the village had extremely poor diets and oral habits, which included chewing sugar cane for several hours a day. Due to a combination of lack of oral health care and lack of education regarding oral health, the people in these areas are forced to live with extreme pain, infections, and a continuously degenerating oral situation. The amount of discomfort associated with the caries and pulpal disease that I witnessed in these patients was absolutely unimaginable. Our clinic provided these people with a service that was otherwise unattainable. That fact alone is what motivated me and my team to work extremely hard, even until the last hour of the last day. We powered through physical exhaustion and heat in order to provide as much care as possible during our time in the village.

Although service trips are a remarkable experience for the volunteer, several questions have been raised in regard to ethical situations that arise while participating in these international charity trips. Do ethical standards apply to charity care? Is there a difference in

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the standard of care with charity work provided in other countries versus fee-for-service treatment in the United States? If so, should there be? Why go to another country when people here in the United States need dental care too?

In my personal opinion, based on my own experience and professional moral standards, I believe that the same code of ethics applies to all of dentistry; whether I am practicing in or outside of the United States. The main ethical principles of veracity, beneficence, nonmaleficence, justice and respect for autonomy still exist while on charity trips. The goal of charity trips should be to help as many people as possible receive dental care that they would not ordinarily have access to. The objective is to help the people by relieving pain and suffering and offering them a service that would otherwise be unattainable.

Our clinic was organized in such a way that the patients would enter and go through triage first. Here, their chief complaint and diagnostic data would be obtained via radiographs, history, and clinical evaluation. Next, patients were informed of their oral condition and what their treatment needs were and what we could do for them that day. Due to the language barrier in the Dominican Republic, the dental providers spoke through translators to make sure that the patients understood all of the information that they were given. Patients were then given the options of pursuing the proposed treatment in our clinic, seeking alternative treatment if that opportunity was present, or to not seek treatment in our clinic. After a treatment plan decision was made, consent was obtained and treatment was provided. We had the ability to give prescriptions for infections and pain and we did all that we could to provide comfortable and quality dental care. My team and I held ourselves to the same ethical standards as we do back in the United States, our patients were informed, made an informed decision, and we provided the best care that we possibly could. Although our options for treatment were limited, the ethical code and moral thought process was still the same.

The standard of care while on international charity trips, in my opinion, depends on the circumstance and location of the clinic. On my trip, working conditions were difficult. There was limited access to suction and adequate lighting. Positioning of patients in the mobile chairs was also difficult. We had to choose restorative materials very carefully due to limitations with suction and isolation of the operating field. We used composite resin for esthetic areas only and amalgam for all other restorations. We extracted teeth that were symptomatic and had radiographic evidence of caries in close proximity to the pulp or pulpal pathology due to the lack of instrumentation needed for endodontic treatment

International charity trips provide the healthcare provider or professional student with an experience to grow as a person and as a dentist, but also to experience a different culture.

and follow-up care. In this aspect, the standard of care was somewhat altered but I would not say significantly compromised. We provided quality care but the options were more restricted due to the limitations of our surroundings and supplies.

International charity trips have three major difficulties, in my opinion. One of which is the constraints of treatment as described above. Many patients presented to our clinic with multiple dental needs, but because of the sheer number of patients who sought care, treatment was limited to the tooth that was most symptomatic for any one patient. Extracting one tooth on a person with generalized gross decay is not going to significantly improve their dental health status or significantly alleviate the symptoms they are experiencing. Second is the lack of follow-up care after complicated extractions or infections. During these trips, volunteers provide care, ranging from surgical extractions to restorations and prophylaxis. After performing a surgical extraction, we provided patients with an antibiotic and medications for pain management, but further follow-up was not possible. If postoperative complications should have occurred, there were few resources available for patients to access. The third drawback is lack of available supplies due to constraints with travel, funding, donations, etc. This directly affects treatment options available for the patients. Extractions constituted the majority of treatment provided. If the decay was small enough, restorations were performed. The longevity of the restorations placed is also an unknown due to lack of follow-up care. We were able to provide nutritional counseling, oral hygiene instruction, and dental sealants to children in the host facility's nutritional center for malnourished children. It is hoped this will have a significant impact on these children's oral health status in the future.

After providing care in the remote villages of the Dominican Republic, my eyes were opened to a new world that I had not known previously existed. It took days for me to fully comprehend the lifestyle these people were living and the small, seemingly "essential" things that they live without. People in the United States suffer from lack of access to care and lack of dental insurance, and many people suffer from dental pain every year. Those facts are real and I do believe that we as health care providers and compassionate people should do something to decrease those statistics. I do feel that our profession as a whole is somewhat responsible for addressing these shortcomings in care. I do not believe that every single dentist in the United States should be mandated to provide charity care, but I do believe that becoming healthcare providers requires a sense of empathy and compassion and an overall want to help people. Charity care is just one way that dentists can fulfill their desire to help others and really make a difference.

In the United States, there are many programs such as "Mission of Mercy," "Give Kids A Smile Day," etc., that are programs designed by state dental societies or individual schools or clinics that provide free care to specific populations or locations. These, along with other charity organizations, allow people in the United States to have access to dental care when there are no other means for them to obtain it. In remote places, such as in the villages of the Dominican Republic, there are no such options for people. Charity trips, such as mine, may be the only way for the residents there to acquire any type of dental care. During our stay in the Dominican Republic, several patients had traveled from very remote villages to seek our care. International charity trips offer the healthcare provider or professional student an experience to grow as a person and as a dentist, but also to experience a different culture. I do not believe that charity trips should be either international or in the United States, I believe that there should be opportunities to participate in both. Each type has its benefits and rewards.

As a future dentist, I believe that in this profession we all have a deep down desire to help people. Whether it is squeezing emergency visits into our already hectic schedules, taking late night phone calls, volunteering at Mission of Mercy, or traveling to a remote village to provide dental care out of a lawn chair, we all have a compassionate and empathetic side that drives us into action. How each person exercises those qualities is up to him or her, but I personally encourage anyone who has the opportunity to volunteer for an international charity trip to do so. The rewards and experiences of my trip are something that I will have with me forever. ■

Sustainability and the Principle of Respect for Community as a Means of Enhancing Healthcare Equality

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Abstract

Global short-term dental or medical volunteerism has grown significantly in recent years. Dental and medical schools, their faculty, and students, are becoming increasingly interested in the experience of providing care to individuals in low-resource communities around the world. A laudable goal of such care is to provide care to individuals in low-resource communities and to work to achieve equity in health for all people. These goals are consistent with the American Dental Association's ethical principles of justice, beneficence, and nonmaleficence. This paper will discuss ethical guidelines for conducting these volunteer experiences with an emphasis placed on *sustainability*—the provision of ongoing collaborative care, between the institution overseeing the experience and the local community, after the visiting group has departed. The ultimate goal, global health care equity, requires transforming these short-term efforts into long-term sustainable solutions. This goal is based on an ethical principle entitled *respect for communities*. This ethic can be likened to a community-wide application of the ethic of *respect for autonomy* as routinely applied to individuals such as patients. A tripartite model is proposed as a means for transforming short-term efforts into long-term sustainable solutions.

Global short-term dental or medical volunteerism has grown significantly in recent years. Indeed, applicants to dental and medical schools, as well as the institutions themselves collectively and their faculty and students individually, are becoming increasingly interested in the experience of providing care to individuals in low-resource communities around the world. Although there are many reasons for interest in these experiences, one goal of this outreach is to improve equity in health for all people. In 2009, the American Dental Association conducted a survey of dental schools and found that approximately half of all schools offer short-term volunteer opportunities for its students in communities around the world (Cohen & Valachovic, 2012). When conducted in an appropriate manner, these volunteer experiences are important instruments in developing not only greater awareness of global health inequity, but also doing something about it (DeCamp, 2011). However, when conducted in an inappropriate manner, misguided outreach, even with the best of intentions, can cause harm to both the communities and the individuals they purport to serve, as well as possibly wasting the resources invested (Holmgren & Benzian, 2011).

To conduct an international service learning healthcare experience in an appropriate manner entails adherence with the American Dental Association's *Principles of Ethics and Code of Professional Conduct*. Among the relevant principles are justice, beneficence, and nonmaleficence. However, the ethical guidelines for conducting these experiences are in their infancy, (DeCamp, 2011) and this presents a unique opportunity for leadership by the dental profession. As the teaching of global health is becoming an increasingly important part of dental student education, it is incumbent that the profession's leadership develop an ethical framework for the provision of dental care in an international environment. The ethical framework used by the medical community in providing global short-term humanitarian care will be reviewed, followed by a focus on the goal of

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sustainability–the provision of ongoing collaborative care between the institution conducting the mission and the local community after the mission has departed the community. This principle was identified by Suchdev and others (2007) as a guiding principle of ethics for conducting the ongoing outreach experience carried out by pediatric residents and staff at the University of Washington in El Salvador since 2002. We argue that the ultimate goal of improving global healthcare equity requires the commitment to transform these short-term efforts into long-term sustainable solutions.

Ethical Obligation to Promote Global Oral Health

The 2010 Global Burden of Disease (GBD) Study, funded by the Bill and Melinda Gates Foundation, was a comprehensive study that examined the health of the world's population. It found that oral conditions, excluding oral cancer, affected 3.9 billion people, with untreated dental caries in permanent teeth being the most prevalent out of 291 diseases evaluated in the entire GBD study. Severe periodontitis was found to be the sixth most prevalent condition (Marcenes et al, 2013). Thus, the burden of global oral disease is a significant challenge to the dental profession.

In an editorial in the *Journal of Dental Research,* William Giannobile quoted the Roman philosopher Cicero, *Non nobis solum nati sumus*– [translation] "Not for ourselves alone are we born" (Giannobile, 2013). This virtue-based philosophy of caring for another can be used as the foundation for a mission statement describing a framework of ethical principles to guide the profession in responding to the unmet burden of global oral disease. Rectifying this problem entails the profession making a commitment to promote Cicero's goal. This commitment was reinforced by the International Association for Dental Research (IADR) when it declared that promoting global oral health must be a high priority goal of the of the profession and that a particular focus should be placed on the reduction of global health inequality. In working towards the realization of this goal, the IADR has invested in the Global Oral Health Inequalities Research Agenda initiative aimed at providing evidence for a strategy that will reduce inequalities in oral health within a generation. The IADR's call to action is a commitment made by a leadership body of the profession to take on a leadership role in translating epidemiologic research into effective action that will promote global health equality (Sgan-Cohen et al, 2013).

Ethical Principles for Guiding Global Short-Term Dental Volunteer Trips

The traditional approach to alleviating the problem of global oral disease has been the provision of short-term clinical treatment, teams of dentists traveling to individual patients to provide them with care (e.g., the extraction of teeth for the relief of pain), in low-resource countries. While such care may address the immediate needs of those individuals, it usually does not include a strategy to provide continuing care to all individuals within the community following the departure of the visiting team (Holmgren & Benzian, 2011). In the absence of empirical evidence to the contrary, not only have these "mission trips" provided little or no long-term benefit to the recipient communities, but they may result in harm to individuals due to inadequate equipment, improper infection control, and lack of postoperative follow-up care. There may also be an additional harm to the community caused by an unintended, but nevertheless present, devaluing of the local healthcare system and its workers. In areas where there are inadequate numbers of local health care providers, the community is left with no follow-up care. In areas where local providers are present, these providers are now left with managing the burden of follow-up care without choice, or even worse, refusing to provide follow-up care for work that was not their work to begin with. As such, the key missing component from these short-term "missions" is the establishment of a continuity-of-care based environment where the local communities participate in defining the needs of their people and partner with providers in meeting those needs, that is, sustainability (Holmgren & Benzian, 2011).

A new paradigm of humanitarian care based on a set of ethical principles founded in the philosophy of Cicero will emphasize a focus on partnering with persons on-the-ground in the local communities (DeCamp, 2011). This approach has been defined by DeCamp as "establishing a collaborative partnership." DeCamp argues that creating such a collaborative partnership is crucial to transforming the short-term effort into a long-term sustainable solution. We suggest that a strategy of establishing a collaborative partnership flows from a principle of ethics defined as respect for communities (Weijer et al, 1999). This principle was originally promulgated as a fourth principle for clinical research ethics, an addition to the three principles identified in the Belmont Report–respect for persons, beneficence, and justice (Emanuel et al, 2008). It entails the principal investigator (PI) of a research study practicing "community engagement."

By being in a continuous dialogue with the community, the PI recognizes that the community has the right to autonomy in making decisions about what is best for the community. Thus, in respecting the community, the PI grants to the community such rights as the "...right to grant or deny investigators access to their members, (or the right) to withdraw from research at any time..."

One model for sustainable short-term international medical trips is the Children's Health International Medical Project of Seattle (CHIMPS.) This project is a collaborative effort that began in 2002 between pediatric residents and staff at the University of Washington and the community of Los Abelines, El Salvador. This humanitarian endeavor is not a short-term volunteer "mission"; rather, it is an ongoing care environment that works to continually meet the needs of the local community. The University of Washington supports ongoing public health interventions and provides sustainable medical care by collaborating with both the local community and with ENLACE. ENLACE is an on-the-ground local nongovernmental organization that works with the community. With their community partners, ENLACE developed a health committee to provide sustainable healthcare solutions. The committee coordinates health education as well as identifying and implementing simple health interventions. It also employs a local physician who makes weekly visits to the community. Suchdev and colleagues identified seven guiding principles of ethics underpinning the CHIMPS program of care:

1. *Mission:* A common sense of purpose
2. *Collaboration:* A relationship with a community and its infrastructure
3. *Education:* For the community and for the volunteers
4. *Service:* Commitment to doing work the community needs and wants
5. *Teamwork:* Building on each team member's skills and experiences
6. *Sustainability:* Building capacity for ongoing interventions
7. *Evaluation:* A mechanism to determine whether goals are being reached.

These principles are consistent with the ADA's ethical principles of beneficence, nonmaleficence, and justice. Working toward the goal of global health equity means transitioning from the traditional model of a short-term "mission" providing only direct individual care to a model of ongoing healthcare development based on the needs specified by on-the-ground persons in the local community. This transition is based on the principle of respect for communities. The ethical focus shifts from short-term relief of suffering to long-lasting change and the gradual improvement of health thus reducing inequity. Accordingly, sustainability is only a means to an end –the end being *non-sustainability* of the episodic short-term care mindset (DeCamp, 2011). An improvement in global health equity will only occur when change results in long-lasting, self-sufficient communities.

A Model for a Sustainable Solution: The Ahmedabad Dental College and Hospital

The CHIMPS model for sustainable short-term global health care is based on working with a local nongovernmental organization (e.g., ENLACE). Another model for sustainable short-term global dental or medical care is exemplified by the outreach program conducted in India by Indian colleges of dentistry.

In the absence of empirical evidence to the contrary, not only have these "mission trips" provided little or no long-term benefit to the recipient communities, but they may result in harm to individuals due to inadequate equipment, improper infection control, and lack of post-operative follow-up care.

As such, in lieu of collaborating with a nongovernmental organization, an American dental college could establish a collaborative partnership with an in-country local dental college already supporting or desiring to develop an outreach program.

The traditional American model of short-term interventions during a seven-to-ten-day care "mission" is an individual-centric approach that entails treating and educating individuals. Sustainability (ongoing care that meets the needs and wants of the community) does not develop due to the community's sporadic ability to access on-the-ground healthcare professionals. There is a paucity of approachability—the community is unable to rely on a continuing presence of on-the-ground healthcare professionals to approach for a needed intervention. The current situation in low-resource areas of India features huge unmet treatment needs. Millions of people in India are typical of the people surveyed in the GBD study in that they are burdened by a number of oral diseases. Conditions of urban and rural poverty, lack of dental awareness, and the absence of funding to provide basic oral health care, all contribute to creating this burden. The lack of on-the-ground approachability is compounded by the problem of inadequate transportation. In India, the means of transport in rural communities may not be well established or easily accessible, causing transportation to be a major barrier for people seeking basic dental care. Thus, the barrier of inadequate transportation must be overcome in order to provide a community with ongoing care.

In order to help remedy this situation, the Ahmedabad Dental College and Hospital (ADCH) of Ahmedabad, India, conducts outreach activities with underprivileged populations in, and around, the city of Ahmedabad. ADCH works at a community level by organizing outreach programs in which students and faculty screen people in these communities for oral diseases. The records of patients screened and treated during outreach in the local community are transferable to the dental school. In this particular model, the local dental school is able to take on the responsibility for ensuring the progress and completion of the treatment of these patients. This model, where possible, enables the provision of care to be consistent with the ethical principles of beneficence and nonmaleficence. Such sustained, ongoing care duplicates the care provided by the wholly different CHIMPS model in El Salvador.

Two examples of outreach programs conducted by ADCH are *Vatsalya* and *Jagruti Abhiyaan*. *Vatsalya*, Hindi for "love," is an ADCH outreach program that targets the elderly in nursing homes. *Jagruti Abhiyaan*, Hindi for "awareness campaign," is an outreach program that strives to educate these communities about periodontal disease. The main feature of these programs is a commitment by ADCH to creating community-based awareness of oral diseases and a commitment to providing treatment for people in these communities at low cost by dental students under one roof—ADCH. Sustained, ongoing care occurs because of the consistency and frequency of visits of ADCH's health care providers to that community with follow-up in which ADCH provides transportation and free food to bring members of the community to ADCH for ongoing care. Without the dental school providing a weekly bus service for rural communities within a certain mile radius of the dental school, the provision of continuing care will break down. With dependable transportation, the community's low-income families know that they can rely on continued access to care. As such, with reliable transportation, abandonment of the families does not occur.

Clearly, the problem encountered by Indian dental schools is financial. There is a lack of resources to provide ongoing care. The high costs of transportation and treatment are the stumbling blocks to the provision of ongoing dental care to the community. The failure to provide ongoing care would result in the failure to satisfy the principle of justice. In the event of cutbacks in funding, the ADCH could continue to provide ongoing care if it had a collaborative partnership with an American dental school that had the ability to lobby on behalf of ADCH to secure funding. Such action, would not only exemplify the ideal collaborative partnership, but would also exemplify Cicero's philosophy of *Non nobis solum nati sumus.*

Proposal: The Tripartite Model of Collaborative Care

In order to transform the short-term global dental and medical mission into a sustained and effective approach addressing global health equality, we propose that, where possible, American dental schools pursue international outreach in collaboration with local dental schools. A partnership between an American dental school and a dental school in a developing country is a model that is similar to the successful CHIMPS model. It is critical that the creation of such partnerships be based on the principle of respect for communities. In respecting the community, individual-centric care is replaced by community-centric care. Meeting the ongoing dental needs of a

local community must entail working with a local intermediary institution. The local dental school is such an institution. Thus, a tripartite partnership is formed between the low-resource community, a dental school located near to the low-resource community, and the American dental school. A long-term sustainable solution to the problem of global health inequality requires creation of such collaborative, ongoing partnerships.

Conclusion

Clearly, the strategy of partnering with a local dental school is an ideal solution and would work in those situations where a local dental school is both geographically available and agreeable to partnership. But, the benefits to our own U.S.-based students, the in-country students, and the local community are immense. However, what is to be done in situations where there is no local dental college with which to partner? In addition to the models like ENLACE and ADCH, an American dental school could identify a faith-based organization, like a local house of worship, to be the third partner to collaborate with in forming the tripartite partnership between the American dental school and the low-resource community in the distant international site. Such partnerships would lead to sustainability and not just episodic "learning experiences" for its own students at the potential risk of harm to patients and communities in the distant international site. To be avoided at all costs is the sadly all too common circumstance where "benevolence" (narrowly defined here to mean "feeling good about what we do") is the principle value achieved. Feeling good must be secondary to doing good. And doing good entails transforming episodic experiences into long-term sustainable solutions. ■

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Lessons in Health and Human Rights

Providing Dental Care to Torture Survivors

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Abstract

New York City has a large number of individuals seeking asylem who are victims of torture. In addition to dental needs, which include cases of severe trauma to the mouth, these individuasl require special support because of their fear of contact by those they do not know. A cooperative program between the New York University College of Dentistry and Bellevue NYU, known as the Program for Survivors of Torture, is described.

Dentists have an important role to play in promoting health and human rights. This includes ensuring access to dental care for vulnerable populations. In this article we describe an innovative human rights education program at NYU College of Dentistry (NYUCD) through which dental students, as members of a multidisciplinary team, care for refugees from all over the world, now living in New York City, who have endured torture and other human rights abuses.

This human rights educational and treatment initiative, started in 2008, is the first of its kind at any dental school in the United States and perhaps the world. It is a partnership between NYUCD and the Bellevue NYU Program for Survivors of Torture (PSOT).

Background on PSOT

Between 1980 and 2013, nearly three million refugees from roughly 120 countries entered the United States. New York City, with its large immigrant and refugee population, may have more survivors of torture and international human rights abuses than any other city in the United States.

Founded in 1995, PSOT provides medical, mental health, social, and legal services to survivors of torture and trauma. PSOT is the first and largest program of its kind in the New York City area. Nearly 4,000 men, women, and children from over 90 countries have received care (900 in 2013).

Program patients were persecuted and forced to flee their home countries because of their peaceful political activities or because of their religion, ethnicity, gender, or sexual orientation. PSOT clients have endured numerous forms of torture and abuse including beatings; rape or sexual assault; deprivation of food, water, and sleep; mock executions and death threats; and being forced to witness the torture

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or murder of others. Most were imprisoned, many have lost family members because of violence, and almost all have lived as fugitives in their own country, subsequently escaping under harrowing circumstances.

Once here, these survivors often struggle alone to recover from their traumatic experiences. Most are separated from their family. Many are undocumented and awaiting decisions on their asylum applications–the right to remain in the United States because of fear of persecution if forced to return home. Most arrive in the United States not speaking English. They are often homeless, unemployed, and profoundly symptomatic at the time they present to PSOT.

Patients are referred to PSOT through word of mouth, as well as social, medical, and legal service providers. Over half are from Africa (33% West Africa, 20% Central and East Africa); 11% from Central Asia, 12% from East Asia, 14% from Eastern Europe, and the remaining 10% from Central and South America, the West Indies, the Middle East, and other parts of Asia and Europe.

Patients present with multiple physical, psychological, and social health concerns to PSOT. Few have received health services within the past year. Common physical problems include joint and muscle pain, headaches, dizziness, and scars. Patients are also at risk for having infectious diseases associated with abuse and detention under inhumane conditions, including tuberculosis, skin and bone infections, parasitic infections, and sexually transmitted diseases, including HIV.

The psychological consequences of the abuse that PSOT patients suffered are severe and debilitating. Eighty percent of the patients have significant anxiety, 85% depressive symptoms, and 46% PTSD symptoms (Keller et al, 1996).

Need for and Development of PSOT Dental Services

PSOT's service delivery model is based on the premise that care is most effective when it is both comprehensive and interdisciplinary. The physical, psychological, and social dimensions of health and illness are interdependent and all need to be addressed. In order to do so, we have to climb out of the healthcare silos that all too often separate us.

Before developing this partnership with NYUCD, PSOT patients faced an enormous health gap: dental care. PSOT clients had no access to dental services other than emergency extractions. In a study of oral health in torture survivors at another torture treatment center, 76% had untreated cavities and 90% required urgent intervention (Singh et al, 2008). One of the biggest surprises upon starting the program was the complete lack of dental care many of the patients had in their lives.

The following case is illustrative of unmet needs identified.

The psychological consequences of the abuse PSOT patients suffered are severe and debilitating. Eighty percent of patients have significant anxiety, 85% depressive symptoms, and 46% PTSD symptoms.

Students in the program reflect that while working with survivors of trauma presents unique challenges, it is a privilege to help them regain not only their physical health, but also their emotional and social well-being.

TR is a 29-year-old woman from an African country where she was a university student. She and several other students were arrested for distributing fliers about a planned pro-democracy demonstration.

TR was taken to a police station where she was repeatedly beaten, including with a rifle butt knocking out several of her upper teeth. She was repeatedly raped and then thrown into a small, foul-smelling, overcrowded prison cell.

Several days later, TR was released after her family paid a bribe. She remained at home afraid to go out. When she learned the police were again looking for her, friends helped her flee to a neighboring country. There she secured a plane ticket to New York City where she was able to stay with an African family of eight living in a two-bedroom apartment. She spoke very little English. Concerned about her health, a neighbor referred her to PSOT.

Upon initial evaluation, TR had back pain and headaches. She was sleeping only two hours a night, frequently awakened by nightmares. She suffered from profound feelings of hopelessness and shame.

Subsequently, TR received general medical care and individual and group counseling. A social service provider interviewing TR noted that she did not smile and in fact covered her face with her hand. When asked why, TR explained that she felt ashamed of her missing teeth. "Whenever I look in the mirror, I am reminded of what happened," she said.

Program Implementation

Central to the PSOT dental program's growth and development is strong support from the NYUCD Administration. This includes providing supervisory faculty, designated space, and supplies. Most patients lack the means, including insurance, to afford dental care. If one is a patient in this program, we will see to it that oral needs are taken care of regardless of ability to pay.

Since the program began, demand for services has been high and continues to increase. Initially the clinic included ten dental students meeting for a half-day on Friday. This has been expanded to 20 students with the clinic meeting both in the morning and afternoon. At any given time, 15 dental chairs are typically being used. There are always at least two faculty preceptors present. Comprehensive dental services including diagnostic, preventative, interventional, and restorative care are provided. Dental students on a rotating basis attend PSOT's weekly primary care medical clinic, where they conduct initial evaluations and discuss patients with other members of the medical and mental health care team.

From its inception, the NYUCD involvement in PSOT has been a student-driven initiative. The students built the program from the ground up into what it is today. They were the ones who scrambled during our first year to find supplies. They are the ones who make their schedules and worked out coverage issues. We wanted them to own the program—to feel it was their practice.

Interested students apply through what has become an intensively rigorous process. There are typically three applicants for every position. Consistent with this being a student-led initiative, students decide on the new applicants. The students feel responsible for the patients, and want to ensure those they pass on care of the patients to are up to the task. What criteria, in

addition to clinical excellence, are used to select dental students to participate in this program? "But equally important is their humanity, humility, and the size of their hearts.

In 2013 approximately 200 patients received dental care, representing approximately 1,200 visits. The most common dental problems seen were periodontal disease, caries, and tooth injury from blunt trauma, often the direct result of mistreatment and imprisonment under inhumane, unsanitary conditions, poor nutritional status, and no access to dental care.

The emotional challenges for the patient and the provider pose far greater challenges than the dental pathology. It is the people and what they have suffered. They may be afraid of bright lights or of having anyone touch them. They have been violated and hurt. We work to earn their trust.

Educational Initiatives

In order to address these challenges, program participants receive intensive and ongoing training. Team meetings, case conferences, and didactic sessions occur before and after the end of each clinic. Sessions are taught by PSOT's interdisciplinary team. Topics covered in didactic sessions and throughout the clerkship include:

1. What is health?

Distinctions between a pathophysiologic classification and a more holistic view of health is discussed. Reference is made to the World Health Organization's definition of health as "A state of complete physical, mental, and social well-being and not merely the absence of disease." Case presentations and discussions emphasize how the physical, psychological, and social concerns with each patient impact on one another.

2. What are human rights?

Discussions on human rights focus on the roles health professionals can play in promoting human rights and caring for victims of human rights. This includes:

- Identification: being aware that if you are caring for refugees, you are coming in contact with individuals who may have suffered horrific abuse. If you are caring for women, domestic violence may be a factor to consider as a cause for dental trauma.
- Treatment: Ensuring access to care and providing high-quality care to all.
- Documentation: Applying one's skills as a clinician to document findings consistent with allegations of treatment. Such information can play a crucial role in forensic documentation for patient's asylum applications.
- Advocacy: Educating colleagues, policymakers, and the general public about dental health needs, including greater access to dental care.

3. What are the health consequences of torture and mistreatment (physical, psychological, social)?

Ongoing discussions include common medical problems seen in refugee populations and their treatment including musculoskeletal pain, active tuberculosis or exposure to tuberculosis, parasitic infections, chronic hepatitis, sexually transmitted diseases, diabetes, and hypertension.

Additionally, common psychological symptoms and diagnoses seen among victims of torture and trauma are reviewed including depression and posttraumatic stress disorder. Emphasis is placed on symptom reduction rather than making a diagnosis. Treatment modalities including psychotherapy and medications are reviewed. Social service needs are framed as central, rather than peripheral, health concerns. This includes stable housing, food, work, and legal authorization.

Dental students are encouraged to communicate with other members of PSOT's interdisciplinary team. The students need to know they are integral members of the team.

4. How does one use and work effectively with interpreters?

Included in these discussions is the importance of ensuring that accurate interpretation services are available and used. Ethical issues which may arise in working with interpreters, including issues of confidentiality, are reviewed.

5. What are common legal issues encountered in caring for torture survivors ?

Students learn about different legal statuses common among PSOT patients including refugees, asylum seekers, and documented versus undocumented status. Students are educated about the important role examination can play in the patient's legal issues, including their applications for asylum. Students are encouraged to attend asylum hearings so they can learn about the legal process firsthand.

Response from Students

Students in the program reflect that while working with survivors of trauma presents unique challenges, it is a privilege to help them regain not only their physical health, but also their emotional and social well-being. Many students emphasized the importance of establishing trust. As one student said, "If the patient doesn't trust you, he's not going to open his mouth. Or he may open his mouth the first visit, but he won't come back."

Students are required to shift from a clinical focus to a patient-centered approach. For instance, students learn

to adjust their treatment plan to the patient's level of comfort, which may mean breaking a complex procedure that would typically be completed in one visit into two to three less intensive visits.

Another common theme of the students' reflections is admiration for their patients' resiliency. One student noted, "They make you appreciate your life, because these people have been through a lot, but they still have a smile on their face. They are inspiring."

TR (Continued)

TR also complained of chronic bleeding from her gums and tooth pain. She had never been to a dentist in her life. She was referred to the NYUCD Torture Survivors clinic. During the initial evaluation a dental examination was performed, but only after nearly an hour of being spent getting to know the patient and putting her at ease. One of the students on the treatment team who is fluent in French facilitated this process.

Oral examination revealed moderate to severe periodontal disease. Three teeth showed evidence of decay. Her four upper central incisors were missing, consistent with her report of being struck with the butt of a rifle.

The periodontal condition was addressed by performing scaling and root planing. The remaining dental work was conducted over several visits to minimize the patient's anxiety and to build trust. Her teeth with decay were restored. A fixed bridge was fabricated to restore the missing upper anterior teeth.

Upon insertion of the bridge, the patient looked into a handheld mirror provided by one of the students. The patient became tearful with intermittent laughter. When asked if the bridge was painful, she shook her head and said "It's been so long, since I smiled. I guess it will just take me a little time to get used to smiling again."

The students knew they had made a big difference in that woman's life. She was not going to have to feel shame and embarrassment every time she opens her mouth. And that's very satisfying.

While we cannot change the fact that horrible things happen to the people we care for, there is a lot that we can do to help individuals rebuild their lives. To help restore their person, their soul, and show them humanity can treat them well. Clearly TR and the other patients cared for through PSOT's dental program would agree.

Future Directions

Upon leaving the clinic, students express improved self-efficacy for treating vulnerable populations and patients with unique psychological needs, as well as increased desire to work with diverse communities in their future careers.

One student reported that interacting with the clinic's diverse population helped her overcome her doubts about her ability to treat people from different backgrounds than her own, saying, "I've learned we aren't only dentists. We cannot, nor should not, only deal with the teeth. We are caregivers and have to look at the patient as a whole–even before we start the dental work. Before I did the program I was reluctant to work with patients I knew had troublesome histories. I think it was fear of the unknown. Now I have learned how to approach them. "

A similar study that looked at dental students' willingness to treat traditionally underserved populations upon completion of a community-based clinical assignment also found that students were more likely to consider including these groups in their future practices (Kuthy et al, 2007). The importance of preparing students to be culturally competent dentists is increasingly relevant given the rapidly changing U.S. demographics.

Students come away with a much deeper global vision. By training future dentists and teaching them the skills to do such work, we can impact not only on the patients we care for in the clinic, but thousands of patients they will come in contact with through the rest of their careers. ■

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The Ethics of Corporate Social Responsibility

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Abstract

Corporations as well as individual professionals have an ethical obligation to help those in need. There is a sound tradition in American business for companies including social outreach as part of business strategy. This approach works best when corporations and community and professional experts work in partnership. Henry Schein's Corporate Social Responsibility program contributes expertise, logistics, connections, and funds to these partnerships in the United States and worldwide.

The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.

—President Franklin D. Roosevelt; Second Inaugural Address, January 20, 1937

What is needed, then, is a renewed, profound, and broadened sense of responsibility on the part of all...The international business community can count on many men and women of great personal honesty and integrity, whose work is inspired and guided by high ideals of fairness, generosity, and concern for the authentic development of the human family...I ask you to ensure that humanity is served by wealth and not ruled by it.

—Pope Francis; Address to the World Economic Forum January 17, 2014

Much has happened in the 77 years between these two quotes from world leaders. The emergence from a global economic depression, followed by periods of growth and recession; wars that have affected millions of people around the world; stunning advances in technology and communication that have connected our world as never before. And through it all, global leaders continue to urge generosity from those who have wealth—both individuals and organizations—to benefit those who do not.

When President Roosevelt exhorted Americans to "provide enough for those who have too little," Henry Schein was still a small drugstore in Queens, New York, established, just five years earlier with a culture of caring instilled in by its founders. When Pope Francis's address was read to the World Economic Forum in January of this year, Henry Schein was represented in the audience of global leaders—now a Fortune 500 company and the world's largest provider of healthcare products and services to office-based dental, animal health, and medical practitioners. And over the course of eight decades, the company's culture of caring has evolved into a global corporate social responsibility (CSR) program—Henry Schein Cares—with a mission to help advance access to care around the world.

Why would Henry Schein devote so much time and resources to giving back to communities in need around the world? First, it is the right thing to do. Corporations are made up of people, and people have a moral imperative to help others when we are able. Second, it is increasingly what is expected of a

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corporation. Meaningful, socially responsible activities are now the ante of corporate citizenship and attracting the best and the brightest to the company, similar to environmental responsibility and providing competitive wages and benefits. Brand value matters to customers who seek products from companies that are viewed as positive contributors to society. Third, it is good business. For 12 consecutive years, Henry Schein has been included in Fortune's list of the World's Most Admired Companies, usually ranking first in its industry for both social responsibility and global competitiveness. This is proof that a company can effectively balance the short-term investment expectations of shareholders with a long-term desire to make the world a better place. And Henry Schein is not alone; recent studies at Harvard Business School, Babson College, and elsewhere have demonstrated that values-driven companies outperform their counterparts in the long term.

The ethics of corporate social responsibility is a question of whether the company is "walking the talk."

With these three compelling reasons to be a socially responsible corporation, why would anyone question the ethics of CSR? Yet some still do, and it comes down to the issue of intentions. When evaluating the ethics of CSR, it is not a question of whether CSR is a good idea (it is) or whether a company should put in place CSR programs (it should). The ethics of CSR is a question of whether a corporation is serious about CSR, whether the programs that are established have real value or are merely corporate window dressing and whether the company really wants to do good or merely appear to be doing good in the eyes of the world. The ethics of corporate social responsibility is a question of whether the company is "walking the talk."

Henry Schein has been able to successfully "walk the talk" and deliver on the increasing promise of its CSR programs thanks to its philosophy and practice of giving, its higher ambition to do even more in the future, and its model for giving that magnifies the impact that Henry Schein is able to make in the global community.

Henry Schein Cares was established on the philosophy of enlightened self-interest—a belief that the company can "do well by doing good." Centuries ago, Benjamin Franklin advocated for enlightened self-interest when he wrote, "As we enjoy the great advantages from the invention of others, we should be glad of an opportunity to serve others by any invention of ours, and this we should do freely and generously." For Franklin, then, the self-interested pursuit of material wealth is only virtuous when it coincides with the promotion of the public good.

However, the practice of enlightened self-interest is not just randomly giving money or resources to any "worthy cause" in need. As Michael Porter and Mark Kramer first noted in the *Harvard Business Review* in 2006, it is an opportunity to create shared value for society and business: "Businesses must reconnect company success with social progress. Shared value is not social responsibility, philanthropy, or even sustainability, but a new way to achieve economic success. It is not on the margin of what companies do but at the center." In other words, because no single corporation can solve all of society's problems, a company must select issues that intersect with its particular business if it wants to create shared value.

Ethical business practice requires a focus on the creation of long-term economic and social value, as well as

a commitment of business to act as stewards of the full spectrum of its constituencies, including customers, employees, suppliers, investors, and society. This "human-centered" model seeks to build deep, trust-based relationships in the service of society as well as the bottom line. Muhammad Yunus, founder of the Grameen Bank and winner of the 2006 Nobel Peace Prize, observed, "Business is about problem-solving, but it does not always have to be about maximizing profit. So, you can also have social objectives. Ask yourself these questions: Who are you? What kind of world do you want?" The philosopher Alfred North Whitehead argued that business leaders should broaden the orbit of their concerns from those of their individual company or industry to the society at large. In that regard, Yankelovich (2006) has added that a great society is one in which its business, political, and civic leaders exercise their leadership within a framework of stewardship ethics. Stewardship ethics emphasizes as one of its core meanings the conscious effort required to reconcile profitability with social good.

In Henry Schein's case, the company seeks to create shared value by expanding access to care for underserved people around the world. This is the company's higher ambition—its belief that the organization can best realize its potential by creating long-term economic value, generating wider benefits for society and building robust social capital within the organization. Henry Schein is a founding member of the Center for Higher Ambition Leadership, a nonprofit 501(c)(3) with the mission of "leaders helping leaders to realize their higher ambitions." It is helping to create a community of companies that can help each other and other companies achieve their higher ambitions, and build a new generation of business leaders committed to these values.

To achieve its higher ambition of expanding access to care around the world, Henry Schein supports wellness, prevention, treatment, and education programs; it assists in emergency preparedness and relief; and it helps build healthcare capacity.

Henry Schein recognizes that it cannot achieve this higher ambition alone, and this fact is reflected in its model for giving—public-private partnership. Public-private partnership is essential because the health issues the world faces are too daunting for any single sector of society to begin to effectively address. Corporations in the private sector may have the resources and infrastructure to respond quickly, but they lack the necessary broad mandate of a government. Governments can provide this power to act on a broad scale, but they may not have the specific professional expertise that is necessary. Associations representing the various healthcare professions—including clinicians and educators—have this expertise, but they may need the logistical abilities of organizations already on the ground in affected countries. And nongovernmental organizations (NGOs) may have committed staff already in place in these countries, but they are usually dependent on external sources for the products, services, and funding to drive their in-country efforts.

Viewed in this way—with each sector as an integral and interdependent spoke supporting a wheel that can address today's global healthcare challenges—it is easy to see the importance of public-private partnerships. Public-private partnerships harness the unique skills of each participant in concert to make a much more powerful contribution to society than any could alone. Corporate social responsibility should mean more than making financial contributions, which of course are important as well. To be effective, corporate social responsibility should compel companies to meaningfully engage in the work to make the world a better place.

Rather than simply write a check, Henry Schein harnesses its core competencies such as healthcare products and services; logistical distribution expertise; an extensive communications network; and close relationships with more than one million healthcare practitioners around the world, and more than 3,000 supplier partners. Henry Schein is the hub at the center of the wheel that has strong ties to each of the sectors, and the company is willing to leverage these relationships, in collaboration with local communities, to mobilize support for healthcare issues of common concern.

Henry Schein plays a central, catalytic role in forming strategic public private partnerships and building momentum as healthcare clinicians and educators; local, state, and federal government; NGOs; and other industry participants each contribute their complementary core competencies to collectively address global health issues. By working together, this coalition can begin to move the wheel and get traction against the important health care issues of our time. Through Henry Schein Cares, the company helps fulfill its obligations to its five constituencies—Team Schein Members (employees), supplier partners, customers, investors, and society—and provides a path for their participation in social responsibility activities as well.

Meaningful, socially responsible activities are now the ante of corporate citizenship and attracting the best and the brightest to the company, similar to environmental responsibility and providing competitive wages and benefits.

The clearest example of the success of this public-private partnership model for higher ambition activity is Henry Schein's role in the American Dental Association's (ADA) Give Kids A Smile program. The ADA launched Give Kids A Smile in 2003 as a way for dentists to reach out to their communities to provide oral health services to underserved children and raise awareness of the critical need for enhanced access to oral health care for children. From the beginning, Henry Schein has served as the program's exclusive professional product sponsor, joining Colgate-Palmolive and DEXIS as major supporters of the initiative, and the company serves on the Give Kids A Smile National Advisory Committee.

Working with 30 supplier partners, each year Henry Schein provides 3,000 oral healthcare screening and prevention kits to the program, each containing supplies to serve 50 children. These essential supplies, valued at more than $1 million annually, enable the 40,000 dental team volunteers, including more than 10,000 dentists, to provide free oral health screenings, education and treatment to more than 450,000 underserved children at more than 1,700 events across the country on the first Friday in February each year.

As the ADA's signature access to care program, approximately five million children have received free oral services by almost half a million volunteers since Give Kids A Smile's inception. During that time, the value of products and services donated by Henry Schein and its supplier partners has exceeded $12 million. Give Kids A Smile Day has become so successful that the program has expanded to include events throughout the year and across the country, including at such high-profile settings as NASCAR raceways.

Emergency preparedness and relief is another area of focus in which the public-private partnership model has been very effective. In these cases, Henry Schein works with NGO partners who are on the ground in affected areas; with supplier partners to rally donations of supplies; with healthcare practitioners who volunteer their skills to treat affected people; and with appropriate governmental agencies. Essential healthcare products commonly needed following disasters are pre-staged at strategically located Henry Schein facilities for immediate shipment to NGO partners, and typically within hours of a disaster—as soon as distribution lines are open—the supplies are on their way to the affected areas.

The effectiveness of this model was seen in 2012, following Hurricane Sandy when the Henry Schein Cares Foundation contributed more than $1 million in essential healthcare supplies and financial donations to 11 relief organizations serving affected communities. Similarly, following the devastating earthquake in Haiti in 2010, Henry Schein and its supplier partners shipped 200 pallets of medical supplies valued at $1 million to 10 relief agencies on the ground in Haiti.

Building healthcare capacity around the world is yet another area in which the public-private partnership model has seen success. Henry Schein seeks

to strengthen the academic and educational platforms through which high-quality healthcare personnel are trained, as well as the healthcare clinics where at-risk and underserved populations are treated. One example in this area is Henry Schein's partnership with the NYUCD. For the past five years, Henry Schein and NYUCD have partnered to establish The NYUCD Henry Schein Cares Global Student Outreach Program, which provides oral healthcare education, emergency dental services, screenings, and preventative treatment to underserved communities around the world. The program has provided care to more than 50,000 children and adults in underserved communities in Latin America, Asia, and the United States since its inception, and is going strong to this day. In addition, a donation of more than $2 million in equipment, technology, and healthcare supplies in 2010 led to the establishment of the Henry Schein Cares Wing at the NYUCD. There NYU dental students are educated and oral health care is provided to members of the community through a 56-chair clinic.

Another example is Henry Schein's work with the Muhimbili University of Health and Allied Sciences (MUHAS) Dental School in Dar es Salaam, Tanzania, a nation of 40 million citizens served by only 450 dentists, where 65% of young people live with dental caries. Through a public-private partnership between Henry Schein, the NGO Miracle Corners of the World, and Tanzania's Ministry of Health and Social Service, the MUHAS Dental School clinic was upgraded with new laboratory equipment and ongoing support provides the clinic with technology and products. As a result, the improved facility now provides state-of-the-art treatment to Tanzania's many underserved communities and creates restorative dental work and oral prosthetics for 25 hospitals nationwide.

These are some of the many ways that Henry Schein is demonstrating a serious and ethical answer to the question of CSR; where it is showing the real value of its CSR initiatives in the real world; and proving its desire to do substantive good for those in need. And, as we have seen through the Center for Higher Ambition, many other companies are doing the same. Although it is likely that in another 77 years, world leaders will still be urging the wealthy to give more to those with less, by "walking the talk" Henry Schein is determined to help "provide enough for those who have too little" and committed to use its corporate wealth to help serve humanity. ■

For Franklin, then, the self-interested pursuit of material wealth is only virtuous when it coincides with the promotion of the public good.

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Mentoring

Dentistry's Fountain of Youth

Fred Certosimo, MSEd, DMD

Abstract

A mentor's principal purpose is to help develop the qualities that another individual (protégé or mentee) needs to attain his or her professional goals. Mentors provide their protégé with knowledge, advice, counsel, support, and the opportunity to better position themselves to attain success in the dental profession. They help their mentee's "learn the ropes" and attain the wisdom only a seasoned veteran can pass along about the fundamental assumptions and values of a profession's culture. Mentoring is not a science, but an art—it is often important not merely knowing what to say, but how and when to say it. The mentor and the mentee have different professional goals, and to compound the relationship, both present with varied life experiences and in many cases, from diverse cultures. Wise mentors must be sensitive to the individuality of their protégé and offer wisdom, judgment, resilience, and independence in a custom-tailored manner. Lastly, mentoring is not professional therapy and counseling. Mentors are different from role models. However, despite the many opportunities and potential setbacks, if done properly, the benefits of the mentoring relationship can last a lifetime for both the mentor and the mentee.

"It is only as we develop others that we permanently succeed."

—Harvey Firestone

The 1967 *Archives of Neurology* Aura Severinghaus description of an ideal mentor still seems applicable today. His ideal mentor possesses: "A generous measure of intellectual ability, integrity, both personal and social honesty so obvious and crystal that someone has called it 'transparent integrity,' a passion for truth, a motivation that makes social sense, emotional stability, the habit of working under his own drive, a capacity for growth, curiosity, the ability to respond with imagination and creativity to new or challenging situations, tolerance of the differences among people and reverence for life, personality, and the dignity of man." (Severinghaus, 1967)

The purpose of this article is to demonstrate that in these rapidly changing times, mentorship is a style of servant leadership (Certosimo, 2009) that is consistent with the high ethical, moral, and professional ideals of the dental profession and provides dentistry a mechanism to transfer these ideals to future generations.

Origin

The Greek origin of "mentoring" is found in Homer's epic poem, *The Odyssey*. Mentor was an Ithacan noble and friend of Odysseus. He served as guardian for Odysseus's son Telemachus when Odysseus departed for the Trojan War. Later in the poem, the goddess Athena assumes Mentor's form to guide, protect, and teach Telemachus during his travels. "In this role, Mentor (and Athena) served as coach, teacher, guardian, protector, and kindly parent. Mentor shared wisdom, promoted Telemachus's career, and actively engaged in a deep personal relationship" (Johnson & Ridley, 2008).

Purpose of Mentoring

"Someday I want to be like him or her" (Maxwell, 2008) is a thought on the minds of aspiring young dentists when in the presence of an accomplished and inspiring oral healthcare professional. That thought may be the spark that ignites the potential of the mentoring process. Mentoring is often perceived as the functional relationship between senior and junior faculty in the same field of expertise. Selwa avers that for many years, "mentors have been expected to (a) define possible career paths and provide insight about the general processes that would lead to professional advancement, (b) provide direction by validating specific goals directed toward achieving the trainee's

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long-term plans, and sometimes (c) pass on the knowledge and techniques needed to allow the mentee to extend the work started by the mentor" (Selwa, 2003). Ricer simply offers the purpose of mentorship as "a personal process that combines role modeling, apprenticeship, and nurturing" (Ricer, 1998). Significantly, when employees are asked, "What do you really want from a job?" they ranked "career and learning development opportunities" as their number one preference, followed by "pay," "recognition," and better "relationship with the manager" (Gostick & Elton, 2009). The interest in mentorship in the dental profession may have arisen from dentists who thoughtfully reflected on the value of the mentor-mentee relationship, or it may have risen from many discussions among learned professionals of how mentoring could help achieve several of the important outcomes and ideals of the dental profession. However, no matter how it may have arisen, it is an idea whose time has come. The reasons for which will be further explained in this manuscript.

Why Become a Mentor?

Although many seasoned professionals ponder the idea of becoming a mentor, they often hesitate to act because of what they perceive as the negative (time, commitment, unknown circumstances) aspects of mentoring without ever considering the positive influence they can make on another's career. Helmstetter postulates that "When you help improve the lives of others, your own life will get better." He further lists four reasons for becoming a mentor:

1. When you add value and purpose to someone else's life—you add value and purpose to your own.
2. When you help someone else get better, you increase your self-esteem.
3. When you help other people get better, you naturally and automatically learn and practice positive leadership traits.
4. When you help other people get better, you expand your focus in life in many ways.

Helmstetter continues: "I have never found a single example of a truly "successful" person who was not actively practicing the principle of helping other people prosper or get better. Your own successes are always tied in some way to the betterment you are helping to create in the lives of others" (Helmstetter, 2005). The idea of mentorship mutually benefits the mentor and the protégé.

Four Phases of the Mentoring Process

Let's assume that you now have considered all the positive and negative aspects of mentoring and have decided to finally take the first step. Kram (1983) succinctly elucidates the four phases of the process:

Phase 1: Initiation—marked by excitement, possibility, and beginning.

Your own successes are always tied in some way to the betterment you are helping to create in the lives of others.

Phase 2: Cultivation–most productive phase, lasts a year or two, protégés demonstrate increasing confidence and competence, mentor must be cautious not to encourage protégés to clone themselves in the image of the mentor.

Phase 3: Separation–characterized by leave-taking and distancing. Mentors should reinforce the protégés status as a colleague and reinforce the protégés sense of autonomy.

Phase 4: Redefinition–mentor and protégé may continue a collegial friendship characterized by less frequent and informal contact.

In addition to the "mentoring process," Peddy (2001) provides some practical guidelines for both mentors and mentees: Things mentees should know or learn (Figure 1); Things every mentor should do (Figure 2).

Steps to Becoming a Mentor

As in learning any new skill, there is a learning curve that must be mastered to become proficient at a specific task, and mentoring is not an exception. Part of the mastery includes some recommendations which Maxwell describes as "thinking like a mentor." They are: (1) make people development your top priority; (2) limit who you take along; (3) develop relationships before starting out; (4) give help unconditionally; (5) let them fly with you a while; (6) put fuel in their tank; (7) stay with them until they can solo successfully; (8) clear a flight path (remove obstacles); (9) help them repeat the process (Maxwell, 2008).

Clearly most mentors do not possess all the requisite skills necessary to effectively employ all these recommendations. Social and emotional intelligence (Goleman, 1995) will help guide the mentor to discover which individuals are inclined to provide and accept some of the above recommendations and not respond to others. However, a "good mentor must give consideration to all of the functions that could be performed as part of this role to determine what will be most helpful to his or her individual protégé" (Selwa, 2003).

Qualities of an Effective Mentor

What are the qualities of an exceptional mentor that allows his or her to connect with the protégés in a transformational way? Johnson and Ridley (2008) state that the functional elements of mentoring are knowledge, attitude, and professional skill. While these qualities are self-evident, others may require further description:

1. Seeing your mentee as a "10": The mentor who makes the biggest impact on the mentee is not necessarily the practitioner who owns the biggest practice, or the gifted researcher, or even the most talented clinician. Rather, it is the mentor who recognizes the potential that lies within their protégés, imparts value and provides the encouragement for the individual to surpass their personal expectations–in short, great mentors view their mentees as a "10" (Maxwell, 2008).The memories of those mentors who encourage their mentees to tap the unbridled resources within themselves and motivate them to make their dreams a reality will forever remain within the protégé. George Adams wisely reflected: "Encouragement is the oxygen of the soul."

2. Engaged in their profession: Effective mentors are engaged in their profession. "They are deeply involved in the work of their discipline and are frequently in contact with colleagues and collaborators. Outstanding mentors assume leadership roles in the field and are seen by peers as hard workers and innovators. Whether their product is new business, innovative ideas, journal articles, or research findings, effective mentors simply produce" (Johnson & Ridley, 2008). This quality may have a positive effect on young professionals who feel overwhelmed or even disenfranchised with their profession.

3. Dependability: Strong mentors exemplify consistency, reliability, and discipline. Yet, Johnson and Ridley advance, "dependability is the cornerstone of mentoring. Mentors can demonstrate their dependability by staying true to their agreements and commitments ...and maintaining emotional consistency. The dark side of not being dependable is a breach of trust in the mentor-protégé bond, which can ultimately lead to the dissolution of the relationship" (Johnson & Ridley, 2008).

4. Inspire–"Dream great dreams": Sagacious mentors play a major role in the professional development of our protégés (Palau, 1984). They should inspire, motivate, and pass on knowledge. Exceptional mentors guide their mentees by "framing the possibilities" (Zander & Zander, 2000) of their professional careers, then assisting them in designing a road map necessary to make these possibilities a reality. Hamlin (1989) encourages "inspiring appeals to our deeply rooted willingness to follow a leader or raise our own thoughts to absorb another's enthusiasm and innovation".

5. Communicate the fundamentals: Clark and Crossland state: "The heart of the matter...is to communicate so compellingly as to raise consciousness, conviction, and competence" (Clarke

& Crossland, 2002). This must be effectively accomplished through the delivery of a clear and concise message employing many of the principles discussed in this article. In summary, the message must "inform, involve, ignite, and invite" (Beldoni, 2003). Effective communication and connection with the mentee is an ongoing process with the potential of great rewards for the mentee, the mentor, the patient, and the dental profession. Mentors have the unique opportunity to positively influence the lives of their mentees.

6. "**Being there**": In the book *Fish! Tales*, Lundin and colleagues provide a vital insight into successful mentoring: "You can multi-task with 'stuff,' but you need to 'be there' for people...In no line of work is 'being there' more important than health care." (Lundin et al, 2002). Bornstein refers to the human connection between simple nearness and attraction as the "mere exposure effect–human beings become emotionally bonded to those people they frequently encounter" (Bornstein, 1989). Astute mentors recognize that simply being there or making yourself readily available is often the key to creating a strong and enduring mentor-protégé bond. (Johnson & Ridley, 2008; Miedzinski et al, 2001).

7. **Multipliers**: Great mentors are by nature "multipliers." Wiseman states that multipliers: "attract and optimize talent; create intensity that requires best thinking; extend challenges; debate decisions; and instill ownership and accountability" (Wiseman, 2010).These qualities enable the mentor to provide the mentee with the widest range of professional experiences. Maxwell quips that, "It keeps them growing, stretching, and learning. The broader the base of experience, the better they will be at handling new challenges, solving problems, and overcoming difficult situations" (Maxwell, 2003).

Figure 1. Things Every Mentee Should Know or Learn

- Learning is a lifetime occupation. Even top athletes have coaches.
- Negotiation is better than confrontation.
- Competition is good, but cooperation is better.
- Always share the glory. Always!
- Attitude counts as much a performance.
- Reputation counts.
- If you want good answers, you have to ask good questions.
- Having goals is good, but goals without purpose are meaningless. Goals tell us what. Purpose tells us why.
- You always have a choice, but every decision has consequences.

Figure 2. Things Every Mentor Should Do

- Listen more; talk less.
- Empathize; don't sympathize. Sympathizing makes people feel like victims.
- Share your failures as well as your successes. Focus on what you learned.
- Emphasize your struggles to get where you are' work is work.
- Understand the uniqueness of each individual. What worked for you may not work for someone else.
- Explain the "unspoken" rules, the imaginary lines.
- Encourage responsibility.
- Communicate high, but not unrealistic, expectations.
- Understand your role: To help other grow in wisdom, judgment, resilience, and independence.
- Don't become overly partisan. Part of your role is to offer perspective.

8. **Cross-cultural competency**: In his book *The Word is Flat*, Thomas Friedman (2006) asserts that globalization is making the world flatter, and therefore more interconnected. He states, "This sudden revolution in connectivity constituted a major flattening force." The Internet, cellphones, uploading, and outsourcing make it possible for individuals from cultures previously separated by thousands of miles to almost instantaneously receive, process,

Figure 3. Potential Pitfalls of Mentoring—Mentee's Perspective

- All advice, even from a mentor, should be considered carefully before being followed.
- "If things aren't working out, do something to change the situation."
- Be wary of becoming too dependent on your mentor to the extent that you lose the capacity to act independently.
- Avoid becoming overly associated with mentor, and lose your network association with others."
- Don't become "self-intimidated" by a high-ranking mentor.
- Focus on your learning goals. Don't make the mistake of surrendering the opportunity to learn by putting the mentor in charge.
- Don't let the relationship drift. Take the initiative to keep it going and to keep it energized.

and share information. Zachary (2012) articulates, "Never before in the history of the planet have so many people—on their own—had the ability to find so much information about so many things and about so many other people." Cross-cultural intelligence is a necessary skill for being an effective mentor in our multicultural profession: "Cross-cultural intelligence means beings able to understand cultural differences and use that understanding to communicate and interact effectively with people from other cultures...These include becoming culturally self-aware, having an authentic desire to learn, becoming attuned to other cultures, and developing a flexible cultural lens" (Zachary, 2012).

9. Set goals for growth: A caring mentor helps guide the protégé's progress by encouraging him or her to identify goals for growth. These goals should be "appropriate, attainable, measurable, clearly stated goals that require a 'stretch' and are put in writing" (Maxwell, 2008). Helmstetter (1991) further quantifies the power of setting goals: "It is the goal that shapes the plan, it is the plan that sets the action, it is the action that achieves the result that brings the success." This simple process will greatly increase the odds of the mentee achieving his or her vision for professional growth.

Mentor Versus Role Model

This paper addresses the art and science of being a successful mentor. However, those concepts are frequently confused with that of a role model. While a role model and a mentor are both individuals whom we may wish to emulate as examples of professional growth and behavior, there are some critical differences. According to Biggs, in an Internet posting *Role of Modeling Versus Mentoring*, a role model is "a person whose behavior in a particular role is imitated by others." A mentor is "a trusted counselor, guide, tutor, or coach."

- You do not choose to be a role model; you are chosen. You are not chosen as a mentor; you choose.
- When you are a role model, the primary focus is on you. When you are a mentor, the primary focus is on your protégé.
- The time commitment of role modeling is simply the life you lead, with everyone free to observe. The time commitment of mentoring is a personal involvement in the lives of a select group of protégés.

Kenny proposes that role modeling is the essence of professional character development. "Knowledge and skills are essential, but putting them together in a competent and caring response to patients' needs is learned in personal interaction and role modeling" (Kenny et al, 2003). Wright and Caresse (2002) argue that "role models...represent higher-order clinical skills, including 'assuming responsibility in difficult clinical situations,' 'going the extra mile for patients,' and 'being a patient's advocate.'"

However, Biggs adds, "Mentoring is a way to take role modeling to the next level by teaching protégés the details of who you are, how you think, what you've done, and why you have something worth pursuing. In essence, mentoring is one-on-one leadership—a pairing of a less experienced person (protégé) with a seasoned master (mentor)."

Risks and Benefits and Pitfalls of Mentoring

Extrinsic benefits (usually for the protégé) include reductions in workload, technical assistance, development of a loyal support base, recognition, and enhancement of one's own network. Mentors can delight in the experience of synergistic collaboration. Intrinsic benefits (usually for the mentor) include personal rejuvenation, excitement working with a talented and energetic junior, and the satisfaction that comes from helping someone else succeed.

Intrinsic risks for the mentor may include the expenditure of time and energy, high visibility protégé failures, sabotage or undermining by unscrupulous or disloyal protégé, and subtle innuendo or overt animosity from other professionals who are threatened or jealous. Also, it can impinge upon the mentor's personal life and social responsibilities. Extrinsic risks for the mentor may include increased awareness of your motivation to mentor—including self-serving motivations.

Peddy (2001) articulates seven potential pitfalls of mentoring from the mentee's perspective (Figure 3) which should be considered.

Summary

A mentor's principal purpose is to help develop the qualities the individual (protégé) needs to attain his or her professional goals (Peddy, 2001).

Johnson and Ridley state that "mentors provide protégé with knowledge, advice, counsel, support, and opportunity in the protégé's pursuit of full membership in a particular profession" (Johnson & Ridley, 2008). They help their mentee's "learn the ropes" so they can better understand the fundamental assumptions and values of a profession's culture. Ultimately, this can make the difference between success and failure. Johnson and Ridley (2008) state that "one of the most valuable but rarely discussed elements of mentorship is the practice of conveying wisdom that only a system insider, often a seasoned veteran, can pass along."

Mentoring is not a science, but an art. People have different goals and come from life experiences. A wise mentor is sensitive to the individuality of their protégé and offers wisdom, judgment, resilience, independence in custom-tailored manner—"the art is not merely knowing what to say but how and when to say it."

There is no precise recipe for becoming an effective mentor, but there is a process. Peddy (2001) describes the process as: "Lead, follow, and get out the way!" Leading as showing the way by role modeling, experience, or example; following, is advising and counseling (when asked); and getting out of the way is the art of withdrawing from a supportive relationship, while leaving the door open for a more collegial one" (Peddy, 2001).

Lastly, mentoring is not professional therapy and counseling. However, since mentoring relationships usually occur

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during times when the protégé's life is characterized by change, transition, and growth, it may not be surprising that a mentor may serve as an informal counselor. However, mentors must realize that they are incapable of solving all their protégé's concerns. Some problems are just too big, dark, or serious to handle. As much as possible, though, they can minimize the damage and refer their mentee for competent professional help. (Johnson & Ridley, 2008).

Mentoring provides the dental profession a proven method of passing on its values, traditions, and knowledge to our young professionals in perpetuity –renewing those important qualities that will not only make them successful but keep our profession vibrant. In that sense, it is dentistry's fountain of youth. ■

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Standard of Care

The Legal View

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Abstract

The standard of care is a legal construct, a line defined by juries, based on expert testimony, marking a point where treatment failed to meet expectations for what a reasonable professional would have done. There is no before-the-fact objective definition of this standard, except for cases of law and regulation, such as the Occupational Safety and Health Admintration (OSHA). Practitioners must use their judgment in determining what would be acceptable should a case come to trial. Professional codes of conduct and acting in the patient's best interests are helpful guides to practicing within the standard of care.

Continuing education credit is available for this and the following article together online at www.dentalethics.org for those who wish to complete the quiz and exercises associated with them (see Course 22).

It is hard to imagine a concept in health care more important than standard of care. Virtually every clinical decision must conform to that standard. It seems strange, then, that there is so much confusion and misconception about the concept. This confusion is rarely articulated.

To be fair, standard of care is an intrinsically vague concept that is hard to pin down with any precision. You may recall the time when you were first exposed to the term in dental school. Dental students have a very hard time with it, especially when they are told that:

- They must always practice within the standard of care
- (Therefore) they must know the standard of care
- There is nowhere on the Internet where they can look it up

It may or may not be helpful to expose them to the following PowerPoint slide in class, but this is how they are taught about the standard at the University of the Pacific. Students are told that many powerful forces or agents influence the specifics of a standard of care.

In the end, students are informed that the standard of care is, in fact, not written down in any one place. Rather, it is a group effort, the consensus opinion of practicing dentists, and if one wants to know the standard, one needs to know what colleagues think. They are also taught that the standard is dynamic and constantly changing as materials, techniques, and scientific and clinical wisdom evolve.

Attorneys typically cite the following short legal definition of the standard of care: "The level of care that a reasonably prudent dentist would exercise under the

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Figure 1. Elements of the Dynamic Standard of Care

The standard of care turns out to be the result of competing experts, judged by a jury of lay citizens in specific cases.

same or similar circumstances, time, and location." This is fine, as far as it goes, but still pretty vague.

This essay (and the companion article by Larry Jenson) attempts to answer, with some measure of clarity, the following questions:

- What exactly is the definition of standard of care?
- Who (or what) determines the standard?
- Is there a specific set of laws or regulations that determine the standard of care?
- Is standard of care a legal term, an ethical concept, or both?
- Do you always have to follow the standard of care?
- Is standard of care local, or is there a national standard in the United States?
- Are all dentists held to the same standard regardless of their training?

It is anticipated that this and the companion essay will not clear things up completely, nor will they meet with universal agreement, and such is a healthy thing in a profession. In the meantime, all dentists must still practice within the standard of care.

Legal Analysis

Negligence and Malpractice

The task of unpacking standard of care from a legal viewpoint ends with an examination of the ways that legal claims are adjudicated. Four facts must be established for a successful dental malpractice suit:

- The dentist owed a duty to the patient.
- That duty was breached (the dentist's behavior or treatment failed to conform to the relevant standard of care).
- The patient was harmed, damaged, or injured.
- The breach of duty caused the damage (the breach of duty was a direct, proximate cause of the injury).

Component number two is called "negligence," and in the case of licensed healthcare providers, it is professional negligence, defined in reference to the standard of care. In everyday injury cases such as auto accidents, negligence is defined against the reasonable efforts that should have been exercised by the average reasonable person to avoid causing injury to another party. However, in cases involving licensed healthcare providers, negligence is defined as failure to meet the standard of care. The standard of care is generally defined as what a reasonable healthcare provider would do under that same or similar circumstances. Implicit in the term "circumstances," are the conditions of the same or similar time and location.

Expert Witnesses

It turns out that expert witnesses play a definitive role in the determination of standard of care in specific legal cases, although they do not actually define that standard. The standard of care in claims against healthcare providers is typically determined by the testimony of expert witnesses except when the standard is

determined by statutes such as OSHA. There is one exception: when a lay person can readily determine whether the conduct was negligent, such as when a sponge is left inside a patient's torso or a patient falls out of bed because safety rails were not in place. More commonly, juries determine whether or not the standard of care has been violated by assessing the credibility and veracity of expert witnesses. Expert witnesses, using their understanding of the community standard of care, evaluate the evidence, records, and testimony to determine and then offer an opinion as to whether the defendant was negligent under the specific circumstances of that case.

Science and Evidence

Expert witnesses often support their opinion by citing references such as learned texts, treatises, and literature. The courts (meaning judges) in most states are the gate-keepers of the introduction of such evidence and may preclude testimony from writings if they do not meet the standards set forth by the U.S. Supreme Court in the case of *Daubert v. Merrell*. Those threshold admissibility questions are based upon sound scientific principles and testing, dissemination by peer review publications, or approval by another court of distinction (or if a product, approval by regulatory agencies). Courts in most states are liberal in allowing expert witnesses to testify as to the standard of care. The task of evaluating or testing expert opinions is handled through cross-examination by the opposing party, and judgments as to the veracity and correctness of expert opinion are ultimately left to a jury.

Locality and Expert Testimony

The locality rule aspect of the standard of care (the notion that standards differ necessarily from place to place) had its origin in geography and physical distance, and the generic definition usually includes language such as "under the same or similar circumstances, time, and location." Until recently rural health care providers did not have ready access to specialists, educational programs, continuing education, and cutting-edge, sophisticated equipment. Therefore, rural generalists were permitted to take on more treatments that were in the realm of specialists than urban or suburban generalists were, without being held to the same standard as a specialist. Also, given the time to publish, print, and mail paper journals and texts, there was a time lag for information to reach more remote practitioners. However, with growth of the Internet, digital transmission of education courses and lectures, and the increased number of specialists practicing in rural communities, things have changed. Recent trends in judicial decisions and case law clearly indicate that the locality rule, for the most part, has given way to a uniform national standard of care.

That said, nuances of the locality rule vary somewhat from state to state because of the nature of expert testimony and differences between experts. While there are state-to-state distinctions, most courts will allow expert witness testimony from healthcare providers practicing in other states. Experts from as far away as Alabama and Florida have been allowed to come to California to testify as to the standard of care in malpractice cases. Variances occur because some states have more restrictive laws regarding the nature of expert testimony. It is still the job of the jury to determine the credibility of those experts regardless of where they reside. Generally, any licensed healthcare provider can testify against another similar provider, even one who does not have the same specialty training or is not in active practice. Courts in most states allow that differences of expert opinion are simply credibility issues for the jury to sort out and weigh after cross examination. The following are examples of expert witness or locality rule variations: In Alabama and Arizona an expert must be of the same specialty as the defendant and have practiced for a year prior to the incident. In Alaska the court may appoint a three-expert panel that conducts a minitrial and then reports to the court. In Pennsylvania experts must be board certified in the appropriate specialty, and in Virginia the expert must have practiced for one year prior to the incident in the same or similar specialty as the defendant. That said, the differences from state to state are generally not substantial.

With the aforementioned exceptions, the locality rule is currently limited to situations where a patient would be better served by a specialist, but such treatment is impractical because the closest specialist is far away (generally thought to mean over 90 miles or two hours of travel time). In those cases, a reasonable general practitioner may not be held to the higher levels of care that would be expected of a specialist in the same circumstances. Such would be the substance of a locality rule defense. But this standard is not absolute, and may be subject to expert testimony as to whether or not the patient's condition was so far beyond the skill of the local healthcare provider that a referral was mandated without exception, regardless of time or distance. Ultimately it is a jury that will determine (based on the facts of a specific case) whether or not the standard of care required referral to a specialist. The jury must also decide whether or not a defendant's failure

to meet the standard of care caused an injury.

None of this, of course, excuses care that is below the standard that other general dentists would deliver in other places, meaning that general dentists in rural areas must perform at the same level as their urban colleagues. Rural patients are not required to endure a lower quality of dental treatment.

Duty of Referral

A healthcare provider, whether a generalist or a specialist, has a duty of referral to another health care provider or specialist when a reasonably careful healthcare provider would be compelled to do so under the same or similar circumstances, time, and location. A more practical way of evaluating the need for a referral under the standard of care involves a triad of conditions. The treating generalist must:

- know and be prepared for the potential complications or limitations of a proposed treatment;
- make a timely diagnosis of the occurrence of a complication or limitation; and
- appropriately treat or refer the patient with such a complication for evaluation and treatment by a specialist or provider of a higher level of care.

Failure to reasonably perform these three duties may be an indication of breach of the standard of care. It can, of course, be tempting for a rural practitioner to provide treatments that might better be done by a specialist, especially when patients make it clear that they would prefer to avoid a two-hour drive to the city for more expensive care.

FAQ

Question 1: What exactly is the definition of standard of care and what does it include?

Readers seeking a clear, concise, consistent answer to this question will be disappointed. There is no clear answer, except in those relatively rare circumstances where one of the following is true. First, questions of standard can be determined with confidence in advance of legal action where specific laws or regulations have been established. OSHA, Health Insurer Portability and Accountability Act (HIPAA), and some specific prohibitions related to advertising are examples. When they exist, laws must be followed, and they are a (relatively) clear component of the standard of care. The other before-the-fact guide involves behavior that is obvious to even the casual observer, such as the extraction of the wrong tooth. However, even in this example, there are often mitigating circumstances that make the standard less clear to a layperson.

Question 2: Who (or what) actually determines the standard?

The standard of care turns out to be the result of competing experts, judged by a jury of lay citizens in specific cases. These interpretations must still be anticipated by practitioners in day-to-day, real-life clinical care. This involves clinical judgment by individual dentists who are treating individual cases. The commonly accepted legal standard of care includes the term "would," as in "The level of care that a reasonably prudent dentist would exercise..." So, the standard of care is really an abstraction, a prediction held in the mind of the practitioner who is first of all (it is hoped) focused on the well-being of the patient and remains vaguely cognizant of the possibility that his or her behavior might be criticized or defended by competing experts in front of a jury someday.

This, of course, creates a big problem for dental schools that are obligated to teach the standard of care to students. This is generally framed as "the clinical truth" as understood by dental faculty. (That said, dental schools are exquisitely aware of the standards used by state boards to determine licensure, so they must factor the board's view into the design of their curricula, course materials, and lectures). Clinicians often assert that the way they practice is standard of care as if they somehow represent the truth of the matter. In actual fact, unless a similar case or situation has been litigated or regulated, their opinion is just that, an opinion.

The idea that reasonable, competent dentists determine and reflect the standard of care (as opposed to a fixed set of regulations created by others) reinforces the value and importance of professional autonomy. Members of the profession set standards to be followed to care for patients who are otherwise vulnerable because they cannot effectively evaluate the situation. Patients must be able to trust professionals to use good judgment, skills, and materials.

Question 3: Is standard of care a legal term, an ethical concept, or both?

It's both. Law is generally a lower standard of behavior, mandated by the community for its basic protection. Laws are typically written by legislators, most of whom are people without dental experience or a vested interest in the profession. Typically, their work is informed by members of the dental profession. Professionals often interpret "ethics codes" (sometimes called "codes of professional conduct") as aspirational and personal. Such codes are written by members of the profession, but their enforcement power is very limited, typically resulting only in sanction or expulsion by a professional organization.

There is an absolute legal obligation to follow, or practice within, the standard of care, but this assumes that a clinician's questionable behavior is detected or litigated. Much of daily, clinical behavior is not noticed by others, and patients typically cannot evaluate the full implications of their treatment needs or of care received. This means that dentists could violate the standard of care without consequence, and that makes the ethical question all the more important. Dentists must self-monitor. There are several important reasons to practice within the standard, and the obligation to be trustworthy (to protect the public trust that dentists enjoy) is high on the list. Self-management of high ethical standards protects patients and results in positive feelings for dentists at the end of the day and the end of a career. Because law and ethics inform each other and tend to be aligned, high personal standards also tend to keep a clinician out of trouble.

It is reasonable to conclude that the concept of standard of care is fundamentally an ethical responsibility because the law so rarely weighs in definitively (through regulation or rulings). Independent practitioners must make clinical decisions based upon their judgment of the correct thing to do without supervision or sanction.

Question 4: Is there a specific set of laws or regulations that determine the standard of care?

Not generally. Each state has a dental practice act, but these documents provide a framework typically lacking in clinical detail. You will not find much treatment guidance in a dental practice act. While a few specifics are provided (e.g., the California Act prohibits some specific language in advertising), the dental practice act essentially dictates that you follow the community standard of care, but without providing clinical definitions. If you think about it, practice acts are updated infrequently, perhaps every eight to ten years, while the standard of care is more dynamic. Clinical standards, materials, and practices cannot wait for the legislative process to catch up.

Codes of professional conduct provide some additional written guidance, and they certainly inform the standard of care in a powerful way. But, such codes tend to be general and aspirational, and as such do not provide specific clinical advice on a case-by-case basis. Readers seeking clear, centralized, agreed-upon written standards are bound to be disappointed.

Question 5: Do you always have to follow the standard of care?

The short answer is "yes." The law, the profession, and the public expect this of you. There may be rare clinical situations where you are tempted to do something that you perceive to be different from the way your colleagues do it, in variance from the way that most agree is "correct." Should you choose to do something that seems outside the standard of care, the only defensible reason is that it would be in your patient's best interest, assuming it does not violate a law or regulation. While you might be criticized by colleagues, your actions would ultimately be judged in court. If your case is not adjudicated, the rightness of your actions would remain an open question.

Question 6: Is standard of care a local thing, or is there a national standard in the United States?

It turns out that the answer to the locality question is: maybe, or sometimes, or it depends. The most durable answer is "it occasionally does vary," but one cannot generally count on a local

Recent trends in judicial decisions and case law clearly indicate that the locality rule, for the most part, has given way to a uniform national standard of care.

standard of care. In the relatively rare instances where a specific law or regulation covers a clinical situation, there is little room for variation within the jurisdiction covered by the rule. So, if the law is federal, then practitioners across the nation should follow it. In situations not covered by formal rules, local variation will be determined by the expert witness process, and even then, only when relevant cases are actually adjudicated. This implies that dentists can make clinical decisions based on their (perhaps unfounded) perception of a local standard of care without consequences—as long as treatment turns out well and they never end up in court.

More local consistency is to be expected in states where experts must be licensed in the state where the court is located. But, in a large state such as California, diversity prevails. Experts in northern, rural areas may indeed differ in their views from experts in a heavily populated, technically cutting-edge metropolitan area.

As the Internet and dental technologies evolve, it may become implausible for a defense expert to assert that a country doctor does not have access to the same or similar diagnostic and treatment information. High-tech equipment is getting smaller, more portable, and less expensive, and "virtual" offices allow dentists from one geographic area to intervene in distant clinical cases using real-time video over the Internet. Radiographs can be instantaneously transmitted cross-country, evaluated by a specialist, and shot back to the generalist within minutes. While local variation may never completely disappear, it has become difficult to justify. Once again, individual practitioners will still have to speculate as to how experts (in court) might judge the treatments they provide in order to determine whether they are practicing within the legal standard of care.

National professional organizations, such as the ADA, the American Association of Endodontists, and the American College of Dentists tend to influence the behavior of American practitioners, and they tend to imply a national standard. But, once again, the rubber hits the road when experts (who presumably read the journals of these organizations) testify and juries deliberate.

Question 7: Are all dentists held to the same standard regardless of their training?

The law does not recognize differences in circumstances of professional training. There is no margin of error or buffer of benefit given someone because of advanced years or, conversely, because of youth. All are held to the same standards. Older dentists may claim that their techniques are tried and true and have evolved and been refined over the years and are therefore superior to those taught to recent dental school graduates. That may be true. Once again, the matter of standard of care is only factually resolved when those techniques are adjudicated in a court case and argued by "experts" in that venue. In the meantime, one hopes that all clinicians submit their techniques and judgment to empirical testing and research on an ongoing basis.

Sometimes a younger practitioner has an advantage, having been born with a laptop and raised with a cell-phone and tablet. Some have no problem embracing technology and its benefits. As just one example, recent electronic advances really do make it easier to create detailed and abundant records. When compared to brief, hand-written chart notes, such records often challenge the traditional standards of care in charting. Similar examples can be seen in radiology, endodontics, caries control, continuing education, computer versus paper treatment planning, and perhaps, the taking of impressions.

Conclusions

The standard of care is a crucial but challenging concept. Practitioners must understand it and practice within it. Nonetheless, it is impossible to actually know for certain what the specific standards really are unless they have been recently tested in court. This means that clinicians must continuously speculate about the standards they follow on a day to day basis.

While such a statement is unnerving, there are clear guidelines and ways through the ambiguity.

First, learn and know available laws and regulations and stay current with changes in clinical methods and standards. This probably requires involvement in organized dentistry along with continuous reviews of practitioner literature. It is essential to stay connected with colleagues, as the standard is a group opinion, tested only occasionally in court.

Use effective and thorough informed consent procedures, including discussions with patients in lay language, so that patients have understood and agreed to any treatment you provide.

Refer liberally and intelligently. If you want to be safe, make referrals on the conservative side, not just to protect yourself, but to protect patients.

Finally, the patients' best interests are a valuable proxy for standard of care when things are unclear. That guideline is likely to modulate potential standard of care problems in clinical practice. If what you do is in a patient's best interest, that case is unlikely to end up in front of experts in court and is good for patients as well. ■

Six Common Misconceptions about the Standard of Care in Dentistry

Larry E. Jenson DDS, MA

Abstract

As a legal concept, standard of care refers to the set of practices that are accepted as appropriate based on the body of common case law decisions. This is contrasted with a concept of ethical standard of care, which is defined as the conscientious application of up-to-date knowledge, competent skill, and reasoned judgment in the best interest of the patient, honoring the autonomy of the patient. The article probes six areas where the understanding of standard of care is ambiguous.

"Standard of care" is a term frequently used when dentists discuss questions of appropriate clinical care of patients. Unfortunately, there are a number of misunderstandings about the term. This article seeks to clarify the concept for dental practitioners, first by exploring what the term is not and then by offering a clearer idea of what standard of care actually is. It will also introduce a distinction between ethical standard of care and legal standard of care. This essay explores a list of "mis-conceptions" to make its points. Let's start with what standard of care is not.

Misconception #1: The standard of care is a legal term and not an ethical one

Though definitions vary somewhat, a common definition of standard of care is best summed up by George Annas (1993):

> Standard of care is a legal term denoting the level of conduct a physician or healthcare provider must meet in treating a patient so as not to be guilty of negligence, usually called malpractice. That standard is generally defined simply as what a reasonably prudent physician (or specialist) would do in the same or similar circumstances.

Both dental law and dental ethics are concerned with appropriate behavior by dentists, and it is important to note that they are not the same disciplines. It is entirely possible to be acting unethically and not be in violation of a Dental Practice Act or be committing malpractice. Likewise, arguments can be made that—in rare instances—violating a law in the best interest of a patient may be an ethical thing to do. For instance, it is against the law in most states to operate a radiographic machine without a license to do so. From an ethical standpoint, if one has had the proper training and uses good judgment in the use of such a machine in the best interests of a patient in an emergency situation, the lack of a license is not necessarily an ethical breach. Too often, the disciplines of dental law and dental ethics are conflated, and with resulting confusion; practitioners often think that if they are in compliance with the law, they have met all their ethical duties. However, dental law is a subset of dental ethics, limited in scope and different in its intentions. As Annas (1993) notes:

> ...while the standard of care in the United States is strongly influenced by the law, for this standard to be beneficial to both patients and the public it must be based much more on doing the "right thing" (which is practicing good medicine with the informed consent of the patient) than doing what is legally safest in terms of potential liability.

The unavoidable argument here is that ethics often only begins where the law ends.

Granted, standard of care is a phrase most often used in the legal sense: How does a court decide whether or not a dentist has been negligent in his or her care of a patient? However, it would be hard to argue that dental ethics is not also concerned with what constitutes good and bad dental care. The difference is that the law is limited by the actual case history and statute; it is concerned with what has been demonstrated in court proceedings through expert testimony and mandated by legislation.

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Increasingly, "evidence-based" is taken to include (though not be determined by) the long-term anecdotal experience of the practitioner.

Dental ethics is concerned with what ought to be the standard of care... whether or not there is any case law or legislation to support its conclusions. In other words, dental law is more descriptive and thus after-the-fact, whereas dental ethics is more normative and thus proscriptive in nature. A great example of this is the concept of patient confidentiality. Where once this was the ethical standard of care: One would be acting unethically if one violated the confidentiality of a patient, it has in recent years been codified in the law through HIPAA. For a long time violating a patient's confidentiality was below the standard of care ethically. Now it violates the standard of care legally.

Though it is usually not presented this way, dental ethics is concerned with establishing a standard of care for dental practitioners over and above the legal standard. Ethics is concerned with what is best for the patient at all times. Malpractice law is more concerned about specific cases that actually result in damages and specifically in determination of negligence.

Misconception #2: The standard of care is determined by legal statute

Would not it be nice if the conscientious new dental school graduate could simply purchase a volume detailing the standard of care for each and every dental procedure? Alas, such a volume does not exist, and for good reasons. Legislatures that create laws and the courts that interpret them, generally, do not presume—and rightly so—to have the expertise required to determine the standard of care (abortion and end-of-life issues notwithstanding). Quite reasonably, they rely on those who actually research and practice the craft in order to determine the proper behavior by those within the profession. While one might be able to look to the dental practice act of the relevant state in order to determine whether or not one has committed a crime (such as allowing an auxiliary too much latitude), one is unlikely to find in that type of legislation guidelines regarding diagnostic technique, therapeutic regimens, and specifics regarding surgical technique. Thus, one must look elsewhere for what is generally understood to be the legal standard of care.

Misconception #3: The standard of care is determined by what is commonly practiced in a given community

For years this was indeed the accepted definition of the term in the legal world under the "Frye ruling," also known as the "locality rule" (Niederman, 2012). This is no longer the case. A subsequent ruling by the U.S. Supreme Court (1993), known as the "Daubert ruling," has substituted a more scientific basis for determining the legal standard of care. It is no longer legally defensible to claim that the treatment of a patient was within the standard of care because it was within the accepted standards of a given community. Despite this, one can still read such misinformation, especially on the Internet (see http://clinicallawyer.com/2010/09/what-is-the-standard-of-care).

From an ethical standpoint, arguing that it is acceptable to treat patients poorly just because "everyone else is doing it" is hardly justifiable. And yet, dentistry has an unfortunate history of condoning practices that support this herd instinct among practitioners. What follows are a few examples.

For years, research showed, with little doubt, that routine use of prophylactic antibiotics for dental patients reporting a heart murmur was bad practice. As it turns out, the risk of

death from the antibiotics was much larger than the risk of endocarditis. And yet it took many years to change this professional practice, and it is no doubt still being practiced this way in some offices. One of the reasons for this continued practice is the fact that many attorneys would advise that the odds of being sued (not to mention a successful outcome in such a case) for creating an endocarditis was far less than creating an adverse reaction to the antibiotic. The legal profession is not above using the standard of "what is commonly done" in order to defend clients from what actually should be done in the best interest of the patient.

More recently, research has shown that prescribing antibiotics before dental procedures for patients with joint replacements is also highly suspect (Olsen, 2010). Yet this practice continues in most dental offices, helped along by the fact that orthopedic surgeons sometimes follow their own herd instinct and have resisted incorporating these new findings into practice. The dentist is in the unenviable position of doing what is best for the patient (i.e., not prescribing antibiotics in most cases) yet risking legal action for going against the status quo.

Closer to home is the example of prescribing dental radiographs. Many if not most dental offices routinely take a full series of radiographs on any new patient. However, guidelines for prescribing radiographs, carefully researched and vetted by experts in the field (and available for over 25 years), do not condone such practice (Council on Scientific Affairs, 2012). Radiographs are to be prescribed based on the dental history, risk factors, and presenting symptoms of the patient. Those offices that "prescribe" radiographs before the dentist has examined or interviewed the patient are practicing below the ethical (and legal) standard of care, yet it happens all the time, justified (presumably) because such practice is common within the community. From a strictly legal standpoint, this practice most probably continues because the likelihood of being sued (as any attorney might, once again, advise) for taking too few radiographs is much higher than for taking too many.

Misconception#4: The standard of care can vary from community to community

As all dentists in all communities in the United States have access to the same information these days, it would be difficult to defend treating a patient differently based on geographic location. It is no doubt true that some communities lack the resources and facilities to provide ideal care, and here one might make a good ethical argument (based in the concept of justice) that when a dentist does the best he or she can do with what is immediately available it is within the ethical standard of care. From a legal point of view, however, it is unlikely that the geographic argument is going to be successful in court. Most states interpret standard of care as a national legal standard. (See the companion essay by Curley and Peltier).

Misconception #5: The Standard of Care Is Determined by the Latest in Technology and Best Practices

It would be hard to argue that a dentist performing root canal therapy without proper isolation of the tooth is practicing within the standard of care. But, what about performing the same procedure without a high-powered surgical microscope? Is this below the standard of care? Though such may well be the case someday, it is not generally accepted as a superior treatment now. David Ozar argues well that dentists have every ethical right to use their personal practice preferences (in fact, are obligated to do so) as long as the patient's general and oral health (as well as their autonomy) is not put at risk and that the dentist has every expectation that good results will be obtained (Ozar, 2002).

Moreover, technology is often slow to take hold within the profession and for good reason; adequate if not excellent results can be obtained with a variety of older technologies, and it is far better for a practitioner to use what is "tried and true" for him or her rather than to risk an outcome on new technology. New technologies, once in the spotlight, are notorious for fading after further testing and experience. From an ethical standpoint, a dentist who uses older technology may be well within the ethical standard of care if his or her concern is primarily with the patient's benefit and he or she obtains adequate results. Could we really argue against a practitioner's choice to use a technique that has reliably produced good results over many years of practice? On the other hand, avoidance of new technology that is clearly superior only in an effort to save money or save the effort in learning the new technique is hardly justifiable, either.

As for best practices and evidence-based clinical care, there is a growing awareness that these terms are problematic in real-life application. First, courts are increasingly made aware that the scientific literature is often less than

definitive on any particular procedure. Second, when trying to establish a standard of care, either legal or ethical, it is hard to discount a practitioner's experience and judgment. Increasingly, "evidence-based" is taken to include (though not be determined by) the long-term anecdotal experience of the practitioner.

Misconception #6: Bad outcomes are necessarily a result of practicing below the standard of care

Dentists who achieve a bad outcome from a procedure often believe that they must have committed malpractice or in some way acted unethically. Yet, it is quite clear from the dental ethics literature that one can have a bad outcome without being unethical. A conscientious application of accepted practices meets the ethical demands of practice. Being uninformed, incautious, unpracticed, or otherwise putting one's own interests ahead of good patient care is without a doubt below the ethical standard of care. However, no one can argue that dentists must be perfect in the outcome of a procedure at all times. The question is always whether or not a bad outcome was the result of negligence. From a strictly ethical standpoint, negligence is an absence of conscientiousness; did the dentist make every effort to achieve the best for his or her patient? One might argue that even without a bad outcome, one is guilty of practicing below the ethical standard of care if the ethical standard of care is taken to be the conscientious application of good technique, judgment, and action in the best interest of the patient. What happens when one is not conscientious and yet no bad outcome results? The "no harm, no foul" rule is more appropriate to the legal world than the ethical. Being lucky is not the same as being ethical.

In this sense, "standard" is an odd choice of words, given that what one is trying to describe is a contextually specific judgment that not only includes but goes beyond an agreed-upon set of criteria determined a priori.

Standard of Care Defined

If all of the above are misconceptions, then what exactly is the standard of care in dentistry? I hope by now it is clear that there is a distinction between the ethical standard of care and the legal standard of care, so we must therefore be more precise. Oddly, the ethical standard of care may be much easier to define than the legal one.

I offer the following definition for the ethical standard of care in dentistry: the conscientious application of up-to-date knowledge, competent skill and reasoned judgment in the best interest of the patient, honoring the autonomy of the patient.

To be within the ethical standard of care, the practitioner need only ask, "Am I up to date in my knowledge of the procedure, sufficiently experienced in the procedure and putting the best interest of the patient before my own interests while respecting the patient's autonomy, then acting accordingly?" This is what we mean by being conscientious. Acting below the ethical standard of care is to have never considered these questions at all or to act contrary to one's honest answers to them. Regardless of outcome, the question is always: Did one act conscientiously?

The legal standard of care, on the other hand, is much harder to define for any specific instance. When a dentist asks the question: What is the standard of care for this procedure? What he or she really wants to know is how to act in a particular case. It may well be that the

legal standard of care is of little help to the dentist due to the fact that the legal standard of care is determined on a case-by-case basis, after the fact, by expert testimony and with legislated judicial guidelines.

When one asks the question: "What is the legal standard of care for this procedure?" one can only look to similar legal precedent for an answer. While helpful, it does not provide necessary clarity for the practitioner who is faced with a unique patient under unique circumstances in a particular moment. To say to the dental practitioner that the legal standard of care is "what a prudent practitioner would do under similar circumstances" is just not very helpful. At best, an attorney can only advise the probability of losing a court case if one achieves a bad outcome. He or she cannot advise the practitioner on what to choose to do in the moment, as this must necessarily involve the clinical judgment and experience of the dentist. In this sense, "standard" is an odd choice of words, given that what one is trying to describe is a contextually specific judgment that not only includes but goes beyond an agreed-upon set of criteria determined a priori. It is no wonder that there is much confusion about this important issue. In essence, the legal standard of care is a moving target, an ever-evolving history of case precedent, always in hindsight, and not a set of rules to be followed by the profession. Though previous court rulings are certainly relevant to the practitioner, they offer no conclusive guidance and certainly no guarantee for legal success.

Conclusion

There is a significant difference between the legal and the ethical views of standard of care. Every dentist ought to aspire to the ethical standard as described here, and every patient should be able to expect this of his or her dentist. Whether or not following the ethical standard of care will result in legal safety for the dentist is a question that is, unfortunately, left to the courts and, unhelpfully, after the fact. ■

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However, it would be hard to argue that dental ethics is not also concerned with what constitutes good and bad dental care.

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