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2 HOURS OF ETHICS CE

CONTENTS Issue 03 **2023** | **ETHICS**

Ethics: At the Heart of Everything We do

Dr. Tom Blake

ON BEHALF of the Indiana Dental Association, I welcome you to our biennial Ethics and Opioid Issue. The authors of the articles within this issue have worked hard to provide you the necessary materials that you will need for your next license renewal. By reading and reviewing the materials herein, we are hoping that you further your understanding of these two broad topics and who knows, you might learn something new. Please take the time to read each article and take the quizzes to obtain the credentialing requirements for your next licensure cycle. Thank you for your time and for being an IDA member.

Those of us who have been around awhile have had the concepts of the five fundamentals of dental ethics presented to us many times over the times of our licensure requirements and yet the review every two years is probably not a bad idea. These are dealt with in depth in one of the articles within this Journal, but I will briefly outline them here. The five pillars include: Patient autonomy or self-governance. In other words, meeting the patient where they are and keeping each patient involved in his or her treatment; Non maleficence, or doing no harm to the patient; Beneficence, or acting for the good of our patients; Justice, or delivering dental care without prejudice; and finally Veracity, or our obligation to be truthful and honest in dealing with our patients.

These five principles are the foundation of an ethical practice and an essential piece of the ADA code. In our ever-changing landscape, there are many other things that we need to look at in creating an ethical environment for ourselves, our staff and most importantly our patients. The main issues that come to mind for me include access to dental care, cultural competence, environmental sustainability and technological advances. Many of these were not even a part of our consideration when I graduated four decades ago.

Let's address each one of these on an individual basis. First of all is the access to care which is a topic near and dear to my heart. As we have been so blessed to be a part of this profession, it is my thought that it is incumbent for us to give back to the less fortunate members of our community. We have many opportunities to share our services here in Indiana. There is Donated Dental Services, which has been granted more money from the state. Medicaid is a more difficult issue to deal with after the recent legislative session, but there are many free and income-scaled clinics (FQHCs, etc.) who could use volunteers to help see patients. You could also see some of those special needs or socio-economically challenged patients in your offices on a pro bono basis. All of our patients deserve the right to have better oral health and oral health education. This is not a comprehensive solution, especially for the more remote regions of our state, but it is a start.

Cultural competence and the knowledge of diversity, equity and inclusion (DEI) have really come to the forefront in recent years. It is important as health care providers that we attempt

to understand customs that may be different from our own. Communication and understanding are key to being able to treat patients from various cultural backgrounds as most all of our communities have become more diverse in nature. Differences in culture are not the only considerations when providing health care in our ever-expanding environment. Other aspects of diversity that need to be addressed are differences in gender, ethnicity, religion, disability, socio-economic status, and sexual orientation to name a few. Please take the time to get to know about these differences among this growing melting pot of patients. You both will be better in these future interactions.

Environmental sustainability's importance is ever increasing. Dentistry generates much disposable waste each and every day. It is important for us to utilize materials which are biodegradable as well as being especially prudent with hazardous waste. The pandemic dramatically increased the amount of waste generated in our offices. Let's try to make good environmental decisions for us and the next generations. It is next to impossible for us to know all of the ramifications of our selections of products but reaching out to our sales reps and suppliers to ascertain which items may be more environmentally friendly would be a good first step.

New technologies are now and ever will be something that we need to address. Teledentistry and AI-based diagnostic tools open ourselves to privacy breaches and misdiagnosis. Remember that you are the professional and your knowledge and application thereof still remain the most important thing in the treatment of our patients. These new "toys" are certainly a good adjunct to what we already know and are time saving in many cases, but they must be used judiciously and with your own application to assure proper diagnosis and treatment. These technologies promise to become more and more sophisticated over time but until then please take the time to treat each patient as an individual who deserves your unique attention.

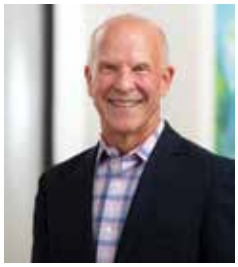
So now we circle back to one of the original fundamentals of dental ethics: Non maleficence, or doing no harm. I recently watched the Netflix series Painkiller, which recounts the origins of the opioid abuse scandal of Oxycontin. Over the years, dentists and physicians alike have attempted to curb the number of opioids prescribed in their offices due to the potential side effects of imminent possible addiction. As we all know, the opioid problem is rampant in the U.S. and we need to do our part in limiting opioid prescriptions given from our offices. The opioids half of this publication deals with exactly this issue.

The reasons for this requirement are numerous but two of the main factors are that according to a 2019 study, dentists are the leading prescribers of opioids to adolescents in the United States and dentists are among the top prescribers of opioids for acute pain following dental procedures not just limited to surgery. Prior to this requirement, it was felt that there was not adequate up to date knowledge that healthcare providers possessed and as a result a regular review was mandated to make certain that these drugs were being administered judicially.

Opioid education has now become a part of dental school curricula fairly recently; however, many older graduates had not received the most recent statistics and training and it was deemed necessary to bring all practitioners up to speed in this area. As a matter of fact, it is the goal of the ADA to reduce the number of opioid prescriptions by 50 percent by 2025: a great goal indeed. Realize too that the DEA is now requiring a one-time eight-hour total opioid training on or after to June 27, 2023 to maintain your DEA license. There will simply be a box for you to check on your DEA license renewal. The good news is that prior trainings may be used to fulfill this requirement and multiple classes can be used to complete the eight hours. For more information on this please visit **www.DEAdiversion.usdoj.gov**.

We all hope that you find this Journal helpful in your upcoming license renewal. The members of the IDA staff and authors in this publication have worked countless hours to make certain that this issue will inform you of all of the updated information you will need to be current with the topics of ethics and opioids and their proper administration. It is a pleasure to provide you with this succinct way to "check off the box" for license renewal. The IDA is always looking for ways to help its members in any way it can to make your practice lives easier and richer. Thank you for your participation in this edition of the journal. Let the IDA office know if there is any way we can help you in this or other issues that you may have in your practice. Until next time…

About the Author



Dr. Tom Blake is the 2023-24 IDA president and a general dentist in Fort Wayne.

Peer Review: An Ethical Obligation

Dr. Nicolette Polite
Dr. Wayne Kinney
Dr. Mark Mihalo
Dr. Katy Patton

IN THE ADA's *Principles of Ethics & Code of Professional Conduct*, Section 3.B, "Every profession owes society the responsibility to regulate itself." The IDA's Peer Review Program satisfies that requirement of self-regulation.

Peer Review is dentistry's dispute resolution program available to all patients in Indiana. Peer Review accepts cases involving IDA members as well as non-members. Peer Review is a benefit to our profession and to the public. All dentists are guided by these 5 Principles of Ethics. Here are some examples of recent IDA Peer Review complaints and how they relate to at least one of the principles:

AUTONOMY: *Involve the patient in treatment decisions.* Communicate, Communicate, Communicate! Many of the Peer Review complaints involve a breakdown, or lack, in communication. For example, one patient went through several months of treatment with her dentist preparing for fixed implant-supported upper and lower prostheses. At the final try-in appointment, the dentist casually mentioned that the "teeth" would be removable. This was a surprise to the patient and completely unacceptable. The dentist ended up refunding this patient so that she could start treatment with a different dentist.

NONMALEFICENCE: *Protect the patient from harm.* A dentist who takes on treatment beyond his/her training and does not know when to refer to a specialist is doing harm to the patient. Peer Review mediated several cases where the general dentist restored crowns over implants which eventually failed due to challenging occlusion and position of implants. Know your limitations and when to refer to a specialist. Know when to delegate to your auxiliaries.

BENEFICENCE: *The patient's welfare must be put first.* A third party should not dictate treatment. A dentist who only does the dental treatment that is covered by the insurance is placing less value on the patient and more on the insurance contract. Contract obligations with an insurance company do not excuse a dentist from his/her ethical duty to put the patient's welfare first. Peer Review has seen cases of dentists not taking diagnostic radiographs because the insurance company only covers bitewing radiographs every two years.

JUSTICE: *Treat patients and colleagues fairly.* Do not criticize another dentist's work without knowing all of the facts. A patient who had been seeing her dentist regularly for over 20 years started with a new dentist after moving to a different town. The new dentist told her that she had several areas of decay and had been "neglected" by her previous dentist. This patient lost faith in her previous dentist and her new dentist.

VERACITY: *Communicate truthfully.* Keep accurate records. If you didn't document it, you didn't do it! Poor record keeping is often the reason that a dentist has not met the Standard of Care in a Peer Review decision. A patient received a full refund because of failed upper arch restorations: the dentist claimed he had followed the Standard of Care, but had no written record, radiographs, photos, models, and no signed Informed Consent.

2022 Peer Review Case Summary

Total Resolved Cases	**80**	
Cases involving members	45	
Cases involving non-members	35	
Mediated cases-settled	58	73%
Mediated cases-withdrawn	12	15%
Resolved by panel review	10	12%
Outcome of Panel Reviews		
In favor of patient	5	
In favor of dentist	5	
Timeline of Process		
Resolved within 30 days	7	
Resolved within 60 days	18	
Resolved within 90 days	18	
Resolved after 90 days	37	
Cases Formally Opened	**80**	
Average number of weekly calls	25	
Mediation forms sent by mail	76	
Forms downloaded from website	194	
Non-case correspondence	29	
Cases referred to Indiana State Board of Dentistry	0	

2022 Peer Review Overview

Type of Dentist	
General	62
Orthodontist	6
Oral Surgeon	5
Endodontist	4
Pediatric	1
Prosthodontist	2
Periodontist	0
Type of Procedures Under Complaint	
Crowns	14
Dentures	11
Extractions	11
Root canals	10
Braces	8
Implants	5
Restorations	5
Treatment plan–diagnosis	5
Bridges	3
Billing	1
Cleaning	1
Flippers	1
Skin tag	1
Provider Status	
Repeat providers	17
First time providers	63
Graduation Year from Dental School	
2017-2021	14
2012-2016	19
2007-2011	12
2002-2006	5
1997-2001	7
1992-1996	6
1987-1991	5
1982-1986	8
1977-1981	3
1976 and before	1

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Peer Review Key Points

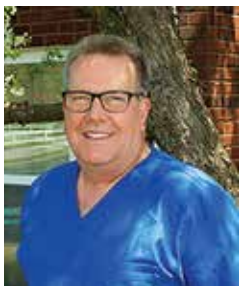
- **Protects the profession** and demonstrates that dentistry cares
- **Serves the dentist** and provides mentoring opportunities
- **Litigation** may be avoided
- **Serves the public** and provides **expert second opinions**
- Provides **voluntary and non-binding** dispute resolution
- Successful mediation is **non-judgmental** and both parties agree
- Panel Review determines clinical **acceptability and standard of care**
- Findings are **not admissible in court**
- Program is **defined and protected** by Indiana statute
- **Process is confidential**

Peer Review Mission

Provide impartial expert (non-binding) resolution of disputes involving quality or appropriateness of care, professional judgment, and utilization between patients and dentists that are not already in litigation or other review process through each committee member's sense of fairness, objectivity, and clinical skills by mediation and panel reviews after the initiating party has attempted in good faith to resolve the issue.

About the Authors

Dr. Nicolette Polite is a general dentist in Munster and serves as chair of the IDA Peer Review Committee.



Dr. Mark Mihalo is a general dentist in La Porte and a member of the IDA Peer Review Executive Committee.

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Dental Professionals as Mandated Reporters of Child Abuse and Neglect

Dr. Tammy Gierke Button
Sara Hoyt

AS AN IU/Riley Hospital for Children trained pediatric dentist, I am so grateful for a career that can positively affect families' lives in so many ways. Dental practitioners' caring presence and healthy influence have the potential to impact the trajectory of a child's life in immeasurable ways. We also have the added joy of watching a child grow through the many stages of development. Children possess an innocence and unguarded honesty that helps us remember and see the world from their perspective.

Some of my most significant challenges as a pediatric dentist have been ones in which I had concerns regarding child abuse, neglect, and trafficking. I must admit I was not fully clear on how to report these concerns or how to handle the situation chairside—only that I had an ethical obligation to report my concerns. With the assistance of other oral healthcare providers, a helpful conversation with the IDA, and conversations with a local child abuse prevention and intervention organization in Michigan City called Dunebrook, I was able to figure out exactly what to do. Fast forward a few years and I am now the Executive Director of Dunebrook.

Through getting to know the staff and programs Dunebrook offered, I began collaborating with their Healthy Families Home Visitation program to offer pregnancy and infant oral health education. Eventually we worked together to secure a grant through the Indiana Department of Health to create a training program for home visits on pregnancy and infant oral health. I am halfway through my second year as executive director and we are finishing up Year 2 of the grant. If you would like to see more information on the pregnancy and infant oral health for home visitors training, visit **https://southshoreskippingstones.org**.

My new role as executive director of Dunebrook has given me countless opportunities to intertwine oral health and overall health to child well-being.

All oral heathcare providers—dentists, dental hygienists, assistants, and office staff—all play a very critical role in keeping children healthy and safe.

Such protections were not always in place for our nation's children. One hundred fifty years ago, children had no protections. They were considered as nothing more than property.

> The statistics are staggering: 1 in 10 children will be the victim of child sexual abuse. (U.S. Dept. of Health and Human Services, 2023)

YOU ARE A MANDATED REPORTER

Every adult in the state of Indiana is a mandatory reporter of child abuse and neglect. Any adult who has reason to believe that a child has been abused or neglected is required to immediately call the Department of Child Services (DCS) or law enforcement. DCS operates a 24/7 hotline for reporting suspected child abuse or neglect: **800-800-5556**

A frail little girl, Mary Ellen Wilson, changed all of that in 1874.

Through a series of sad events, Mary Ellen lost her parents. Her already tragic life took another abrupt turn when she was just two years old. She endured non-stop physical, verbal and emotional abuse, all at the hands of the adult who was charged with her care.

Neighbors heard the poor little girl's screams, but even Mary Ellen's loudest wails could not move their silence to action. Finally, after seven excruciating years, a neighbor called the local mission that conducted welfare checks on the tenement's elderly residents. Armed only with a fabricated story of concerns for an elderly neighbor and her unyielding perseverance, the mission's volunteer persuaded her way into Mary Ellen's apartment. Mary Ellen, who had been hidden from the world's view, was a vision of scars, bruises and malnourishment.

The mission volunteer was mortified, but there was no protocol for what to do next. If Mary Ellen had been a dog, it would have been a different story. After all, animals had laws protecting them. Children did not.

With an internal fire to bring this little girl to safety, the mission volunteer turned to advocates for the prevention of cruelty to animals. Using the logic that humans are members of the animal kingdom, Mary Ellen's advocates cited that the laws which protect animals should be applied to her. They successfully argued for her removal from the abusive home; her abuser was sentenced to a year of hard labor.

The mission volunteer's kind family adopted Mary Ellen. Against all odds, and with the love and nurturing of her new family, she grew up to be happy and thriving, as well as a doting mother and grandmother. She lived to the ripe old age of 92 years.

Our nation has come far from those days of protecting children in the same manner as if they were dogs. Yet, we still need to do better when it comes to preventing and responding to child abuse.

Generally speaking, society is still unsure of what to do, or who to call when it comes to concerns for a child's safety. Questions such as "What if I'm wrong?" "What if I misinterpreted what I saw or heard?" or "Surely someone else reported it" are common. The self-talk can discourage a person from making a report. Ask yourself this question: How would you feel if you did nothing, and the next day that child was the headline? It would be a jarring realization to have not acted on a suspicion. In Indiana, anyone 18 years of age and older is considered a mandated reporter of child abuse. As oral healthcare providers and Indiana residents, it is critical that you and your staff are aware of this responsibility and how to advocate on behalf of the safety and well-being of your patient.

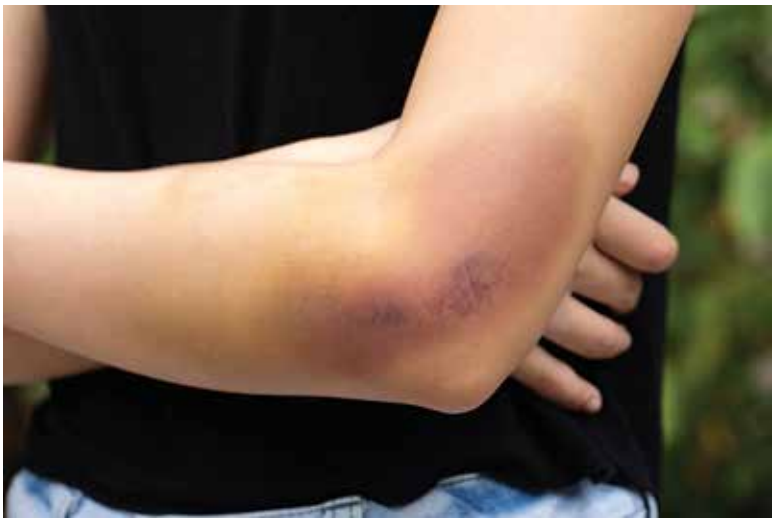
How prevalent is child abuse?

In 2022, Hoosier children suffered 20,053 cases of child physical abuse, sexual abuse, neglect, and human trafficking. Nearly 165,000 reports were investigated, (Indiana Department of Child Services, 2023) but evidence did not exist at the time of the investigation to indicate abuse. The Indiana Chapter of National Children's Alliance, which is the credentialing body for the nation's Child Advocacy Centers, reports that Indiana's child abuse rate is twice the national average. Sadly, our state ranks as the ninth worst in the U.S. for child abuse and neglect.[1]

Physical abuse is often the most obvious, as it may present in the form of fractured bones, bruises, scalding or burns. On the other hand, sexual abuse is less visible. Its injuries are often hidden underneath clothing—or perhaps in the

Continued on page 12

mouth. We see possible signs of trauma in fractured or mobile teeth, a raw palate, torn frenum, or oral sexually transmitted diseases. Fewer than 25 percent of children ever disclose to anyone that they have been sexually abused, and even fewer disclose to authorities.[2] According to the Academy of Adult & Adolescent Psychiatry, often there are no obvious external signs of child sexual abuse.



While sexual abuse comprised just 12 percent of all substantiated child maltreatment cases in the state, the Centers for Disease Control and Prevention believes that reports likely underestimate the true impact of the problem. Experts also surmise that during the COVID-19 pandemic, while children were stuck at home and away from the "eyes and ears" of others, cases were not reported. Because 90 percent of child sexual abuse is perpetrated by an acquaintance of the child,[3] it is likely that in many cases, children were left in isolation with their abuser.

Your critical role

Oral healthcare providers are in a unique position to get a glimpse of a child's private world, simply by examining their teeth, tongue and gingiva. It may never be a straightforward interpretation of bodily bruising, bite marks, fractured teeth or a damaged palate. A child's accompanying adult may be able to explain away such obvious signs of trauma; perhaps it was a utensil, a fall, wrestling with a sibling, or prolonged use of a pacifier.

As dentists, we do not carry the responsibility of positively identifying abuse. We do, however, have the ethical responsibility to our patients to report those suspicions or concerns.

In Indiana, child protection is overseen by the Department of Child Services, or DCS. Suspicions of abuse should be reported to Indiana's hotline at 800-800-5556. Just state what you know and your concern. You cannot be prosecuted for a call made in good faith. And your name remains confidential—the fact that you called and made a report is not shared. You can even choose not to give your name. Your report will still be taken.

Some parents who may be neglecting dental care are not intentionally trying to harm their children. They may simply be struggling to juggle the multitude of tasks shouldered by a parent or perhaps a lack of financial resources or limited access to transportation prohibit follow-through on a care plan. Your call to child protection may be the very first step in getting help to the family. DCS does not set out to whisk children away from their families. Instead, DCS aims to get help to families and keep children safely with their parents. Dentists also can help families by placing brochures of local community resources, such as parenting programs, food pantries, and soup kitchens, in a kiosk or book shelf in your waiting room or operatories.

As dentists, not only do we need to be able to recognize possible signs of trauma, we also need to know how to respond to a child who may disclose abuse during the course of an examination. A child has to feel believed and safe. Your reaction of horror or disbelief may prompt the child to become scared and possibly recant, keeping him or her under the continued threat of abuse. Instead, a gentle and calm demeanor will be reassuring to a child in this situation.

A disclosure must be handled with deference. It is imperative to not take the matter into your own hands by extensively questioning the parent, guardian, or alleged perpetrator. This is necessary to preserve the integrity of a potential criminal investigation, to keep the matter confidential and to keep the child safe.

At Dunebrook, Public Educator Director Sara Hoyt is passionate about empowering children with self-protection strategies and teaching adults how to prevent, identify and respond responsibly to concerns for a child's safety. Her presentations are in high demand and reach more than 30,000 children, educators, and parents annually. Beginning in kindergarten, she helps children identify a "safe" adult. A safe adult is someone a child can go to if they ever feel unsafe, have ever been hurt, or if they're not sure if a situation is unsafe.[4]

Hoyt urges that every member of the oral healthcare team can put themselves out to children as a "safe adult." During the course of a dental visit, she suggests saying to your child patient, "I'm a safe adult. Do you know what that means?" "That means I can get you help if you're ever hurt or feel unsafe, or that you can talk to me about something that may feel uncomfortable or is difficult to talk about." Hoyt is a trained presenter for Stewards of Children, which is a trauma and evidence-informed training that teaches adults to prevent, recognize, and react responsibly to child sexual abuse. It is a two and a half hour presentation which includes interactive conversation, exercises, and video victim testimony. Stewards of Children may be presented in person with groups of up to 25 adults, or virtually from the comfort of your own home or office with groups of up to 10 adults. Stewards of Children is approved for 2 hours of CE credit for dentists and dental hygienists for both the in-person and virtual trainings. Contact Sara at sara@dunebrook.org to bring this invaluable education to your practice.

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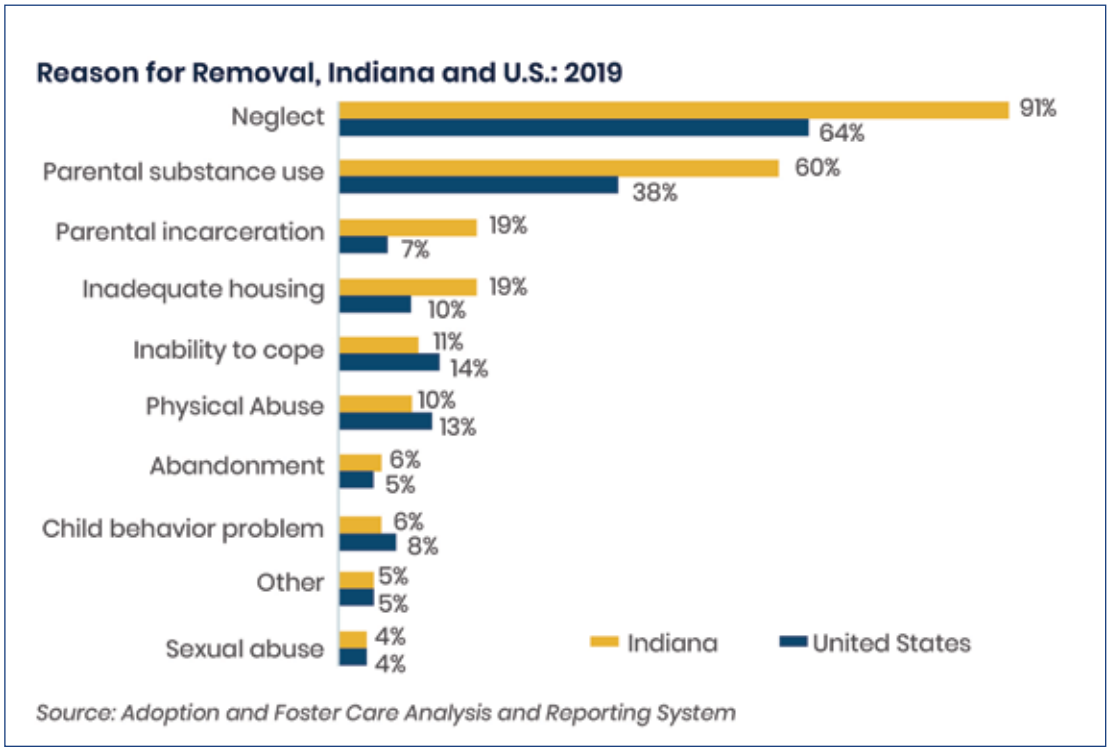

Indiana Youth Institute, 2022 Indiana KidsCount® Databook: ***www.iyi.org/indiana-kids-count-data-book/***

About the Authors

Dr. Tammy Button's favorite patients are pregnant moms and a baby before they have any teeth! She lives in Michigan City with her husband and four-year-old daughter where they enjoy spending as much time as possible in Lake Michigan.

Sara Hoyt is an 11-year veteran of Dunebrook, and in addition to directing Dunebrook's Public Education Program, she is a trained child forensic interviewer and parent educator. When they are not camping, she lives in Valparaiso with her husband and twin seven-year old daughters.

What You Need to Know About Patient Consent

Doriann Cain, JD
Larissa Morgan, JD

BEFORE TREATING a patient, every dentist should consider the fundamental principle of consent. Has your patient, or a legal representative of your patient, granted you permission to perform the procedure? Be sure the patient (or parent/guardian, if the patient is a minor) understands the procedure you intend to perform. The liability exposure for performing a procedure without patient consent is significant. Therefore, good communication and an understanding of the laws addressing consent are of paramount importance.

The Basics

In Indiana, the age of majority is 18 years. This means that in most cases, when a patient reaches the age of 18, he or she becomes responsible for making his or her own health care decisions. There are exceptions that permit minors to make their own treatment decisions before reaching age 18 (IC 16-36-1-3; IC 16-36-1-3.5). These include:

- Emancipated minors
- Those who are at least 14 years old, living apart from their parents, not depending on their parents for support, and managing their own affairs
- Those who are married
- Those who are serving in the military
- Minors who are pregnant and meet certain conditions

On the other hand, a dentist may encounter a patient who is over 18 but appears incapable of making a treatment decision because of impairment. Such a patient's consent may not be valid. When in doubt, the dentist should seek professional legal counsel.

Exceptions to the general principles often create the most confusion. The follow questions and answers address consent-related issues you may encounter in your practice:

Can consent to treat a minor be delegated to another party?

Yes, a representative authorized to consent to the minor's health care may delegate consent to another party under certain conditions:

1. The delegation of consent must be in writing.
2. It must include the signature of the person to whom responsibility is being delegated.

3. It must include the signature of an adult third-party witness.
4. It may specify the conditions of the delegated authority.
5. Unless the condition of written consent indicates otherwise, a delegate cannot transfer authority to another representative.
6. A delegate can revoke the delegation of authority by providing written or verbal notice to the representative or health care provider.

The dentist should keep a copy of the permission form in the patient's record. The dentist also should pay close attention to the scope of the delegation of consent. Did a parent delegate consent for any needed procedure or one particular procedure? Did a guardian delegate consent for a single office visit or all future visits? Delegation of consent may be very broad or very limited in scope. (IC 16-36-1-6).

Who can receive treatment information (protected health information) for a minor?

Generally speaking, the person who has the authority to consent to care has the right to information regarding treatment that has been provided. (IC-16-36-1-11).

What if a consent to treat delegation form has been forged?

The law recognizes that the health care provider is subject to deception. Perhaps the person claiming to be a parent actually is someone else. Perhaps a signature on a delegation to consent has been forged. Under Indiana law, the dentist who provides treatment, or refuses to provide treatment, based on the dentist's judgment of proper consent is not subject to criminal prosecution, civil liability, or professional discipline, if the dentist acted in good faith to determine the legitimacy of consent. (IC 16-36-1-10).

What's the difference between consent and informed consent?

The ADA recognizes the difference between general consent and informed consent. Although both require the dentist to discuss treatment and procedures with patients, informed consent is more detailed in scope. General Consent refers to a grant of permission by a patient or authorized representative of a patient to a health care provider for the provision of health care services. A patient typically is required to sign a consent form, authorizing the dentist to proceed with services and acknowledging risks associated with treatment.

Informed consent refers to consent voluntarily given by a patient or authorized representative of a patient after robust dialogue between the dentist and patient about a particular procedure. Informed consent involves the dentist explaining and educating the patient on the diagnosis, proposed procedure, treatment, alternative treatment options, benefits, and potential risks. The ADA recommends that these discussions increase in detail as the level of risk or complexity of the procedure increases. Patients may also be required to sign informed consent forms, which are specific to the procedures and may include a witness signature. The informed consent process ensures that the dentist is complying with the ADA's ethical principle of "patient autonomy" since the patient is directly involved in treatment decisions. Informed consent can offer a dentist significant protection against a claim of malpractice since the patient makes this type of consent knowingly, voluntarily, and equipped with comprehensive information.

Why is informed consent helpful?

Written informed consent offers several advantages:

1. A written documents outlines the issues the dentist wishes to discuss and lessens the risk of overlooking an important point.
2. It allows the patient time to review the information in the office or at home, creates opportunities for questions and discussion, and helps the patient make a decision based on all available information.
3. A signed informed consent document demonstrates that the dentist explained all aspects of the procedure, including potential risks and alternative options, if any, to the patient. This could be important to the dentist's defense in a professional liability lawsuit.

Because of these benefits, the ADA advises that dentists obtain a signed informed consent form before providing treatment.

Must informed consent be made in writing?

Indiana law does not require a provider to seek written informed consent for dental procedures and services performed by a dentist. The dentist may prefer to explain routine procedures and seek the patient's verbal informed consent. Notations that the procedure, along with its potential risks, were explained can be placed in the patient's chart. But for the reasons already explained, written

informed consent is preferable. Written informed consent may not eliminate a lawsuit, but it enhances the dentist's defense should legal action be taken.

Where can I find additional information?

ADA members can obtain additional information on informed consent by visiting the "Members Only" section of www.ada.org and searching "informed consent." For publicly available information and sample consent forms, visit **www.ada.org/en/resources/practice/practice-management/types-of-consent.**

About the Authors

Dori Cain is a partner at Faeger Drinker and provides strategic counsel to health care providers on the regulatory and compliance matters they must address in the rapidly evolving health care landscape, including informed consent matters. She also develops privacy and cybersecurity compliance strategies related to the use and disclosure of health information and technology platforms.

Informed by her bioethics background, Larissa Morgan assists health care providers, payors, and advocacy organizations with regulatory, compliance, and policy matters to navigate the complexities of the U.S. health care system, including telehealth, licensing, and patient consent requirements. In addition, Larissa serves as regulatory counsel in nationwide strategic transactions and affiliations, providing health care regulatory subject matter knowledge.


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Thinking Straight: Ethics and Mental Health

Dr. Michael Kurkowski

DISCUSSION OF ethics may often feel like an esoteric or aspirational exercise. A delineation of uncommon words with legalese-type descriptors that bear little application for day-to-day dental operation. Yet the Principles of Ethics & Code of Professional Conduct that we subscribe to provides the backbone of the social contract we enjoy in our freedom to operate as a dental profession. The Principles unify our responsibilities to our patients and the public. Practitioners are provided with a tangible set of guidelines that relieve each individual of trying to create his or her own rules of behavior based upon individual morals and values.

Addressing a Challenging Issue

In any given year 26 percent of Americans aged 18 and older suffer from a diagnosable mental disorder.[1] From 2009 to 2021 the CDC reported the number of high school students with persistent feelings of sadness or hopelessness rose from 26 percent to 44 percent. The highest level ever recorded.[2] The increased prevalence of mental disorders challenges dental offices in multiple ways. To fairly address this rising tide of patient circumstance, a review of how the ADA's ethical principles may inform and direct our treatment of these patients is useful. Forethought or mental rehearsal can facilitate appropriate behavior and help avoid an unintended or thoughtless reaction inconsistent with the Principles and our personal values.

Principle #1: Autonomy (self governance)

Important excerpts:

- " … involving the patient in treatment decisions in a meaningful way"
- " … safeguarding the patient's privacy"

To exercise the principle of autonomy, a patient must be able to understand the information necessary to make a choice or decision; be able to rationally weigh the options and exhibit a degree of consistency over time in his or her decision making. All patients need a level of clarity or competence in their ability to process information. A patient's mental disorder does not diminish a practitioner's ethical obligations but likely elevates the level of responsibility. It may be necessary to turn up your "interpersonal sensory dial." Coping, for some patients, can be a daily mountain they climb, to get out of bed, stay on schedule, interact appropriately, and stay in the present. Breaking information into discrete morsels that can be adequately digested may be needed to allow proper consideration and help someone to weigh offsetting options. Patients in denial about the import, value, or urgency of treatment or who repeatedly fail to reach a decision or conclusion may need encouragement to enlist a friend or family member in shared decision making. Suggesting a patient consider discussing his or her care with a trusted individual or having them invite that individual to a treatment planning appointment can be appropriate.

A patient who defers to your judgment without interest or questions may not simply be exhibiting trust but could be intimidated or not really listening or understanding. Asking the patient to repeat or teach back critical choices can be of value to gauge his or her level of autonomy.

Principle #2: Nonmaleficence (do no harm)

Important excerpts:

- " … refrain from harming the patient knowing one's own limitations and when to refer"
- " … dentist's primary obligation includes keeping their knowledge and skill current"
- " … they are obliged to seek consultation if possible whenever the welfare of patients will be safeguarded or advanced."
- " … avoid the development of a dependent relationship by patient with the provider."

The second Principle of doing no harm (nonmaleficence) takes on multiple altered nuances. Mental health must begin with the entire dental office. Dentists must be certain that they and their staff's mental status does not jeopardize a patient's well-being. The entire dental team must be able to manage the unique responsibilities required. A competent and professional frame of mind is required to usher patients through their dental appointments. Office personnel struggling with mental health must avoid allowing such problems to spill into patient settings. Recognition of the need to monitor the interactions of anyone experiencing a mental health challenge can protect vulnerable patients and safeguard office standards.

Patients with mental health challenges can also elevate the risk of harm from dental treatment. Their ability to cooperate is an important consideration both during procedures and in their ability to comply with follow-up and post-op requirements. An assessment of the patient's likelihood to consistently present for ongoing treatment is an equally essential element of any treatment plan. A patient's past appointment history may lend some insight into the discussion.

Most dental appointments include some component of stress. Caution is warranted to prevent allowing those common components of fear, the unknown, costs, and adding to a busy schedule to overwhelm a mentally challenged patient. A goal is to prevent dental care from being the additional straw for our potentially burdened camels.

The typical dental professional does not have the expertise or experience to treat a staff member's or patient's mental disorder. A cooperative relationship with a mental support team for referral or ongoing advice can help prevent compounding someone's mental health issues or slowing their progress toward health. Removing ourselves from direct psychological intervention may also help patients avoid developing an unhealthy dependent relationship with you, a dental provider. Mental health is not within our scope of practice, and we should avoid attempting a mental health diagnosis. Patient charting should be limited to description of observed or reported behavior such as agitation, lack of emotion, profound sadness, failure to attend, reports of self-loathing or injury, etc. Since records may be transferred to another provider, a subjective non-professional mental diagnosis by a dentist can follow a patient and bias future practitioners in a manner that could be adverse to a patient's status.

Principle #3: Beneficence (do good)

Important excerpts:

- "… involving" … competent and timely delivery of dental care within the bounds of clinical circumstances"
- " … obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care."
- " … a dentist's ethical obligation to identify and report signs of abuse and neglect."

This Principle dictates awareness of a patient's status and condition when his or her parents or guardian appear to be wrestling with mental health. Family members, including a patient, will often be in denial or overprotective of a mentally troubled individual to avoid further complications or trauma to that person. The person wrestling with mental illness may not currently have the capacity to provide adequate custodial care. The child or senior (dependent individual) may lack any additional advocates in their world. They may not have the perspective to realize that things are clearly off track. Careful inquiries can elicit important clues

regarding home life and circumstances that could require intervention. The first step would nearly always be direct conversation with the guardian to advocate for a patient's care and circumstances.

For our patients with mental health issues, beneficence could lead to creating a dental environment less challenging to them. Scheduling appointments at a particular time of day or day of the week may be useful. Shorter, multiple appointments may be more successful,[1] and finding time with fewer staff, other patients, even service people present may help. Being aware of the impact of ambient noise or music could also be a useful tool to modify and allow greater ease in accomplishing (doing good) treatment.

Principal #4: Justice (fairness)

Important excerpts:

- " … a duty to be fair in their dealings with patients, colleagues and society."
- " … delivering care without prejudice."
- " … actively seek allies throughout society on specific activities that will improve access to care."

This Principle speaks to non-discrimination and patient selection, based primarily upon a practitioner's ability to provide quality treatment. Refusal to treat or accept a patient should rely on the office's inability to manage the patient and his or her dental needs. Just as offices make accommodations for physical issues and disabilities, an honest effort to support and treat those on the mental health spectrum is indicated. Most patients battling mental illness can, with a measure of empathy and attention, be managed in a typical dental setting. Working with a patient's mental health team or referral to a potential mental health provider can expand the ability of an office to effectively manage a wider range of mentally challenged patients. Since mental illness is often transient or episodic, treating or welcoming these individuals into your practice can be a practice builder. Using mental illness as a vehicle to exclude a particular element of society, especially protected groups, could be considered unethical behavior.

Principle #5: Veracity (truthfulness)

Important excerpts:

- "… obligation to communicate truthfully and without deception and respect the position of trust inherent in the dentist-patient relationship."

Loss or interruption of someone's mental health may undermine the individual's ability to properly weigh alternatives and offsetting considerations. Clear communication in task performance, and realistic expectations following procedures will be useful in preventing misunderstanding by a patient wrestling with his or her mental health. Maintenance of trust is always a key goal of any patient interaction, and much simpler than attempting to restore that trust once it has been lost or eroded. Utilizing a teach-back method (where the patient repeats or rephrases a discussion summary) or written materials can often be valuable.

Conclusion

The Principles of Ethics & Code of Professional Conduct were likely written and revised by rational minds for a "rational world.". This rational world can at times seem underpopulated and the rational viewport challenging to apply to our varied office settings. Our increasing awareness of the prevalence of mental health disorders provides opportunities to create a more non-judgmental environment.

Dentists accommodate all manner of patient physical limitations to provide treatment. Dental offices may benefit from mental health screening questions and elaboration or follow-up for patients using psychoactive prescriptions. Non-judgmental inquiries can help overcome stigma surrounding the topic of mental illness and solicit voluntary candor by our patients.

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HIPAA and Your Dental Practice

Compliancy Group

HIPAA CONSISTS of complex regulations dictating patient information privacy and security. Because of its complexity, many people fail to understand HIPAA and how it applies to them. Much of the everyday operations at your dental practice are heavily regulated by HIPAA. Answers to FAQs are discussed to guide dental offices in complying with HIPAA standards.

How Does HIPAA Apply to Dental Practices?

Dental practices are considered covered entities under HIPAA. To be HIPAA compliant, dental practices must meet the requirements of each of HIPAA's three main rules.

HIPAA Privacy Rule

The HIPAA Privacy Rule provides guidance on the appropriate use and disclosure of protected health information (PHI). Under this rule, PHI access must be limited to only those employees that require access to perform their job (known as the minimum necessary standard). To comply with this rule, employees should be granted access to PHI based on their role within the practice. For instance, an employee scheduling a patient appointment would not need to be granted access to a patient's entire medical chart. They would only need to know the basic information required for setting a new appointment.

For dental practices using an EHR, access to the platform should only be given to employees that need it. EHR platforms will allow you to designate different levels of employee access through unique login credentials. Dental practices still using paper records may have difficulty limiting access to specific parts of a patient's file. However, paper records must be kept in locked rooms or cabinets to prevent access by unauthorized parties. To ensure that employees access paper records appropriately, it is essential to have written privacy policies that dictate the proper uses and disclosures of PHI.

The HIPAA Privacy Rule also requires dental practices to develop a Notice of Privacy Practices (NPP) that outlines how your practice uses and discloses patient information. Patients must be given a copy of your NPP for review upon intake. If your practice would like to use or disclose PHI for reasons other than what is outlined in your NPP, you must receive written authorization from the patient. For example, you may wish to share patient testimonials on your website or through social media, but to do so, patients must give explicit consent for you to use their information in this manner.

Also, as outlined in your NPP, patients have the right to request copies of their medical records. Should patients request their records, your practice has thirty days to provide the copies. Records should be provided in the format the patient requests (i.e., paper, CD, USB, etc.) when reasonably appropriate. Additionally, practices may only charge a reasonable cost-based fee for requested records, such as the cost of the CD.

HIPAA also imposes annual employee training requirements. Training must include HIPAA basics, cybersecurity best practices, and an overview of your practice's HIPAA policies and procedures. To meet

HIPAA training requirements, employees must legally attest that they have read and understood the training materials and agree to comply with the standards outlined in the training.

HIPAA Security Rule

The HIPAA Security Rule requires dental offices to ensure the confidentiality, integrity, and availability of PHI. This is accomplished by implementing administrative, technical, and physical safeguards. Conducting an annual security risk assessment (SRA) is essential to determine what safeguards are appropriate for your practice. SRAs identify risks and vulnerabilities to electronic PHI (ePHI). By conducting a risk assessment, your practice can prepare against potential threats to the privacy and security of ePHI.

To ensure that your practice adheres to the HIPAA Security Rule, it is essential to have written security policies and procedures. These policies and procedures guide how your practice implements safeguards to protect PHI.

HIPAA Breach Notification Rule

The HIPAA Breach Notification Rule requires breaches affecting PHI to be reported. Breaches affecting 500 or more patients must be reported within 60 days of discovery to HHS' OCR, affected patients, and local media outlets, while those involving less than 500 patients must be reported within 60 days from the end of the calendar year in which they were discovered (March 1).

Your practice must have written policies and procedures for breach notification. These policies and procedures provide guidance for employees on what to do should they suspect a breach, and to whom they should report an incident.

What is a Business Associate?

Dental practices must also ensure that all their business associate vendors are HIPAA compliant, and have signed business associate agreements with these vendors.

A business associate is any vendor that creates, transmits, receives, stores, or maintains PHI on behalf of their clients. Common examples of business associates include online appointment scheduling services, electronic health record providers, cloud storage services, and email service providers. Business associate agreements (BAAs) are legal contracts that must be signed before allowing vendors to perform business associate functions. By signing a BAA, each party agrees to be HIPAA compliant, and be responsible for maintaining their compliance.

How Are HIPAA Violations and Fines Determined?

The Department of Health and Human Services (HHS) sets forth specific standards that dentists must follow, while the Office for Civil Rights investigates potential violations. HIPAA violations can occur for a variety of reasons.

The most common reasons that healthcare practices are fined are:

- Failure to conduct an annual security risk assessment
- Failure to provide patients with timely access to their medical records
- Improperly using or disclosing patient information
- Lacking signed business associate agreements

Healthcare organizations that are investigated by the HHS' Office for Civil Rights and found in violation of HIPAA are subjected to costly fines, OCR monitoring, and corrective action plans. In the past, dental practices have been fined $5,000 to $62,500 for right of access violations, impermissibly disclosing patient information in response to an online review, and impermissibly disclosing patient information to a third-party marketing firm.

How Do I Become HIPAA Compliant?

To become HIPAA compliant, you must implement a documented compliance program that meets HIPAA Privacy, Security, and Breach Notification requirements. To do so, you must:

- Conduct annual self-audits, identify gaps in your compliance, and implement remediation plans.
- Implement documented HIPAA policies and procedures, and review them at least annually or when there is a change in your business operations.
- Have signed business associate agreements with all business associate vendors.
- Conduct annual employee training and have employees attest to the training.
- Have a system in place for detecting and responding to breaches.

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Need assistance with HIPAA compliance? As the only HIPAA solution endorsed by the Indiana Dental Association, dentists can be confident in their compliance program. Find out more about Compliancy Group and HIPAA compliance on our website: **https://compliancy-group.com/hipaa-for-dental-associations/**

Guardrails for Supervision and Delegation of Duties

Jay Dziwlik

GUARDRAILS ARE a good thing. They keep us within the boundaries of safety and on track in the direction we desire. Whether it's business, parenting or supervising and delegating the dental team, knowing where the guardrails is helpful to practicing within the Indiana statutes in order to keep patients safe and effectively utilize staff.

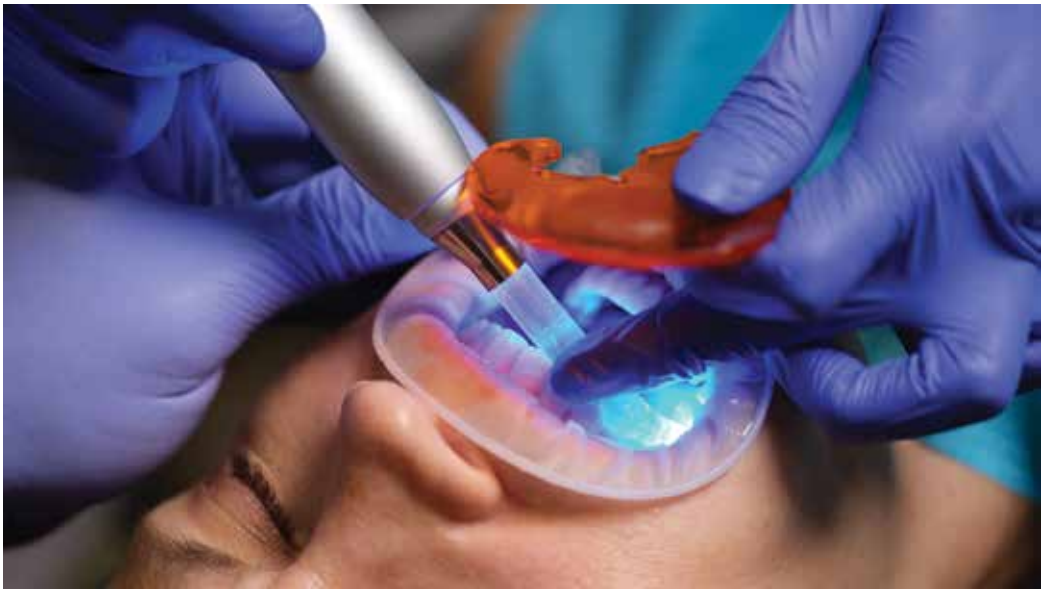
Supervision and delegation of dental auxiliaries has changed in the last decade, especially with the introduction of prescriptive supervision, administration of nitrous oxide, coronal polishing and fluoride application. Recent pressures on the workforce have also impacted the everyday delegation in dental offices as dental teams adjust to patients, employees, workforce demands and processes in their practices.

General landscape of delegation and supervision in Indiana

With all these different aspects and the pressures on effective use of auxiliaries it is good to review overarching principles of the Indiana Practice Act and how it frames delegation and supervision within Indiana law. There are three overarching "guardrail" principles to delegation supervision in the state of Indiana and in the ADA Principles of Ethics and Code of Professional Conduct.

Guardrail Principle #1:The dentist as leader of the oral health team

Dentists are the doctors of a patient's oral health. Indiana Code 25-14-1-23(a)(1) defines the practice of dentistry in Indiana. It includes a person who "Directs and controls the treatment of patients within a place where dental services are performed." Your 8+ years of college and graduate training, your dental licensing and interdisciplinary cooperation in medicine in oral health makes you part of primary healthcare and the leader of patient oral health. Any delegation to auxiliaries is determined and directed by you and is connected to your dental license. You pay close attention to your team's training, knowledge, qualifications, and skills prior to delegating. The dentist does not abdicate supervision or oral care in delegation. The "buck stops" with the dentist and all care in someway reflects on the dentist and their dental license as the leader of oral healthcare in that practice.



Guardrail Principle #2:There is a distinction in the supervision of dental hygiene and dental assistants

Each office has a unique mix in the dental team. Training, skills, personality and flow all may alter day to day operations slightly. Under Indiana statutes, all dental assistants operate under the direct supervision of a dentist who is present in the facility in which care is being rendered. IC 25-14-1-1.5 (4-5). No assistant should be doing direct clinical care without the presence of the licensed dentist. This is true even in emergency situations like a temporary falling off or a wire or bracket coming loose. In 2014, Indiana House Bill 1061 created Prescriptive Supervision for Indiana licensed dental hygienists. This new law, IC 25-13-2(j), opened the possibility for a dentist to have the option to direct patient care to be done by a hygienist without the dentist being physically present in the facility. A dentist can do this under the following conditions:

1. The dental hygienist has completed, with at least an average of 20 hours per week, at least two years of active practice as a dental hygienist under the direct supervision of a licensed dentist.
2. A licensed dentist has, in a dental office setting, provided the patient with a comprehensive oral examination and any appropriate care in the previous seven months.
3. A licensed dentist has issued a written order for the specific care to be provided that is valid for not more than 90 days and provided in a dental office; and
4. A licensed dentist has notified the patient that the licensed dentist will not be present when the dental hygienist is providing the patient care; or
5. A written order for the specific care to be provided that is valid for not more than 90 days; and
6. The patient has provided a current medical history.

All prescriptive duties are within the definition of hygiene duties outlined in the practice act except for administration of injectable local anesthetic and the administration of nitrous oxide, which may be performed under direct supervision in prescribed circumstances. IC 25-13-1-10.6 and 10.7. Topical anesthetics are allowed. Again, assistants are all under direct supervision and hence in a prescriptive supervision hygiene visit where the dentist is not present, dental assistants would not do any direct clinical care, including taking radiographs.

Guardrail Principle #3:There is a distinction of what duties a dentist may be delegated to auxiliaries

As leader of the oral health team, it is important to know that you determine what is and is not delegated in the office and that any delegation follows the state laws and abides by your obligation to protect the health of your patients. Sometimes the law may allow some delegation but you as a dentist do not want to delegate that or maybe your staff needs to grow in knowledge and skill proficiency in a delegable duty. The ADA Principles of Ethics and Code of Professional Conduct outline the Use of Auxiliary personnel under the concept of non maleficence “do no harm,” “Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.” It is clear delegation, protects the health of the patients, and is given only to qualified staff under the clear direction and supervision of the dentist. Any staff who does not feel qualified or expresses concern about a task delegated may be an indicator to train up or maybe not delegate that duty.

There is no list of delegable duties. It makes sense for several reasons. Technology and procedures change and then rules or statutes would need to be changed to include a new procedure. Not every delegated duty is suited for every office or every staff member. Dentists, as the directing lead in oral healthcare, need to determine the best treatment not based on a list of allowed duties but on the patient, staff and what is best for the health of the patient. Some duties require extra education, training or certificates and the list would not outline all of those requirements.

Delegation in Indiana is outlined by the Indiana Statutes and Rules of the Indiana State Board of Dentistry in the definition of dentistry and the definition of hygiene. A dental license is attached to the definition of dentistry which reads as follows in IC 25-14-1-23:

“A person is practicing dentistry within the meaning of this chapter if the person does any of the following:

1. Uses the word “dentist” or “dental surgeon,” the letters “D.D.S.” or “D.M.D.” or other letters or titles in connection with dentistry.
2. Directs and controls the treatment of patients within a place where dental services are performed.
3. Advertises or permits to be advertised by sign, card, circular, handbill, newspaper, radio, or otherwise that the person can or will attempt to perform dental operations of any kind.

Continued on page 26

4. Offers to diagnose or professes to diagnose or treats or professes to treat any of the lesions or diseases of the human oral cavity, teeth, gingiva, or maxillary or mandibular structures.
5. Extracts human teeth or corrects malpositions of the teeth or jaws.
6. Administers dental anesthetics. (Except as provided in IC 25-13-1-10.5 and IC 25-13-1-10.6)
7. Uses x-ray pictures for dental diagnostic purposes.
8. Makes: oral images for the fabrication of a final restoration, impression, or cast; impressions; or casts of any oral tissues or structures; for the purpose of diagnosis or treatment thereof or for the construction, repair, reproduction, or duplication of any prosthetic device to alleviate or cure any oral lesion or replace any lost oral structures, tissue, or teeth.
9. Advertises to the public by any method, except trade and professional publications, to furnish, supply, construct, reproduce, repair, or adjust any prosthetic denture, bridge, appliance, or other structure to be worn in the human mouth.
10. Is the employer of a dentist who is hired to provide dental services.
11. Directs or controls the use of dental equipment or dental material while the equipment or material is being used to provide dental services. However, a person may lease or provide advice or assistance concerning dental equipment or dental material if the person does not restrict or interfere with the custody, control, or use of the equipment or material by the dentist. This subdivision does not prevent a dental hygienist who is licensed under IC 25-13 from owning dental equipment or dental materials within the dental hygienist's scope of practice.

A dentist delegates to a hygienist based on their definition of hygiene (IC 25-12-1-11) as outline in the statutes: A person is deemed to be practicing dental hygiene within the meaning of this chapter who:

1. Uses the titles "Licensed Dental Hygienist," "Dental Hygienist" or the letters "L.D.H.," "R.D.H." or "D.H." in connection with his or her name;
2. Holds himself or herself out to the public in any manner that he or she can or will render services as a dental hygienist;
3. Removes calcific deposits or accretions from the surfaces of human teeth or cleans or polishes such teeth;
4. Applies and uses within the patient's mouth such antiseptic sprays, washes, or medicaments for the control or prevention of dental caries as his or her employer dentist may direct;
5. Treats gum diseases
6. Uses impressions and x-ray photographs for treatment purposes; or
7. Administers local dental anesthetics or nitrous oxide, except for the administration of local dental anesthetics or nitrous oxide by:
   A) A dentist as provided in IC 25-14-1-23(a)(6)
   B) A physician licensed under IC 25-22.5; or
   C) A dental assistant as defined in IC 25-14-1-1.5(4) in compliance with section 10.7 of this chapter.

Newer "guardrails" for delegated duties for hygienists and dental assistants

Dentists have coordinated with hygiene and assistants legislative changes to improve oral health and expand how a dentist might supervise and delegate in the practice over the past decade. There have been several changes and clarifications to both hygiene and assistants. Let's start with hygiene in the areas of administration of local anesthetic, use of lasers, coronal polishing and application of fluoride.

Dental hygienists, with proper cardiopulmonary and emergency procedure training and earning a dental board issued dental hygiene anesthetic permit, can administer local anesthetic injections under direct supervision of a dentist. The requirements for earning the Dental Hygiene Local Anesthesia Permit include the following course work:

An applicant for a dental hygiene anesthetic permit shall complete a course in local anesthesia administration in an educational program accredited by the Commission on Dental Accreditation of the American Dental Association that includes, at a minimum, 15 hours of didactic instruction and 14 hours of laboratory the following subject areas:

1. Theory of pain control
2. Selection of pain control modalities
3. Anatomy
4. Neurophysiology
5. Pharmacology of local anesthesia
6. Pharmacology of vasoconstrictors
7. Psychological aspects of pain control
8. Systemic complications
9. Techniques of maxillary and mandibular anesthesia
10. Infection control.

As part of the educational requirement, the dental hygienist will be required to take and pass the Commission on Dental Competency Assessments, or CDCA (formerly North East Regional Board or NERB) local anesthesia examination or a substantially equivalent regional or state examination prior to completion of the program. The hygienist then would complete and application for dental hygiene local anesthetic permit, verification of licensure; course work, etc.

Expanded Duties Training Requirements

A dentist may use professional judgment in delegating duties to a dental assistant practicing under direct supervision, provided the procedures do not require a dental or dental hygiene license. Indiana law states: "Procedures delegated by a dentist may not include dental duties outlined in the definition of dentistry, "those procedures which require professional judgment and skill such as diagnosis, treatment planning, the cutting of hard or soft tissues, or any intraoral impression which would lead to the fabrication of a final prosthetic appliance." Procedures delegated to a dental assistant may not include procedures allocated under IC 25-13-1 to a licensed dental hygienist."

Dental assistants can also earn certificates through didactic and competencies to be delegated, including radiology, application of fluoride and coronal polishing. Requirements of completion are outlined in state law and have been topics of previous Indiana Dental Association publications.

Administration of Nitrous Oxide by dental hygienist and dental assistants is new in 2020 as defined in IC 25-13-1-10.7, under direct supervision by a dentist (IC 25-14-1-1.5). Requirements for any wishing to administer nitrous oxide must meet the following:

1. Has been employed in a dental practice for at least one year or has graduated from a program accredited by the Commission on Dental Accreditation of the American Dental Association;
2. Satisfactorily completed a three-hour didactic nitrous oxide administration course containing curriculum on pharmacology, biochemistry, anatomy of nitrous oxide administration, emergency procedures, and the mechanics of operating a nitrous unit, accredited by the Commission on Dental Accreditation of the American Dental Association; and
3. Demonstrated clinical competency on at least five patients under the direct supervision of a licensed Indiana dentist whose license is in good standing. The licensed Indiana dentist supervising the clinical competency shall provide to the dental hygienist or dental assistant a signed affidavit certifying the competency. Upon receipt of the affidavit provided to a dental hygienist or dental assistant under subsection, the provider of an educational program or curriculum shall issue a certificate of completion to the dental hygienist or dental assistant. The certificate of completion must be publicly displayed in the dental office of the dental hygienist or dental assistant.
4. Before permitting a dental hygienist or dental assistant to administer nitrous oxide, the supervising dentist shall:

- Verify that the dental hygienist or dental assistant has completed the requirements as listed in the previous column;
- Determine the maximum percent-dosage of nitrous oxide to be administered to the patient; and
- Ensure that any administration or monitoring of nitrous oxide by dental hygienists or dental assistants is done in accordance with relevant guidelines and standards developed by the American Dental Association or the American Academy of Pediatric Dentistry.

There is a lot to delegation and supervision of the dental team. That is because there is a lot at stake in providing the best oral healthcare for your patients. A careful review for yourself and your staff on these delegation and supervision "guardrails" will ensure clear communication of standards that best comply with current Indiana rules and statutes of the state and eventually provide the best dental care for all of your patients.

About the Author

Jay Dziwlik is the IDA's assistant executive director and a frequent speaker on topics related to ethics, jurisprudence and HIPAA. He can be reached at **jay@indental.org**.

The Legalities of Service and Comfort Animals in the Operatory

From the ADA Practice Management Resources

PART OF treating patients with disabilities is the possibility of having a patient's service animal in the office. These animals can provide invaluable help to the patients and families bringing them in, but they can also pose numerous questions about the legal, ethical and even medical ramifications of having an animal in the operatory or common areas of the office. The following guidance from the ADA will help guide your office to determine your rights and responsibilities in the presence of a service animal.

Definition and Duties of a Service Animal

The Americans with Disabilities Act defines a service animal as "a dog that has been individually trained to do work or perform tasks for an individual with a disability" and states, "The task(s) performed by the dog must be directly related to the person's disability." In recent years the Americans with Disabilities Act has added separate regulations for miniature horses who are trained as service animals.

Some examples of how service animals assist people with disabilities include guiding the visually impaired, bracing a person at risk of experiencing seizures or falls, calming a person with post traumatic stress disorder, and assisting in mobility and access for people who use wheelchairs.

Animals that provide emotional comfort, often called comfort animals, are **not** considered service animals in context of the Americans With Disabilities Act. It can be difficult to distinguish between a service animal and an emotional support animal, especially in relation to assistance with psychological disabilities. The key difference is determining whether or not the animal has a specific task or function related to the handler's disability.

A dental office may inquire whether an animal is a trained service animal and not merely a pet, but may not ask for official certification for the animal. Office staff may also ask what specific tasks the animal is trained to do for the patient, but they may not ask about the nature of the patient's disability. Your office is not allowed to charge extra fees for the animal or treat the patient differently from other patients.

Service Animals in the Dental Office

Under the Americans With Disabilities Act, a dental office must allow service animals anywhere the patient must go. This

includes allowing the service animal to escort the patient into the office and even operatory (if appropriate for the planned procedure) when necessary.

Section 4A of the ADA Code, Patient Selection, articulates criteria for patient selection and delineates what are not acceptable criteria for excluding a patient. Among these criteria are disabilities. However, there are procedures in which the presence of an animal would not be considered safe or appropriate. For example, a procedure that requires sterile conditions may preclude the presence of a service animal. In this case, the dental office should make every effort to make backup arrangements, such as using a second handler to wait with the dog.

Considering the Rights of All Patients

In Section 2 of the ADA Code, the principle Nonmaleficence ("do no harm"), expresses the dentist's obligation to avoid harm. In accommodating the needs of a patient with a service animal, however, the dentist also needs to consider the rights of other patients and the staff members in the office who may have an adverse reaction to an animal in the office. Justice must be applied to all patients.

Although the Americans with Disabilities Act states that fear or allergies are not valid reasons for denying access or refusing service to a patient with a service animal, the dental practice still can take measures to apply fairness to all parties. Care in scheduling and patient flow can be applied to minimize contact with other patients who are allergic to or scared of dogs. A dental practice that makes such accommodations honors the ADA Code Principle of Justice ("fairness") and remains compliant with the Americans with Disabilities Act as long as the person with disability is not isolated or treated less favorably than the other patients.

The same housekeeping procedures used for humans are adequate for service dogs as well. It may be advisable to remove animal dander immediately after a service animal has been in the dental office, particularly as a courtesy to other patients or staff who are allergic to dogs.

Service Animals and Behavior in the Dental Office

Because the Americans With Disabilities Act does not allow businesses to require official certification of the animal, there is no way to screen for bad animal behaviors in advance.

According to the standards published by Assistance Dogs International (ADI), service dogs must perform tasks on first command 90 percent of the time. A well-trained service dog will not whine or growl, bark, bite, sniff people or objects, interact with other animals or people, or toilet inappropriately. The dog will remain quietly by its handler's side unless it is performing a task for which it has been trained or it is responding to a command from its handler.

Businesses do have the right to remove a service dog that is aggressive, growling, snarling or biting. Businesses also have the right to remove a service dog if it is wandering around and/or bothering others in the office—In short, not acting as a trained service animal. When a dog is disruptive, staff should ask the handler to bring the dog under control. If that doesn't happen, staff may ask the handler to remove the service dog. The patient should always be given the option to return without the dog.

The Americans with Disabilities Act requires service animals to be harnessed, leashed, or tethered unless that would interfere with the tasks the service dog performs.

Comfort Animals

It's become trendy in the past few years for medical and dental offices to have therapy, or "comfort" animals. These animals, usually dogs, are trained to provide affection and comfort by helping to calm patients and reducing anxiety in people with dental phobias.

Proponents of therapy animals maintain that therapy dogs calm anxious patients, making dental procedures go more smoothly. From both a marketing and oral health perspective, patients who are excited to visit a dental office because of its pet may be more likely to schedule follow-up appointments.

If you're considering having a comfort pet in your office, here are some best practices to consider:

- It is important to have a handler, preferably a certified pet assistant, in charge of the dog 100 percent of the time in order to control the dog and any situation that may arise.
- Consider designating a specific day each week or once a month to invite the therapy pet to the office. That way patients know ahead of time that there will be a dog in the office during their appointment.
- Inform all patients in advance of the dog's presence so that those with allergies to or fears of dogs can change their appointment.

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Service Animal Quick Reference

Your office may:

✔ Inquire about what specific tasks the animal is trained to do.

✔ Require the animal to remain outside of areas that must remain sterile.

✔ Ask for the animal to be removed if it is disruptive or behaving inappropriately.

✔ Require a service animal to be leashed or harnessed unless that would interfere with the animal's assigned tasks.

Your office may not:

X Deny the presence of a service animal on the grounds of allergies or fear from other patients.

X Require proof that an animal is certified as a service animal.

X Charge extra fees for the animal.

- Inviting a hypoallergenic dog may minimize dander and fur allergies.
- The CDC maintains that animals do not pose a more significant risk of transmitting infection than people, but it is still important to consider where the animal may go within the office. It is likely wisest to confine any therapy animal to the waiting room and areas for simple treatments such as cleanings and fillings, rather than operatories where surgeries and more complicated procedures are taking place.

Conclusion

The vast majority of service dogs are extraordinarily well trained and obedient, and in most cases the animals are received enthusiastically by other patients and staff members. Your office is very likely to have a positive experience with a patient's service animal, but knowing the laws and best practices surrounding a patient's rights and responsibilities regarding service animals is important for all dental offices.

How to Receive Credit for this CE Issue

Thank you for taking the time to read this IDA self-study CE publication in ethics. All Indiana dentists and hygienists must obtain two hours of ethics CE by the next license renewal date of **March 1, 2024**.

Once you have finished reviewing this publication, you will be ready to take the online quiz and receive two hours of CE credit. The cost of the quiz and certificate of completion is **$30 for member dentists, $50 for hygienists** and **$200 for non-members.** To access the online quiz, visit our website:

www.indental.org/ethics

If you prefer a paper or PDF version of the quiz, email keely@indental.org. Regardless of how you choose to take the quiz, upon completion with a score of 80 percent or higher, you will receive a certificate from IDA. You may re-take the quiz up to two times if you are not satisfied with your score.

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Should Dentistry Be a Profession?

Dr. Richard Jones

WHAT ARE the advantages of dentistry being considered a profession? Does it help patient care? Is it worth all of the restrictions? Do we make less money? Is it out of your control or might you have an impact?

A profession is an occupation that requires a high degree of technical knowledge. That knowledge is too complex for an untrained individual to completely understand. The only way that the lay person can fairly relate to the professional is if the "professional" commits to a professional code of conduct that protects the lay person. For instance, if you enter a transaction to purchase a car, you have the ability to understand as much of the process as the salesperson. If you require brain surgery, you cannot fully appreciate the technicalities involved and you must rely upon the ethical conduct of the surgeon. In fact, dentistry has a contract with government and society to self-regulate. Because we have accepted the responsibility of self-governance, we have been given the privilege of self-governance. Only a trained dentist can understand a dental treatment well enough to fairly evaluate the standard of care for that treatment. It is just and accurate to be judged by peers.

We trace dentistry back to 7000 BC in the Indus Valley. French physician Pierre Fauchard, who is considered to be the father of modern dentistry, published his influential book The Surgeon Dentist in 1723, a Treatise on Teeth, which for the very first time defined a comprehensive system for caring for teeth and treating dental ailments. Still, at that time, dentistry was barely considered a profession. Attempts to improve training are noted with the establishment of the American Journal of Dental Science in 1839. That was followed a year later, when the Baltimore College of Dental Surgery (the first dental school in the United States) opened in 1840.

Dentistry was not too technical for a barber to understand 200 years ago. There have been rapid scientific, technical, and organizational advances in the past 100 years. The American Dental Association was founded in 1859.

The early leaders of the American College of Dentists initiated the noble profession of dentistry with standards for education, research, and journalism. In 1923, the American Association of Dental Schools was established. The following year, the American Dental Assistants Association was founded. Dental schools became university-based after the Carnegie Foundation issued the Gies Report, a comprehensive report that covered the state of dental education, in 1926. The noble profession of dentistry was taking shape.

A chronology as dentistry develops to be a profession:

- The 1950s and 60s are considered by some to be a Golden Age for the profession. By the 1950s, dental knowledge and ability had advanced to a high technical level and dentists achieved high income, respect, and community leadership opportunities.
- Dental benefits became widely available by the 1970s. Access to care increased with an average annual insurance benefit of $1,000. Since the 1970's, dental health insurers, responding to the demands of their policyholders, have attempted to contain the cost of dental treatment by, among other devices, limiting payment of benefits to the cost of the "least expensive yet adequate treatment" suitable to the needs of individual patients. Nevertheless, more families could go to the dentist. Dentists got busier and made more money. The number of dentists increased. Preferred Provider Organizations (PPOs) came into being and peaked in 2011 with a 65 percent market share. As benefits decreased, dentists dropped their participation as they were unable to run a profitable practice.

- In the early 1970s, the federal government placed additional scrutiny on state licensing boards and professional association ethics committees. Some of these groups' efforts to regulate advertising were deemed anti-competitive and potentially in violation of federal antitrust rules. This had a chilling effect on the enforcement of advertising standards, opening the door for misleading and unprofessional advertising, claims of fake specialization and promotion of unnecessary and non-dental treatments. Some state boards have lost in litigation and now must allow "specialists" in non-ADA accredited areas to claim specialty status. Even the ADA Principles of Ethics and Code of Professional Conduct has been altered for those states. Professional regulation has been undermined. These factors have contributed to the emergence of commercialism in dentistry. One might argue that the door has been opened for overtreatment and lower quality. FTC actions have contributed to making self-regulation and enforcement of the ADA Principles of Ethics and Code of Professional Conduct difficult.
- 2000s: DSOs have increased dramatically in the past 20 years. In 1999, 65 percent of dentists were in private practice. By 2021, that percent had declined to 46.2. No doubt educational debt and the cost of running a practice have contributed to the transition from traditional solo practice. Group practice provides economy of scale, cost sharing, and delegation of duties that come with a larger support staff. Available hours for clinical care increase as does doctor efficiency. Cost of care and access to care are benefits. The commercial aspect of dentistry is stimulated by profit opportunities and by non-dentist ownership. Generational differences impact solo practice as the priority of life balance increases.
- The past 30 years have seen an historic evolution in clinical dentistry: evidenced based practice, expansion of duties for non-dentists, scientific knowledge, technical developments—implants, bone grafting, digital dentistry, imaging, and computer assisted design to name a few innovations. Unfortunately, these advances also can be corrupted for personal gain.

Dentistry is at the fork in the road of professionalism vs commercialism. Dentistry has always been a marriage of clinical care and business management much like the two lanes of a highway with each headed in the same direction. As a respected profession, the emphasis has been on patient care. Socio-economic changes have favored the business side of dentistry in the past 40 years. During that period, the lanes have diverged and now have become a fork in the road. Different communities of dentists have favored one lane or the other since Painless Parker, an early 1900s traveling dentist whose advertising and gimmicks were labeled "a menace to the dignity of the profession" by the ADA. Certainly, the 20th Century saw a prevalence for the lane of professionalism, but these two lanes are diverging in the 21st century.

There will always be a patient type for every doctor type. One has only to look at the United Kingdom with some dentists working solely under the National Health System, but with the vast majority in private practice, many as a hybrid with the NHS. There will always be dentists who choose to serve as professionals practicing the standard of care, as well as discriminating patients that will choose those dentists.

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We will always observe an ebb and flow of three communities of practicing dentists: the upper echelon with a focus on patient care and professionalism, the lowest echelon, most commercially focused, and the largest middle group that enjoys the protective aspects of belonging to a profession but is concerned about the economic realities.

Unfortunately, commercialism is here. Dental education squeezes an influx of technical developments into the same four years of education and other knowledge is displaced with financial pressure to minimize cost. The pressure on educational institutions to operate at a profit pervades the system from the top down. Young dentists are beginning their professional/business careers with unprecedented debt from school and set up costs and with an unprecedented expectation of earnings. Do they have the luxury of preferencing professionalism over money? There is societal pressure that places financial success over all else that is important. “A hundred thousand dollars is not enough; I must make a million.”

It is easy to make the case that financial pressure forces the dentist to be commercial. The Enron scandal of 2001 made it clear that conventional professional standards can be compromised by financial pressures. The case can also be made that, because of curriculum changes, the young dentist is desperate for information that is required to be more successful but is less equipped to evaluate the sources of information, so clinical and management guidance from the social media sites with the most hits becomes the convenient source.

Modern technologies (implants, lasers etc.) and societal fads like cosmetic alteration are marketing levers that can push dentistry away from our professional roots. These marketing levers may be acceptable unless claims are unfounded or misleading. Where does the “untruth in advertising” begin? It used to occur only with isolated individuals; now it is present at the national level. Dentists as a group, indeed the entire arena of oral healthcare, is being preyed upon by powerful national forces.

- Societal pressures like avarice.
- Cosmetic dentistry.
- Manufactures that hit the marketplace with products that are supported by heavy marketing rather than sound evidence.
- Purveyors of Continuing Education whose mission is to make excess profit at the sacrifice of sound information.
- Social media as the convenient guide to patient care.
- DSOs with production quotas that instill unprofessional practice paradigms.

Dentistry is at a fork in the road. The younger dentists may not know about the fork and can’t afford to notice. Some manufacturers, some supply houses, some purveyors of CE, and some publishers of non-peer reviewed literature are becoming wealthy at the fork in the road.

The face of dentistry is changing rapidly. The huge baby boomer population is retiring and being replaced with individuals from a generation with different core values, different motivational factors, different financial realities, and different stress factors. The professional memory is being lost. The bodies of evidence and professional standards are less relevant. Many dentists are oblivious to the envelope of professional standards being changed. The new peer standard will redefine the practice of dentistry. Soon it will be too difficult to turn around. Eventually, the government and consumer groups will discover that dentistry has changed.

We do not have a convention for right fork vs. wrong fork so I will define the left fork of dentistry as being a retail industry void of required professional principles of conduct, ethics, and established standards of care.

What is the appeal of dentistry as a business? Is it just money? There are benefits of autonomy of practice:

- Freedom from intervention by those with knowledge of the science.
- The universe of advertising.
- Increased spectrum of treatment options.
- Little need to invest in evidenced based dentistry or continuing education.
- The ability to emphasize business efficiency and profitability over optimum clinical care.
- And of course, the anticipation of increased income, at least initially.

But what will be sacrificed if dentistry is no longer a profession?

- Increased regulation by government.
- Loss of a political action and lobbying representative with government.
- Judgment by those without technical understanding.
- Loss of patient confidence and respect.
- Loss of personal doctor/patient relationships.
- Increased litigation.
- Loss of collegiality.
- Loss of protection from unscrupulous dental manufacturers, suppliers, and providers of continuing education.
- Increased competition.
- Eventual decline in income as patients become more wary.

The right fork of dentistry as a profession provides substantive and altruistic benefits. The income brackets for almost all dentists are in the top 10 percent, with a majority in the top 5 percent and with many reaching the 2022 US 99th percentile of $400,000.

Being in a profession also provides:

- Opportunity for great clinical care.
- Vast and intentional academic and research support.
- Professional organizational guidelines and support.
- Professional organizational representation with the government.
- Less governmental intervention compared to a retail marketplace.
- Control of competitive stresses.
- Enhanced personal doctor/patient relationships.
- Respect in the community.
- Community leadership opportunities.
- The opportunity to feel really good about the service that you provide and how you enhance the lives of others.
- The reward of treating generations of the same family.

The shortcomings of being a member of a noble profession are similar to the benefits of not enjoying the structure of a profession. A good illustration is the dynamics of children in a divorced family with one parent providing structure, support, and guidance. The other parent provides freedom and access to a broad base of social options. The latter provides immediate gratification. The maturing child comes to realize that the nurturing and promise of a successful future comes from the parent with structure and consistency. Structure is an essential attribute of a community.

Dentistry has always been a marriage of clinical care and business management—the good and the bad or maybe the necessary? Painless Parker may conjure up terrible images, but if you read his biography, he was not all bad. Some qualities that were out of sync at the time were insightful and opened the door for innovation. The new normal includes advances in communication, expanded access to

> The face of dentistry is changing rapidly. The huge baby boomer population is retiring and being replaced with individuals from a generation with different core values, different motivational factors, different financial realities, and different stress factors.

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care, cost sharing, volume purchasing, decreased fees, increased salaries, and profits, enhanced auxiliary support, and access to expensive technology.

Of course, there are some painful aspects. They can be managed by confidence in the mission and belief in dentistry as a noble profession. Why are we here? Why are you here?

My paradigm of professionalism is so strong that I have difficulty imagining dentistry as a purely retail industry. But my observations of some practices and my logic paint a dismal picture.

What can be done? What are our options? Perhaps we could resign ourselves to the inevitable. Or we could respond with intention and focus. We may not be able to impact the most noticeable lower commercial group, but we can strengthen the upper echelon and engage the largest middle group.

As they have in the past, the American College of Dentists can guide us toward the right fork and restore the profession of dentistry for patients and for dental professionals. In fact, The ACD has a history of identifying problems and activating the appropriate groups to action. It is considered the conscience of dentistry.

The College Executive organization, the Section leadership, and the individual Fellows are the disciples of the profession that have the ability to enhance excellence, ethics, professionalism, and leadership for oral healthcare. The College provides online ethics courses, publications, the Ethics Handbook for Dentists, scholarships for ethics and leadership training, support for high quality local projects, strategic guidance for initiatives on such issues as diversity, relevance, communication, group practice guidelines, professionalism, and medical-dental integration.

The ACD also supports and collaborates with the American Society for Dental Ethics, the American Association for Dental Editors & Journalists, and the Student Professionalism and Ethics Association and actively works on outreach projects with other organizations. The College provides connections to healthcare organizations.

What can SPEA do? The Student Professionalism and Ethics Association is the discipleship of the future. They are trilingual with digital and social media as native languages. They understand their peers: the pressures, motivations, communication styles, and values. SPEA connects with the College, and we engage and empower one another. SPEA members can do what disciples do to create positive change. Remember the three communities? SPEA members are in the upper echelon. Do not focus on the extremes of the lower group but engage the large middle group. Educate your peers on the advantages of dentistry as a profession. Engage and empower your colleagues and students because you can make a difference for the middle group.

First begin with yourself. You may be familiar with the six Expectations of the Professional from Rule/Bebeau, (Quintessence, 2005):

1. Acquire the knowledge/skills of the profession to the standard set by the profession.
2. Continue learning as new advances and technologies emerge.
3. Put the oral health interests of patients before self.
4. Abide by the profession's code of ethics.
5. Serve society (not just those who can afford your care).
6. Participate in personal self-regulation, the monitoring of the profession, and participate in professional associations.

Second, look to the future by nurturing professionalism in others. The responsibility of mentorship should be number 7 on the Expectations of the Professional. Let your associations and study clubs know that you value professionalism. Educate your patients about our Code of Ethics and Professional Conduct and the standards of care. Encourage patients to seek out dentists who value professionalism.

But what can we as individuals do?

- Know that you can and do have impact.
- Know your core values.
- Recognize to which community you belong: the upper, the middle, or the lowest.
- Understand the significance of dentistry being or not being a profession.
- Acknowledge your role, potential for impact and the butterfly effect.

- Live and practice as an exemplar.
- Engage your dental community.
- Engage other communities.
- Engage another generation through support and mentorship.

All of us make choices. Collectively, our choices impact the status of dentistry in society and government and allow us to enhance oral health for our patients and our community.

As previously stated, dentistry has always been a marriage of clinical care and business management. The respected professional enjoyed a high income without optimal business practices. New systems for clinical delivery and practice management increase quality of care, access to care, affordability of care, and profitability.

I honestly don't know if we are still a profession, but I am not ready to give up. I know that it is important that dentistry be a profession. It is important that the lowest common denominator be ethics and not financial gain. Being a profession protects the public, it satisfies the government and society, and it enhances the image of the professional group. Being a profession, creates an environment where dentists can focus on providing good, quality, evidenced based healthcare in a profitable way with less external infringement. Our time is limited; we can use it providing good care and running a successful healthcare business or dealing with public and governmental onslaughts as an individual. In other words, if a group ascribes to and abides by a code of ethics, the government and civic groups can have confidence that the professional association will protect the public. When a group becomes a non-professional business, they lose their protective covenant with society that affords them the luxury of self-regulation. They also lose many reasons for belonging to the ADA tripartite.

Weighing the advantages of being a respected professional health care provider with academic, research, and journalism support and a high income against being a wealthy retailer in a competitive marketplace without organization enhancements leaves me with an obvious path-the right fork. And I am doing something about it. What will you do?

About the Author

Dr. Richard Jones completed his prosthodontic training at Indiana University in 1978. He was in the full-time practice of prosthodontics and maxillofacial prosthetics in Munster for 30 years. Dr. Jones has a strong interest in ethics and evidenced based dentistry and a mission to collect and share knowledge that makes quality dental care easier and more predictable. He chaired the IDA Council on Peer Review from 1989 to 2018 and chaired the IDA Task Force on Ethics and Professionalism. Dr. Jones is a past chair of the Indiana Section of the ACD, past ACD Regent of Regency 4, 2015 to 2019, and the American College of Dentists President 2021-2022.

Colleagues, Calling and Care

Lawrence Garetto, Ph.D., FACD

This article is a transcript from the Convocation Address at the American College of Dentists Annual Session 2022 in Houston, Texas.

I FEEL honored to be asked to share a few thoughts with you this afternoon at this meeting of an organization that I believe is tremendously important.

First of all, congratulations to the new Fellows who have just been inducted into the American College of Dentists. This ritual of induction is one that represents, in a symbolic manner, a binding together of those of you present today, as well as those across time, as a unique group of colleagues. It is an acknowledgment for some of you of your many accomplishments across years of service to the profession, and for a some of you who are closer to the beginning of your professional life than the end, the recognition of the potential you have already shown for continued contribution in this esteemed and respected healthcare profession.

If you were able to attend the presentations this morning at the business meeting, you heard that the College was founded 102 years ago. This induction ceremony, in which you have just participated is a tradition that goes back 101 years even to the point of having similar academic garb to that you are wearing now. You are part of a long tradition here today.

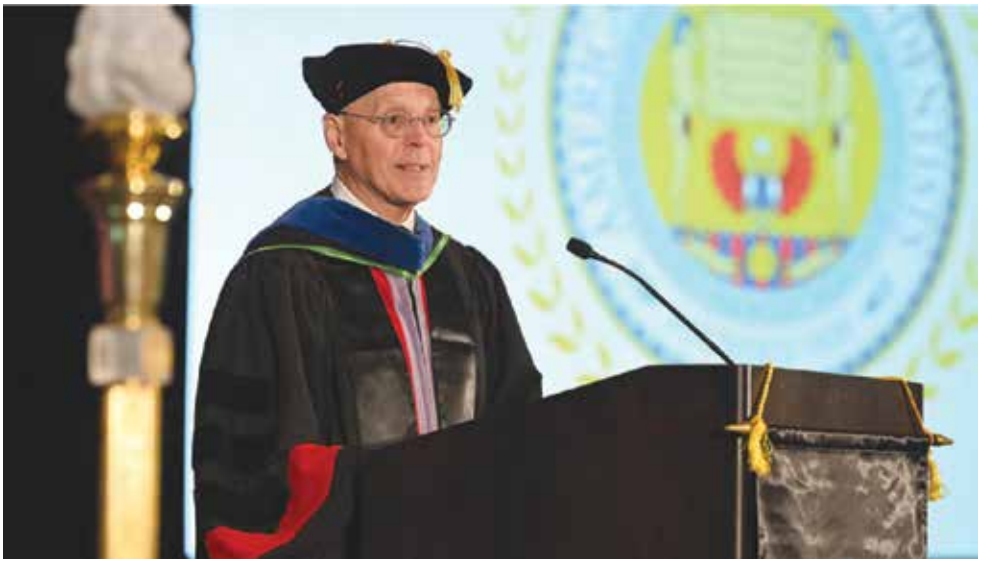
Rituals and symbols are important in professions. Ceremonies like this, bind us to each other and serve as tangible reminders that you are not just individuals, but part of a collective...colleagues who share esoteric knowledge, specialized skills and, especially in this ceremony, important values, at the top of which is the calling to provide care for a fellow human being whose health may be compromised in some way, sometimes very significantly. And, you are expected to do so prior to any consideration of self-interest.

You were nominated for Fellowship by two colleagues who were already fellows of the College and in doing so, they had to describe very specifically how you met the four principles of Fellowship: Excellence, Ethics, Professionalism and Leadership. And meet them you did, or you would not be sitting here today.

Now, I'd like to take us back for a minute, to another ceremony that routinely occurs at the beginning of professional life, a ceremony that many of you may have participated in especially if you graduated from dental school in the past 20 years or so, the White Coat Ceremony. It too is a "binding" ceremony, like this one you have just experienced. But of course, it's different as well because it can be viewed as the induction of lay people into a profession.

Why do we do such a ritual at a school? And, a white coat? Certainly in this day and age, white coats are not typically worn during patient care. Why not just pull a scrub top over their heads and call it a day? Well, we're back to that concept of a ritual that is symbolic. The white coat is symbolic of the long history of care providers who have come before you, who have built the profession into one that is trusted and valued by society.

Think about it...why in the world would a patient, a person whose oral health is compromised in some way, perhaps significantly, and who may be in pain – someone who may not know you at all – why would they trust you to invade their physical space, literally get in their face to invade their privacy by asking them questions about very personal details of their life and



Lawrence Garetto, Ph.D. giving the Convocation Address at the American College of Dentists Annual Session in Houston in 2022.

health. Why would they allow you, someone they may not know well at all, to put sharp pointy instruments into their mouths and move about? Why?

Well, I believe it is because of the trust that has been developed by those of you sitting in this room today being honored not just for who you are, but for what you have demonstrated in your commitment to service to other human beings who are in need, as well as to the long line of clinicians who have come before you. You benefited from them, you stood on their shoulders as our current students and new colleagues now benefit from you. It is because of the institution to which you belong, and the trust and respect that has already accrued and is acknowledged by the society. But it's so important to recognize that you not only benefited from this initially when you began your life in the profession, but that you have become the next generation of "those who came before us" to subsequent cohorts of Fellows who have not yet been nominated or inducted. I have to also say, I am so happy today to see among your ranks some of my own students…students whom I have always viewed as colleagues. While it some respects, it makes me feel my age, I could not be prouder of you than to see you sitting here among finest clinicians and scholars that dentistry has produced.

Well today, you're not wearing a white coat, rather you're wearing an academic gown that represents the mantle of Fellowship recognizing you for your accomplishments. But this honor comes with some strings attached. Certainly, you have the continued responsibility of upholding the principles of the College, in clinical excellence, in the ethical and professional nature of your practice and in the leadership you demonstrate by being an empathetic, compassionate health care provider for all who are in need. But even more so, you must recognize your responsibility to actively model of the principles of Fellowship to all colleagues, including our students and our young practitioners.

Now, this word and concept of "colleague" is an interesting one. As an ethicist, and at this stage of my life as a "seasoned" educator (I'm old), it may surprise you to know that I do not believe students become our colleagues upon graduation from dental education programs. And, I will respectfully but strongly argue that point with anyone who does think it. I believe they became our colleagues the moment they crossed the threshold into dental school to begin their studies.

Why do I think that? Because beginning at that moment and going forward until the end of their careers as healthcare providers, when they are recognized for doing good works at school or in the community, they are not just recognized by society as an individual, but as a member of a community of practitioners, and because of that, the entire profession is honored.

But there's even a more powerful reason. When it comes to light a student, as an individual, or indeed a class of students, were to behave in a manner that is dishonorable, even at the very earliest stage of their education, the entire profession is detrimentally affected. Therefore, if one's actions positively or negatively affect the view society has of the entire profession, then by default, they are our colleagues, and we must work to make it for the better, not for the worse.

Why do I spend the limited time we have together today speaking about this. Because an important component of your leadership in the profession, your leadership as a

> The white coat is symbolic of the long history of care providers who have come before you, who have built the profession into one that is trusted and valued by society.

Fellow, involves modeling and mentorship – about the role one has in a profession. Professionalism is not innate to the person, it has to be learned and internalized, accepted an acted on. Frankly, I believe it to be a skill, not much different in character than the esoteric technical skills you all learned. And like those technical skills, one continues to learn them, to do them better as time goes on. Ignoring this ethical dimension of professional life, and even not adequately paying attention to it, results in a downward path away from that of a profession.

I would like you to consider this mentorship and modeling as an essential component of what we term "self-regulation" and "peer review" and I view these as something we do for someone, not to someone — for the profession.

Peer review – hold your schools accountable as well. Recently we had a very disturbing example at a midwestern medical school white coat ceremony of newly arrived students disrespectfully turning their back on an esteemed physician BEFORE she began to speak because they disagreed with a viewpoint she held. This is intolerance. Disagreement is normal and reasonable, and reasoning individuals may certainly hold different views. Intolerance is anathema to life as a professional and should be called out. Otherwise, that we espouse tolerance and respect as virtues of professionalism is contradicted and overwhelmed by our acceptance of such behavior. One has to ask the question as to whether these students will do that to patients who do not share their views, or look like them, or value the same things they value? Which by the way, was the very topic of that physician's address to them that day.

I would like to close by asking you to reflect that the academic robe you wear today, much like the white coat we invest our students with, represents a symbolic mantle of professional life as a health care provider, and more importantly, that it represents a promise that each of you have made, and continue to make to each other, in front of colleagues and very importantly in front of your family and friends, that you will continue to do the work you did that allowed you to develop into a skilled practitioner and leader, who every day demonstrates your calling to care for fellow human beings in need.

I believe it is an awesome responsibility to hold the profession to these ideals...to hold our young colleagues to these ideals...and I challenge each and every one of you to view this recognition you have received today as emblematic of an obligation to hold each other to that promise. They are you, as they go, so go you. You are not just individuals, but a community of practitioners...you are colleagues whose integrity and reputation are integrally bound to each other. And lets also remember what you permit, you promote.

The greatness of a profession does not consist of having great wealth, or in the high intelligence of its members, or in power over other people, or in high status or fame. Its greatness consists of the spirit of service and servant-leadership seeking always the well-being of those people for whom you care.

You have achieved an honor today, but you are honored every day when you care well for another human being. Let's keep things in perspective and remember, that is greatest of your honors.

It has been my honor to be with you today to celebrate this wonderful occasion and once again, I congratulate you. Thank you.

About the Author

Lawrence Garetto, Ph.D., FACD, has a Ph.D. in physiology from Boston University School of Medicine. Dr. Garetto served as director of the Bone Research Laboratory and associate dean for dental education and director of the Problem-Based Learning program at IUSD. He also was the founding chair of the IUSD Professional Conduct Committee and advisor to IUSD's Student Professionalism and Ethics Club. Dr. Garetto is a Past-President of the American Society for Dental Ethics.

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Student Commitment to Professionalism and Ethics

Dr. Odette Aguirre

AMONG DENTAL educators, there has been debate about whether we teach ethics or we merely teach about ethics.[1] There is no question about the importance to teach students to recognize the ethical dimensions of patient care, cultivate their ethical sensitivity, contribute to their knowledge about appropriate and justified options, and help grow their moral courage to take action. However, this teaching must go beyond textbooks, traditional lectures and seminars because ethical decision-making does not depend only on knowledge and theoretical education.

Ethical action is informed by real-life situations, awareness of diverse interpretations and interaction with peers in a supportive environment where questions are encouraged and expected. Therefore, ethics should be taught through multiple approaches that are engaging and lead to introspection and reflection beyond the didactic information. In recent years, one of the most engaging approaches to promote the learning of ethics actually came from dental students and their desire to express their deep support of ethical principles and professionalism in dental school and beyond. This is how the Student Professionalism and Ethics Association (SPEA) was born.

The beginning of this association can be traced back to March 2007, when a group of students with faculty guidance at the Herman Ostrow School of Dentistry of the University of Southern California (USC) came up with the idea of a Student Professionalism and Ethics Club (SPEC) to promote ethics in dental school. By 2008, SPEC had gained national recognition from the American Society for Dental Ethics (ASDE), the American College of Dentists (ACD) and the American Dental Association (ADA).[2]

In 2009, the American Student Dental Association (ASDA) passed a resolution to bolster the formation of organizations like SPEC at every dental school, and the ADA offered support through its Committee on Ethics, Bylaws and Judicial Affairs (CEBJA) and its Joint Subcommittee on Ethics in Education. At that time, the USC group put together a start-up kit so that other dental schools could form their own local chapters.[3] In the Fall of 2010, Indiana University School of Dentistry (IUSD) established its own SPEC.[4]

In May of 2011, a committee of 10 dental students from six different universities (Indiana University, Dugoni University of the Pacific, Midwestern University, USC, UCLA and Virginia Commonwealth University) attended a meeting at USC School of Dentistry in Los Angeles to lay the foundation of a new organization with dental school chapters focusing on the promotion of ethics and professionalism. The group drafted a constitution and bylaws,

deliberated about the leadership structure on a national, regional and local level, and developed a strategic plan. At the ACD Annual Session in October 2011, the bylaws were ratified, and SPEC was renamed the Student Professionalism and Ethics Association (SPEA), formally becoming a new national organization. IUSD was involved from the beginning of this process, as then-dental student Ewelina Ciula (Class of 2013) was one of the 10 students who originally met at USC. She later served as co-president of IUSD's chapter and as vice-chair of SPEA at the national level.[4]

Of note is that IUSD has maintained to this day their active involvement in the organization and has had several national officers: Ewelina Ciula as vice-chair; Patrick Mangan (Class of 2018) as chief information officer and regent; Jill Stetzel Torkeo (Class of 2019) as regent for Regency 4; Josh Bussard (Class of 2020) as regent of Regency 4, vice-chair and executive chair; Maria Contreras Mantilla (Class of 2020) as regent for Regency 4; Tim Nye (Class of 2022) as regent intern for two consecutive years; and Raphael Raganit (Class of 2023) as vice-chair.

In June of 2012, IUSD's SPEA chapter was honored by receiving a Presidential Citation from IDA president at the time, Dr. Terry Schechner. The association was recognized for their dedication to support and promote professional ethics.[5] IUSD's SPEA chapter has continued to receive numerous local and national awards, and this is a testament to their motivation, hard-work and creativity. In 2012, a group of students from IUSD's SPEA chapter were runner-up in the national ethics video contest sponsored by the ADA's CEBJA. The IU entry was titled "Back to Ethics" and was produced by Ewelina Ciula (Class of 2013), Katherine Hungate (Class of 2012), Gabrielle Johnson (Class of 2014), Tadziu Kula (Class of 2014) and Ali Sajadi (Class of 2012). They donated the $1,000 winnings to IUSD's chapter as a fundraising effort.[6]

To conclude a very eventful 2012, at the convocation of the ACD in October, national SPEA was honored with the Ethics and Professionalism Award.[3] In 2017, IUSD's SPEA chapter received awards for "Best Chapter" for Regency 4 and "Best Event" among all the regions for their "Cases That Haunt Us" annual presentation of challenging cases by faculty. IUSD's chapter was further honored in October 2018 when they were named U.S. Chapter of the year at the SPEA annual meeting in Hawaii.[7] At SPEA's 10th annual session, IUSD's chapter received the "Best ACD Relationship" award for maintaining a close relationship with the ACD.[8] Proof of this fruitful collaboration is the fact that ACD speakers have been invited to give presentations organized by SPEA and that the president of SPEA has been invited to join the Indiana Section of the ACD's monthly meetings to discuss expectations, accomplishments and goals for their collaboration.

> Ethics should be taught through multiple approaches that are engaging and lead to introspection and reflection beyond the didactic information.

The mission and objectives of SPEA include supporting students in the development of their personal and professional ethical values (by providing resources, encouraging safe spaces for discussions, and promoting awareness of ethical issues in dentistry), and actively collaborating with dentistry's leadership to advocate for their members.[2] Their mission is facilitated by SPEA's structure, which was designed as regencies by geographical region that work closely with ASDA and the ACD. Each regency is overseen by a regent, elected for a one-year term at the annual session.

The duties of a regent include serving as a national board member, representing the regency's constituents, and being the point of contact between chapters, SPEA executives, and ACD members. They also are a valuable resource for each of the SPEA chapters. Currently there are 46 active chapters in the 7 Regencies (Regency 1: Northeast, Regency 2: Canada, Regency 3: Southeast, Regency 4: Great Lakes, Regency 5: Midwest, Regency 6: South, Regency 7: West Coast). Indiana belongs to the Great Lakes SPEA Regency 4.[9]

The ACD maintains a close and collegial alliance with SPEA. Locally, the ACD collaborates with SPEA chapters through shared functions and provision of funding. On a national level, SPEA and the ACD support each other through leadership connections, participation in each other's media presence and SPEA representation in ACD meetings.[10] One of the ways in which the IUSD chapter works to accomplish SPEA's mission and objectives is by organizing a series of presentations on topics of interest to them. Some examples of the topics that have been pre-

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sented are: “Uncomfortable Conversations – Racism in Dentistry”, a panel discussion of faculty and ACD members including Dr. Lorraine Celis, then chair of the Indiana section of ACD; “How to get your dental license, and keep it,” presented by Jay Dziwlik and Ed Rosenbaum from the IDA, “Peer Review” presented by the Indianapolis District Dental Society peer review committee members, and “Understanding Wealth, a value-based approach” presented by Dr. Richard E. Jones, current ACD president.

The history of IUSD’s SPEA would be incomplete without mentioning Dr. Lawrence Garetto and Dr. Susanne Benedict. Dr. Garetto was instrumental as an advisor during the formation of national SPEA and the IUSD chapter and provided guidance and support to students in his role of SPEA advisor for many years. Dr. Susanne Benedict (sadly now deceased) was a beloved chapter advisor in more recent years.

Our IUSD SPEA chapter continues to have strong participation at a national level and serves as a role model for the Indiana dental community. It has been gratifying to see how students have responded to the increasing ethical challenges to the profession of Dentistry. Through SPEA, they not only learn ethics, they also teach about ethics. What better way to keep our faith in the ethical and professional behavior of students and future IU graduates than the continued and successful existence of a student-led organization that embodies the values necessary to achieve the excellence of character expected of dental professionals.

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Current Indiana Dental CE Requirements, 2022–2024

Dentists (at least 20 hours total)

- Indiana Ethics, Professional Responsibility & Jurisprudence (2 credit hours)
- Practice Management (not required, but a maximum of 5 credit hours can be applied in this category)
- Annual HIPAA Training as a Federal mandate (no specific amount of hours)**
- Opioid Prescribing and Abuse (2 credit hours for all dentists with a CSR license)***
- Annual OSHA/Infection Control Training as a Federal mandate (no specific number of hours)**

Hygienists (at least 19 hours total)

- Indiana Ethics, Professional Responsibility & Jurisprudence (2 credit hours)
- Practice Management (not required, but a maximum of 5 credit hours can be applied in this category)
- Annual HIPAA Training as a Federal mandate (no specific amount of hours)**
- Basic Life Support Certification
- Annual OSHA/Infection Control Training as a Federal mandate (no specific number of hours)**

** OSHA and HIPAA training are required by federal mandate but can also apply toward Indiana CE requirements.
*** Dentists with a DEA Registration must complete 8 hours of opioid CE before their next registration renewal. Current and past opioid CE taken to fulfill Indiana requirements may be used to apply toward this requirement.

For both dentists and hygienists, **half of all CE hours must be live**. Online courses are considered live if there is real-time interaction between the instructor and the participants.

Truth, Trust, and Success: A Practical Guide to Ethical Dental Marketing

Kelli Bock

IN THE ever-changing landscape of modern dentistry, ethical marketing has become a cornerstone of success for dental professionals. Today, building trust, fostering meaningful patient relationships, and providing valuable information are paramount. Ethical marketing embraces a transparent, patient-centric approach, prioritizing education, empowerment, and well-informed decision-making. By empowering patients to take charge of their oral health journey, ethical marketing cultivates lasting patient relationships built on trust. In this article, we will explore best practices for ethical dental marketing, drawing inspiration from the ADA's 2023 Principles of Ethics and Code of Professional Conduct.

Central to ethical dental marketing under the ADA's Principles of Ethics is the principle of veracity, emphasizing the dentist's duty to communicate truthfully. The dentist-patient relationship is characterized by a position of trust, making honesty and trustworthiness paramount in all interactions. Ethical marketing centers on providing genuine value and forging authentic connections with patients, refraining from exaggerated claims or misleading information that could compromise patient satisfaction. Upholding transparency in all promotional materials, including websites and social media content, is vital to establishing enduring patient relationships based on trust and credibility.

Section 5.D.2 of the ADA's Principles of Ethics highlights the importance of ethical conduct in the marketing or sale of products and procedures to patients. Dentists must exercise caution to avoid exploiting the trust inherent in the dentist-patient relationship for financial gain. Misrepresenting the value of products, the necessity of procedures, or the dentist's expertise in recommending them is considered unethical. Moreover, dentists have an independent obligation to verify the truth and accuracy of claims made about health-related products. Full disclosure of all relevant information is essential to enable patients to make informed purchase decisions, including the availability of products elsewhere and any financial incentives tied to the dentist's recommendation. As a best practice, dental professionals should:

- Avoid superlatives like "best," "most effective," or anything you cannot prove.
- Do not promise any results you cannot consistently deliver.
- Refrain from showing other dental practices in a bad light.
- Steer clear of fear-based tactics.

These standards also extend to the digital realm, where dental professionals often utilize websites to introduce their practice, team, and philosophies while sharing oral health care information with the public. If patient education and providing high quality oral care are at the core of your practice's mission, consider crafting engaging content that not only informs but also addresses common oral health concerns to empower patients to take proactive steps towards their dental well-being. Additionally, prioritize the user experience on your website by ensuring seamless navigation, fast loading times, and mobile responsiveness. Finally, regularly audit your website content for any inadvertent stereotypes, exaggerated claims, and biases. In this way, you can go beyond having just a basic online presence to standing out from the crowd by positioning your practice as a trusted source of dental expertise in the digital realm.

In addition to your practice website, search engine optimization (SEO) services are frequently employed to increase website visibility during consumer searches for dental content. Aligning web content and SEO techniques with the ADA's Principles of Ethics and Code of Professional Conduct ensures that websites remain truthful and transparent, while also improving Google rankings. Conversely, sites with lots of click bait, bad links, duplicate content, irrelevant or unethical content, or "black hat" techniques will not pass the algorithm's tests. These types of techniques attempt to trick Google's algorithm into giving a site a better ranking than it should have. That said, Google and other search engines are constantly finding ways to punish black hat techniques, so web masters who think they've "won" the SEO game with black hat tactics do so at their own risk.

Next, as your practice develops patient-oriented content and marketing messages, go beyond generic messages and a one-size-fits-all, "spray and pray" approach. Instead, seek to acquire a deep understanding of your patients' needs, preferences, and concerns. Through thorough market research and analysis of patient data, you can gain valuable insights to shape your marketing strategy. Once your research is complete, focus on creating quality content that resonates with your target audience. Address common questions, concerns, and misconceptions related to oral health in your blog articles, videos, and social media posts. Avoid sharing "fluff" and overly lofty claims. Rather, emphasize authentic patient stories, testimonials, and case studies to showcase the transformative impact of your services while simultaneously building trust and confidence in your practice. By crafting content that genuinely addresses the needs of your audience, you can establish a strong connection with patients based on mutual trust and shared values.

As with any marketing initiative, don't skip the final step of evaluating the success of your ethical marketing strategy. While traditional marketing key performance indicators (KPIs) like website traffic and conversion rates provide valuable insights, it is equally important to gauge the success of your ethical marketing strategy through patient reviews, feedback, and engagement metrics. Monitoring online reviews, patient satisfaction surveys, and social media interactions can serve as valuable indicators of how your ethical approach is perceived by patients. These metrics reflect the level of trust, satisfaction, and transparency conveyed through your marketing efforts. By paying attention to these additional measures, you can gain a comprehensive understanding of the impact and effectiveness of your ethical dental marketing initiatives.

To take things a step further, you can adapt more proactive methods to collect this information by actively seeking, listening, and responding to patient feedback. For example, train your staff to engage with every patient after their appointment to ask for feedback, or send patients a link to leave a review on your website in a follow-up email. Then, demonstrate your commitment to transparency and patient-centric care by promptly responding and addressing concerns in both direct interactions and online channels. Engage in meaningful conversations with patients and adapt your marketing and operations based on their feedback. By doing so, you can continually improve your practice, strengthen patient relationships, and solidify your reputation as a trusted dental professional.

Finally, if your practice does not already utilize an automated patient communication platform, you can consider implementing this type of software to alleviate the administrative workload associated with requesting and reviewing patient feedback. Automated communications software can be set up to automatically send review requests after appointments, recall reminders on a recurring basis, and any other type of proactive care initiative your practice would like to run. When evaluating different software options, it's best to look for options that give patients the ability to opt out of communications if they choose, integrate with your practice management system, and provide key engagement analytics. As a best practice, incorporate the same guidelines for content above to your patient communications and avoid spamming recipients with overly promotional messages. This helps ensure this channel is not only serving your practice but also fostering improved oral health outcomes for your patients.

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In conclusion, ethical dental marketing is not just a trend but a vital strategy for success in today's dental industry. By prioritizing transparency, honesty, and patient centricity, dental professionals can build trust, establish lasting relationships, and drive practice growth. Ethical marketing goes beyond traditional promotional tactics, focusing on accurate representation of services, adherence to professional standards, and the delivery of valuable information to patients.

By understanding your audience, creating quality content, and leveraging digital platforms, you can engage and empower patients, positioning your practice as a trusted source of oral healthcare guidance. Monitoring key performance indicators and actively listening to patient feedback allows for continuous improvement and ensures that your marketing efforts align with ethical principles.

Additionally, technology solutions like ProSites and PracticeMojo can automate these efforts to make your practice more efficient.

For more information on ethical marketing and a free consultation to evaluate your current strategy, reach out to IDA preferred vendor ProSites at **www.ProSites.com/IDA** or 888- 932-3644.

About the Author

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