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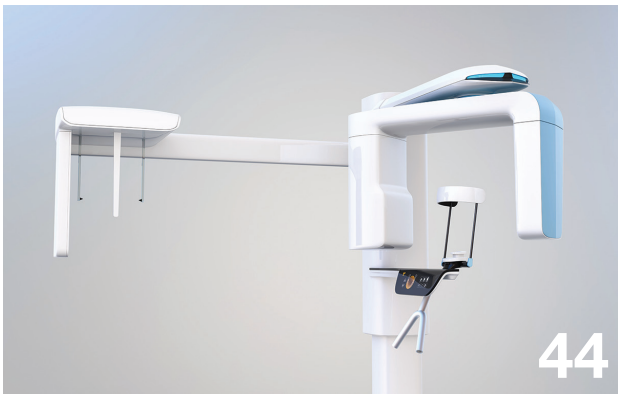


Do Good...

Doug Bush

"BENEFICENCE" IS A two-dollar word that basically means, "Do good." It's the third guiding principle in the ADA's "Principles of Ethics and Code of Professional Conduct." More specifically, the ADA Code states:

> "This principle expresses the concept that professionals have a duty to act for the benefit of others. Under this principle, the dentist's primary obligation is service to the patient and the public at large. …Since dentists have an obligation to use their skills, knowledge and experience for the improvement of the health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession."

Certainly, there are a number of ways dentists serve the public. In fact, I outlined several ways dentists are "doing good" in my last Journal editorial. In this issue, I'd like to narrow the focus to one particular opportunity… Indiana's Donated Dental Services (DDS) program, also known as the "Dental Lifeline Network."

This summer, the IDA officers, trustees, chairs and staff gathered for a planning retreat to update our three-year strategic plan. In addressing the IDA Mission Statement, a great deal of discussion focused on our efforts to "improve public health," specifically, Indiana's Donated Dental Services program. While revisions to our Strategic Plan are still in the works, one goal being contemplated is to increase the number of DDS volunteer dentists by 100 by the end of 2026.

With all of the opportunities for charitable dental care, why focus on Donated Dental? There are several reasons:

- The program was intentionally developed to be "dentist friendly." Volunteers provide care in their own office, on their own schedule, using their own equipment, with support from their own staff.
- Patients are prescreened by case managers who assess financial and clinical needs. Patients must be over age 65, permanently disabled, or have an underlying medical condition that necessitates dental care. Case managers then link patients with volunteer dentists, arrange any needed lab services and serve as a resource to resolve any problems that may emerge. This allows volunteer dentists to focus on providing care, without being burdened with administrative responsibilities.
- While some treat more, most dentists treat one DDS patient a year. That may not seem like a lot, but the collective impact is staggering. In the past year, 263 patients received a total of $890,000 in donated care. Since its establishment in 1991, the DDS program has served 6,109 patents and provided over $21.7 million in donated care.

Indiana's Donated Dental Services program also serves as a stellar example of a public and private partnership. Recognizing the positive impact and efficiency of the program, in 2023 the State of Indiana increased its appropriation for the DDS program from $34,000 to $200,000 per year. This allowed the program to hire a second full-time case manager to assist with a significant patient backlog that had occurred.

Even with the additional funding, there are challenges. COVID prompted many DDS dentists to retire, creating a significant drop in the number of volunteers. Further, workforce shortages are leaving dentists busier than ever. When dentists schedule their regular patients months in advance, it makes it more difficult to find time for pro bono services. As a result, there is a growing backlog of DDS patients waiting for care. In some parts of the state, especially central and southern Indiana, the patient backlog is so great the program is unable to accept new applications.

That's why the IDA is taking on the challenge of recruiting 100 new volunteer dentists by the end of 2026. More volunteers means more patients receiving the care they need. The recruitment effort also allows us to go back to the state legislators and show them

the impact of their financial investment in the program, thereby helping us make the case for continued funding.

If you are currently a DDS volunteer, thank you! Now help us recruit your colleagues to join the effort!

If you are not a current volunteer, please consider treating one patient per year. Use the link below and join our efforts to "do good" by making dental care available to Indiana's most vulnerable citizens.

More on Dental Lifeline Network

Case Managers

Adrienne Walker-Bell

awalkerbell@
DentalLifeLine.org
317-733-0585 direct
877-733-6585 main

Gretchen Matsuda, BSN

gmatsuda@
DentalLifeLine.org
317-742-9290 direct
303-534-5360 main

Learn More and Sign Up!

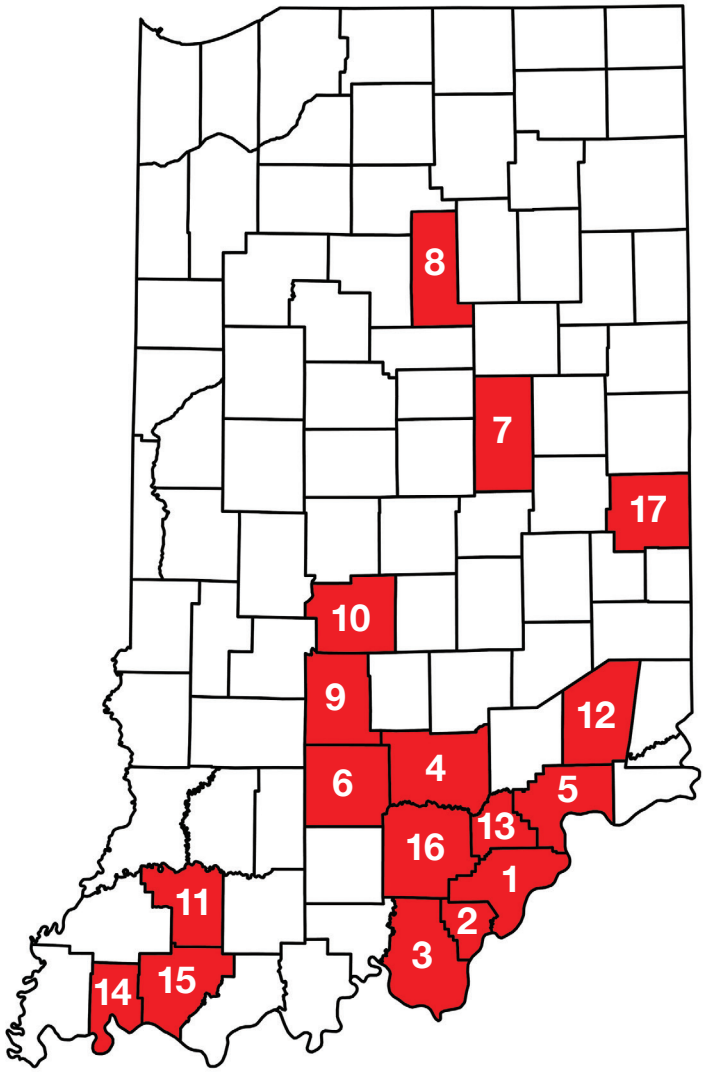
dentallifeline.org/volunteer

About the Author

Mr. Doug Bush is serving his 29th year as IDA Executive Director. He can be reached at **doug@indental.org.**

Counties in Most Need of Dental Volunteers

Applications are currently not being accepted due to a backlog of patients



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5. Jefferson
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8. Miami
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15. Warrick
16. Washington
17. Wayne

Dental Sticky Situations

Jay Dziwlik

DENTISTS FACE ETHICAL dilemmas in their clinical practice and in the daily running of their offices. These ethical situations are not always black and white or a choice between right and wrong. The truth is that most ethical situations facing dentistry are somewhere between the 256 shades of grey or differences between bad or worse and perhaps better and best.

A journey down the ethical road involves familiarity and identification of ethical dilemmas and connecting them with the code of professional conduct, principles of ethics, the laws and statutes of the practice act and the courage of our character to make the best decision. The IDA receives many calls about ethical dilemmas faced in dental offices. Below are some of the real situations with names changed to maintain anonymity. I hope to make these real situations translate into learning situations for our membership. Reflection on these real-life situations can foster learning while developing solutions as they apply to one's practice.

Sticky Situation #1

The patient in this scenario, Gwen, made an appointment for a second opinion at your practice. Following your examination and review of current radiographs, you don't see the need for treatment beyond a dental prophylaxis to help address "localized gingivitis." However, Gwen shares the treatment plan from another area dental office. Your treatment recommendations are very limited, which is in stark contrast to what the patient brought in from the other office.

Reflection and Learning

- How would you handle this ethical dilemma with Gwen?
- What feedback would you have for your colleague?
- How do you determine what is standard of care?
- Does the standard of care change over time, locations, practice settings?

Sticky Situation #2

This week Mrs. Storm came to the office with her daughter for a new patient consultation. She noted many differences between your office and another office that she visited recently. Mrs. Storm said upon her first visit to the other office, she was notified that the dentist was on vacation, and a technician would take records, photos, intraoral photos and 3D X-rays and measurements. She was informed that the dentist would call her back with a diagnosis and a treatment plan.

Reflection and Learning

- What questions or concerns do you have about this situation?
- What clinical responsibilities can you delegate to hygienist, assistant, expanded duty dental assistant or certified dental assistant?

Sticky Situation #3

Mr. Osborne is a patient who has not been seen in about nine months. He requests that you do not take radiographs because he cannot afford the extra expense with his recent job loss. He asks that the hygienist just clean and polish his teeth. Finally, he also asks to skip the examination as well.

Reflection and Learning

- What are your legal and ethical obligations?

- Discuss how you would deal with such requests from patients.

Sticky Situation #4

Friendly Neighborhood Dentistry utilizes prescriptive supervision. Peter Parker recently visited the office for periodontal maintenance and forgot to take the antibiotic premedication that the dentist ordered. The office maintains a small inventory of the premedication needed for these situations.

Reflection and Learning

- Can the hygienist/front office dispense premedication at the office?
- What are the requirements for prescriptive supervision?
- What duties can the dentist delegate to the hygienist under prescriptive supervision?
- What can an assistant do when working under prescriptive supervision?

Sticky Situation #5

During a procedure, the patient reaches over and pinches your bottom and pats you on your back.

Reflection and Learning

How would you handle this situation?

Sticky Situation #6

How would you deal with a 29-year-old patient who presents with fractured teeth following a fight with her boyfriend? Do you have any additional responsibilities beyond providing care for the fractured teeth?

Sticky Situation #7

Mrs. Parker has always been a "jumpy" patient, but she has announced she has found a way to calm herself during her visits. She has a comfort pet, Petunia, a beautiful Rottweiler that she would like to put on her lap for her visit today.

Reflection and Learning

- Can she request this, and can you allow this?
- What legal/ethical considerations do you bring up to Mrs. Parker in the conversation?

Commentary Sticky Situation #1: Second opinions are becoming increasingly frequent. First, this might be the patient's second opinion, but it is your first and best opinion on what is going on in the oral cavity of this patient. Dentists should be confident about their opinion as a practitioner and present the facts and suggestions for treatment as they see them using sound clinical judgment. Dentists may focus on the differences of opinions, as there are often different ways to get to

the same end as it applies to treatment suggestions. There are different opinions—conservative, aggressive or levels of treatment—that dentists have in the profession. Interacting with patients allows them to make their own decisions. This patient decision rests with the patient and may come down to trust. Standard of care is a phrase that does not show up in the dental practice act but has meaning in medicine. It is the convergence of research, practice setting, economy, patient behavior and laws. It can change. For example, what is standard of care for periodontal charting? Does it depend on who provides care, the general practitioner or a periodontist? Standard of extracting a tooth may be influenced by access to endodontist or economy or patient behaviors and frequency of seeing a dentist.

Commentary Sticky Situation #2: This situation leads to many questions. Who is the technician? Are they a dental assistant or dental hygienist? Who is the supervising dentist in this office? Is it permissible for dental staff to do clinical work on patients without a dentist being present? In the state of Indiana, the Dental Practice Act allows hygienists to practice under prescriptive supervision only under certain circumstances. Seeing a new patient would not be allowed under hygiene prescriptive supervision because there is a requirement for a dentist to do a periodic or comprehensive exam in last seven months. Indiana rules or statutes do not allow dental assistants to do any clinical treatment outside of direct supervision by a dentist. Direct supervision means having the dentist in the facility in which care is being rendered.

Commentary Sticky Situation #3: Let's take the radiograph and examination question separately. There is no law that requires a dental radiograph. Most would agree that a dental radiograph is ethically required during treatment. It is a basic diagnostic tool that would be considered standard of care. Since the patient in the scenario is an existing patient, it may not be as critical or ethically wrong to not take the radiograph, but specifics of the patient's oral health and length of time since last radiograph would influence the need. This patient request is not uncommon but begs the question of how many

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times should a practitioner let the patient waive a radiograph? At some point, the dentist will find themselves not knowing or not in step with standard of care. A great question to ask yourself is, "What would the Indiana State Board of Dentistry think about this procedure/practice?" Examinations are in the Dental Practice Act and would be both required and ethical to do. The reader is urged to review the article Dental Treatment: Who Has the Final Say on Oral Health Care? on page 18.

Commentary Sticky Situation #4: The quick answer to the hygienist dispensing a premedication is "don't do it!" Prescribing or dispensing prescription medication does not fall within a hygienist's scope of duty. Further, dental assistants have no ability to do direct clinical care without the dentist directly supervising the assistant and that would include a prescriptive hygiene setting. Regarding delegation and supervision of a dental assistant and dental hygienist, the reader is urged to review the article Defining Prescriptive Supervision and Delegation in Indiana: The Essential Roles of the Dental Hygienist and the Dental Assistant on the Dental Team on page 10.

Commentary Sticky Situation #5:
Each of these situations unfortunately sometimes occurs. Harassment is unacceptable by anybody at any time and is defined as unwelcome verbal or physical conduct. Dirty jokes, innuendo, touching, grabbing, brushing against, etc. are never acceptable. Each office should have a policy and protocols to make sure both staff and patients are in a safe environment. The reader is urged to review the article Sexual Harassment in Dentistry: Understanding the Issue and Steps to Prevent It From Happening on page 44.

Commentary Sticky Situation #6: The situation with the 29-year-old being hit by her boyfriend is a tough one to deal with in our practices. The state of Indiana has a mandated reporting requirement for any underage, disabled or elderly patient unable to report for themselves as it relates to abuse. In this case, the 29-year adult should also report this herself to law enforcement. The practice could be prepared to share resources, concern and assistance with getting help.[1] The National Domestic Violence Hotline is 800-799-7233. It is recommended that each practice determines how their office is going to handle a situation if it arises.

Commentary Sticky Situation #7: This question about service, emotional support and comfort animal requests in the dental practice is becoming more frequent. While patients come with requests to help them handle clinical situations, what obligations and considerations should dental practices think about when requests are presented by patients? First, only a trained service animal falls within the American with Disabilities Act federal law requirement. Service animals (dogs, miniature horses) have completed training and passed a test to assist a person with a disability under that federal law. Animals that are in training are not covered by the Americans with Disabilities Act. You can ask what tasks the service animal is trained to perform but, per federal law, you cannot ask the owner what their disability is. It is important to carefully review the patient's medical history and make sure you are aware of any potential concerns in your treatment.

The patient can be asked to remove an Americans with Disabilities Act-recognized service animal if the animal is not under control. Patients with emotional support animals may have a medical diagnosis but are not covered by the Americans with Disabilities Act. A practice would not be required to admit the animal. Comfort animals have no designation in the law and are not required to be admitted to the practice. Each office should decide their policies as they relate to support animals in the operatory. It is important to consider, as not everybody is comfortable interacting with animals. Your office staff as well as the treatment provider may be frightened by them. Infection control, concerns about allergies, animals fighting or biting, size of the operatory are all important to consider in making the office policy. Further information can be obtained from the article in the reference section titled The Ethics of Emotional Support Animals in the Dental Office.[2]

References

1. Little K. Family Violence: An Intervention Model for Dental Professionals- Office of Justice Programs • Partnerships for Safer Communities • www.ojp.usdoj.gov

2. The ethics of emotional support animals in the dental office- Ethics Subcommittee of the Council on Ethics, Bylaws and Judicial Affairs DOI: 10.1016/j.adaj.2019.07.020

About the Author

Jay Dziwlik, CAE, MBA is the IDA assistant executive director, with over 30 years of experience in the nonprofit and association management world. Jay presents regularly throughout the state and nationally through the ADA and teaches regularly in area of leadership development, associations, ethics, marketing and international business. He can be reached at jay@indental.org.

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Defining Prescriptive Supervision and Delegation in Indiana: The Essential Roles of the Dental Hygienist and the Dental Assistant on the Dental Team

Twyla Rader
Abbey Rieck
Michelle Priest

Introduction

According to the 2025 Bowen Policy Snapshot: Indiana Dental Workforce in Context, Indiana faces ongoing dental workforce shortages, with 63 of 92 counties (68 percent) designated as Dental Health Professional Shortage Areas (a federal designation indicating insufficient dental providers). This shortage presents growing challenges for licensed dentists in recruiting and retaining qualified dental assistants and hygienists, roles essential to patient care and practice efficiency. In Indiana, the practice of dentistry and dental hygiene are governed by statutes in the Indiana Code (IC) and administrative rules in the Indiana Administrative Code (IAC). Statutes are laws enacted by the legislature; rules are detailed regulations adopted by the State Board of Dentistry to implement the laws. Together, they define key concepts such as prescriptive supervision and delegation. Understanding these legal distinctions is necessary for ensuring compliance and optimizing team function in delivering patient care.

Note: This article is intended as a general guide and does not constitute legal advice. For legal interpretation, please consult an attorney.

Prescriptive Supervision for the Dental Hygienists

Prescriptive supervision for dental hygienists began in Indiana in 2014 after the Indiana Dental Association, with the support of Indiana hygienists and assistants, advocated for its implementation. The Indiana General Assembly approved legislation allowing for it under certain circumstances. This change meant that dentists were not required to be physically present when hygienists provided services, though amendments were made to the legislation in 2015 and 2020.

The prescriptive supervision statute enables dental hygienists to provide patient care without the physical presence of a supervising dentist, under defined conditions. This model increases patient access to preventive oral health services while maintaining quality and safety standards. In Indiana, the statute under IC 25-13-1-2 (j) describes “prescriptive supervision” as the provision of patient care by a licensed dental hygienist in the absence of a dentist, subject to specific prerequisites related to professional experience, prior examinations, and patient notification.

Statutory requirements outline three core conditions that must be met before a dental hygienist can provide care under prescriptive supervision:

1. Professional Experience Requirement for the Hygienist

- The dental hygienist must have completed at least two years of active practice under the direct supervision of a licensed dentist. This ensures clinical competency and familiarity with standard office protocols before practicing without a dentist physically present.

2. Dentist-Patient Relationship and Written Authorization

- A licensed dentist must have conducted a comprehensive or periodic oral examination prior to hygienist-provided care. The authorization is not valid for more than 90 days.
- In a dental office setting:

-The patient must be informed that the dentist will not be present during the hygiene appointment.

-The examination and any necessary treatment must have occurred within the past seven months. For example, a patient who had a periodic oral exam was on January 1, 2025 would be eligible to be seen for prescriptive care up to September 1, 2025, without having another dental exam.

-The dentist must issue written authority for care. This can be accomplished by creating a document on office letterhead or entering into the office dental software the following information:

-Patient name
-Date of last examination
-Patient consent to prescriptive care
-List what patient is due for (e.g., prophy, BWX, fluoride varnish)
-Leave space for treatment notes
-Doctor must sign and date when this is authorized

- In a non-dental office setting (e.g., nursing home, school, or community clinic, as defined in IC 25-13-1-2(h) and (j)):

  The dentist must issue the written prescription the same day of the examination. This written prescription is valid for no more than 90 days.

3. Current Medical History

- The patient must provide an up-to-date medical history prior to treatment.
- This step ensures patient safety and adherence to medical risk management protocols.

Additional Provision: While the range of dental hygiene treatment is not limited under prescriptive supervision, the statute prohibits the administration of local anesthesia and nitrous oxide unless the supervising dentist is physically present.

The statute allows flexibility for the hygienist to provide care before the dentist's examination, if the examination occurs later the same day.

The Roles of the Dental Assistant (DA) in the Dental Office

In the U.S., individual state laws vary widely in how they define, regulate, and credential dental assistants. All states have statutes and rules defining the practice of dentistry and dental hygiene, and many have no formal credentialing for dental assistants. Others have tiered systems with multiple levels of assistants, each with defined scopes of practice.

While Dental Assisting National Board (DANB) certifications like Certified Dental Assistant (CDA) and Infection Control Exam (ICE) are nationally recognized, they are not required for dental assistants in Indiana. However, these credentials reflect a commitment to professionalism and education, and some employers prefer or require them. Graduates of CODA-accredited programs are eligible for the CDA exam, while others must meet work experience requirements. More information is available at **danb.org**.

CODA program completion or DANB credentials, such as CDA, ICE, and Radiation Health and Safety (RHS) are recognized in many states as part of or in lieu of state-specific requirements. In Indiana only the radiology role of dental assisting is considered a "regulated occupation," under IC 25-0.5-8-1. The Indiana Department of Health (IDOH) oversees radiation safety and licensing through Title 410 IAC Articles 5 and 5.2. Limited dental radiography licensure for DAs is governed by 410 IAC 5.2-10, while dentists and dental hygienists are licensed to perform radiology functions under IC 25-0.5-1.

What does it mean to be a dental assistant in Indiana, if radiology is the only regulated role?

The term "dental assistant" did not appear in the Indiana statute or administrative code until 2010. Adding a formal title in place of the previously used term "qualified office personnel" marked a meaningful step forward for the dental assisting profession in Indiana, offering greater recognition and clarity in the legal framework. Outside of radiology, coronal polishing, caries prevention procedures, and nitrous oxide administration, other duties, credentials, and educational standards remain undefined.

In 2010, Indiana formally defined "dental assistant" as "a qualified dental staff member, other than a licensed dental hygienist, who assists a licensed dentist with patient care under direct supervision." Unlike some states that define specific, functions, titles, and credentials for dental assistants, Indiana provides flexibility by allowing licensed dentists to determine the qualifications necessary for delegation within their practice.

IC 25-14-1-23 outlines what cannot be delegated, helping dentists interpret what can be delegated to assistants. While Indiana statue does not formally recognize "expanded functions," it is generally accepted that procedures like placing restorations and fabricating provisional crowns may be delegated, if the dentist is physically present, deems the DA qualified, and there is no cutting of hard or soft tissue.

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Indiana defines three expanded duties delegated to a DA that require specific training and certificates of completion: coronal polishing, caries prevention procedures, and nitrous oxide administration.

Supervision of Dental Assistants

Per IC 25-14-1-1.5, dentists must be physically present in the facility to delegate any direct patient care to a dental assistant. Direct patient care includes in-person patient services which require hands-on, direct contact with the patient. Examples of direct patient care for DAs include taking radiographs, placing restorations, applying topical fluoride, performing coronal polishing, placing sealants, and removing sutures. IC 25-13-3-7, 25-14-1-1.5, and 25-14-1-23 indicate that DAs cannot provide any direct patient care unless a licensed dentist is physically present. This applies even when DAs work with licensed dental hygienists under prescriptive hygiene or an access practice agreement.

IC 25-14-1-23 gives one exception for a dentist's physical presence and delegation to a DA: "A dentist may, without providing direct supervision, delegate the authority to take X-ray images to a dental assistant working in a state owned or operated correctional facility administered and supervised by the department of corrections under IC 11-8-2-5(a)(2), so long as the dentist is available to supervise the dental assistant remotely."

Delegation to Dental Assistants in Indiana

It helps to review the language across several sections of the IC when considering delegation to DAs. The law outlines specific functions that constitute the practice of dentistry, meaning individuals who are not licensed dentists are prohibited from performing these tasks.

The following excerpts from IC 25-14-1-23 further clarify what may not be delegated, as these are legally defined as practicing dentistry:

"(7) Uses X-ray images for dental diagnostic purposes.
(8) Makes:
(A) oral images for the fabrication of a final restoration, impression, or cast;
(B) impressions; or
(C) 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.
(D) 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.
(E) Directs, controls, or interferes with a dentist's clinical judgment.

However, a person does not have to be a dentist to be a manufacturer of dental prostheses."

Although statutory language can be difficult to interpret, it should be clear that when performing delegated duties, DAs must follow the directions and instructions of the supervising dentist. DAs may not independently alter the treatment plan or procedure unless directed to do so by the supervising dentist. IC 25-14-1-23 also states, "a person is practicing dentistry who directly or indirectly by any means or method furnishes, supplies, constructs, reproduces, repairs, or adjusts any prosthetic denture, bridge, appliance, or any other structure to be worn in the human mouth and delivers the resulting product to any person other than the duly licensed dentist upon whose written work authorization the work was performed." This statute infers that DAs are not permitted to permanently deliver or cement crowns, bridges, veneers, or any fixed prosthesis, including adjustments. Therefore, a licensed dentist is the only dental clinician in Indiana permitted to deliver such permanent appliances.

The excerpt below from IC 25-14-1-23 might be one of the most important in helping Indiana dentists determine what can be delegated, via specifying duties that *cannot*.

"Procedures delegated by a dentist may not include the following:

1. 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.
1) Except for procedures described in subsections (g) and (h), procedures delegated to a dental assistant may not include procedures allocated under IC 25-13-1 to a licensed dental hygienist."

Duties That Cannot be Delegated Based on IC 25-14-1-23 and 25-13-1

1. Diagnosis
   a. DAs may assist with data gathering and testing related to diagnosis, but licensed dentists in Indiana must provide all diagnoses.
2. Treatment planning
   a. Again, DAs may assist with data gathering, records, case presentations, and communications related to treatment planning, but licensed dentists in Indiana must use their professional judgment and skill to direct and control all patient treatment planning.
3. Cutting hard or soft tissue (gingiva, enamel, dentin, etc.)
   a. DAs are not permitted to use cutting instruments or rotary instruments to cut or remove hard or soft tissue.
   b. Instruments and rotary instruments may only be delegated for intraoral use by a DA for the placement, finishing, and adjusting of materials or medicaments, nothing irreversible.
4. Intraoral impression which would lead to the fabrication of a final prosthetic
   a. Taking (placing intraorally) PVS/VPS, polysulfide, or other types of final impressions may not be delegated to a DA.
   b. The DA can assist and prepare final impression materials, load trays, and transfer, but the dentist must take/place the final/master impression intraorally.
   c. What about digital impressions for CAD-CAM? The statues related to impressions were written prior to the age of digital dentistry. Therefore, the roles delegated to dental assistants for digital scans in CAD-CAM may need to be clarified in Indiana.
5. Permanent crown/bridge/veneer placement
6. Denture adjustment
   a. Under Indiana law, a dental assistant would be illegally practicing dentistry if they, "directly or indirectly by any means or method furnishes, supplies, constructs, reproduces, repairs, or adjusts any prosthetic denture, bridge, appliance, or any other structure to be worn in the human mouth."
   b. Thus, in Indiana DAs are not permitted to permanently deliver or adjust any fixed or removable prosthetics.
7. Scaling teeth to remove plaque or calculus
8. Administer local anesthetic injections
9. Treating gum disease
10. Use impressions, X-rays, and photographs for treatment purposes
   a. 7-10 are not permitted because these are specific to the scope of practice for the dental hygienist

The Duties That Dentists Can Delegate in Indiana

Although Indiana law does not provide a list of allowable duties for dental assistants, it does specify procedures that cannot be delegated. The following list reflects commonly delegated tasks that are not explicitly reserved for dentists or dental hygienists and therefore do not require specific education or certification in Indiana. This list will evolve with changes in technology and techniques:

1. Preparing treatment rooms and patients for procedures
2. Chairside assisting, including transferring instruments and materials
3. Infection control procedures, including sterilizing and disinfecting instruments and equipment
4. Various administrative and office management tasks
5. Providing patients with education directed by the dentist as well as providing pre- and post-operative instructions
6. Taking impressions for study models or orthodontic appliances
7. Obtaining bite registration (not directly used for the fabrication of a permanent intraoral prosthetic)
8. Applying topical anesthetic
9. Placing/packing gingival retraction materials
10. Fabrication and temporary cementation of provisional crowns
11. Cement removal (permanent and temporary cement)
   a. DAs may use instruments such as explorers, spoon excavators, scalers, and curettes, but only for cement removal. DAs are not permitted to scale for plaque/calculus removal, nor the cutting of hard/soft tissue.
12. Placing and finishing direct restorations (permanent and temporary)
13. Placing pit and fissure sealants
14. Pulp vitality testing
   a. DAs may perform the testing and record patient responses, but the dentist is responsible for confirmation of the tests and diagnosis
15. Placing and removing surgical periodontal dressings
16. Suture removal (if there is no cutting of tissue)
17. Seating the patients before the dentist arrives and is physically present
   a. Possibly, but only for pre-op instructions/Q&A/pt. education that do not require the professional skill and judgment of the dentist
   b. No direct patient care can be provided without a dentist physically present, including radiographs

Indiana defines three expanded duties delegated to a DA that require specific training and certificates of completion: coronal polishing, caries prevention procedures, and nitrous oxide administration. In addition, radiology procedures may only be delegated to dental assistants with a current IDOH limited dental radiography license.

Radiology Licensure for Dental Assistants

There are specific requirements in Indiana that must be fulfilled before any individual can legally take or process radiographs. For dental assistants, the process includes taking an IDOH approved radiology course/program, passing DANB's RHS exam, and submitting the IDOH application and fee for a limited dental radiography license. To continue taking radiographs legally, this license must be renewed (with fee) every

Continued on page 14

two years. To support DAs pursuing radiography licensure while actively working, the IDA offers an IDOH-approved self-study program designed for flexible, on-the-job learning.

Indiana Certificates for Caries Prevention and Coronal Polishing Procedures for Dental Auxiliaries

Only delegate topical fluoride application and coronal polishing procedures to DAs who have obtained the proper certificates of completion as described in 828 IAC 6-1-1 and 828 IAC 6-1-2. Per this rule, the educational program or curriculum for caries prevention must at least include ethics and jurisprudence, reasons for fluoride, systemic fluoride, topical fluoride, toxicity of fluoride, fluoride application, and infection control; and for coronal polishing at least ethics and jurisprudence, plaque and material alba, intrinsic and extrinsic stain, abrasive agents, use of a slow speed hand piece, prophy cup, and occlusal polishing brush, theory of selective polishing, and infection control.

After clinical competence is confirmed and the certificates are issued, they must be publicly displayed in the dental office. The State Board of Dentistry does not issue the certificates to dental assistants, the educational facility issues certificates of completion after the supervising dentist confirms clinical competence. Per 828 IAC 6-1-3, it is the supervising dentist's responsibility to verify the DA's education and certificates of completion prior to delegation of fluoride application and coronal polishing.

Is silver diamine fluoride (SDF) included in the certificate of completion in caries prevention procedures for dental auxiliaries?

The Indiana statute and administrative rules governing the Caries Prevention Procedures for Dental Auxiliaries certificate were established prior to the U.S. Food and Drug Administration's (FDA) approval of silver diamine fluoride (SDF). Specifically, the 2010 legislative change permitting DAs to apply fluoride did not account for SDF, as its FDA clearance occurred in 2014, followed by the first commercially available product in 2015.

The rule under 828 IAC 6-1-1 is titled "Caries Prevention," which some interpret as excluding SDF, given its primary use in arresting active caries rather than preventing new lesions. However, the rule also states that DAs may "apply medicaments for the control or prevention of dental caries," a phrase that others interpret as inclusive of SDF. While Indiana's statute and rules do not explicitly authorize SDF application by DAs, they also do not expressly prohibit it. This ambiguity mirrors other procedural "gray areas," such as digital impression capture, an indication of clarifications needed regarding the scope of practice for both dental assistants and dental hygienists in applying caries-arresting agents.

Currently, SDF content and application protocols are not included in the Indiana University School of Dentistry (IUSD) continuing education course for caries prevention, which has been offered since 2010 and provides a certificate of completion. Additionally, while the IUSD DA and DH programs in Indianapolis include didactic instruction on SDF, they do not provide hands-on training or assess clinical competency in its application for either dental assistants or dental hygienists.

Indiana Nitrous Oxide Administration Certificate

Historically in Indiana, prior to the nitrous oxide administration statute, dental assistants have been permitted to monitor patients receiving nitrous oxide, provided the supervising dentist remains on-site and is responsible for initiating, adjusting, and terminating the administration of nitrous oxide and oxygen. However, since the enactment of IC 25-13-1-10.7 in 2020, Indiana dentists may delegate nitrous oxide administration to dental assistants (DAs) and licensed dental hygienists (LDHs) who have completed the required certification.

The statute outlines specific educational requirements for certification, including a curriculum [from an institution] accredited by CODA that covers pharmacology, biochemistry, anatomy related to nitrous oxide administration, emergency procedures, and the mechanics of operating a nitrous oxide unit.

Once clinical competency is verified and the certificate of completion is issued, it must be publicly displayed in the dental office. According to IC 25-13-1-10.7, the supervising dentist is responsible for confirming that the DA or LDH has met all certification requirements before delegating nitrous oxide administration. Additionally, the statute requires the dentist to determine the maximum dosage of nitrous oxide for each patient and to ensure that any administration or monitoring by DAs or LDHs aligns with guidelines established by the American Dental Association or the American Academy of Pediatric Dentistry.

Conclusions

Dental Hygienists

Indiana's framework for prescriptive supervision for dental hygienists serves as a balanced approach to expanding access to oral healthcare while maintaining a high standard of patient safety. By permitting qualified, experienced hygienists to practice without a dentist physically present in certain settings, the state has addressed persistent barriers to care, particularly for vulnerable populations in facilities like nursing homes and for routine hygiene services.

This model is built on clear criteria that uphold the integrity of dental care, such as requiring significant prior experience under direct supervision and ensuring the dentist has conducted a recent comprehensive exam. Ultimately, Indiana's prescrip-

tive supervision laws streamline dental practice, allowing dentists greater flexibility to focus on complex procedures while leveraging the skills of dental hygienists to efficiently meet the state's broader oral health needs. Future policy discussions may focus on evaluating the long-term impact of this model on public health outcomes and exploring opportunities for further refinement

Dental Assistants

In Indiana, the proper delegation of duties to dental assistants is essential for maintaining an efficient dental practice while ensuring the highest standards of patient safety. By clearly defining roles and responsibilities under the framework of state law, dentists can empower their staff and improve the overall delivery of care.

Effective delegation, which includes administrative, clinical, and radiologic tasks, allows dental assistants to leverage their training to support the dentist and other team members. The dentist, however, maintains ultimate responsibility for all procedures performed under their supervision. This system fosters a collaborative environment where dentists can focus on complex clinical decisions and advanced procedures, while assistants contribute to a smoother workflow and enhanced patient experience.

In conclusion, a clear and well-executed delegation strategy in Indiana dental practices is not just about efficiency; it is a critical component of ensuring legal compliance, maximizing productivity, and upholding patient trust. By staying current with state regulations and investing in the ongoing training and certification of their assistants, dental offices can build a stronger, more effective team capable of providing excellent dental care.

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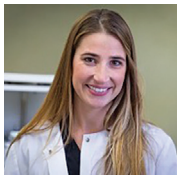
About the Authors

Twyla Rader, LDH, M.Ed., clinical associate professor, is the Dental Hygiene Program Director at the Indiana University School of Dentistry in Indianapolis and currently serves as the appointed dental hygienist on the Indiana State Board of Dentistry.



Abbey Rieck, LDH, B.S., MS. Ed., is an assistant professor in dental hygiene at the Indiana University School of Dentistry. A 2010 graduate of IU, Abbey spent a decade in clinical practice before transitioning to full-time academia. She loves combining her passion for clinical hygiene and preventive care with educating the next generation of oral health care providers.

Michelle Priest, CDA, EFDA, MBA, clinical assistant professor, is the Dental Assisting Program Director at the Indiana University School of Dentistry in Indianapolis. She has been a passionate dental educator for almost 20 years and has a current focus on dental ergonomics and four-handed dentistry.

Safeguarding Ethics: The Work of the Indiana State Board of Dentistry

Kathy Walden

DENTISTS PRIDE THEMSELVES on belonging to a profession that maintains high standards, strong patient satisfaction and professional excellence. At the heart of these guiding principles of dentistry in our state is the Indiana State Board of Dentistry (ISBD), which focuses on establishing and enforcing ethical conduct and adherence to state law for Indiana's 4,769 dentists and 5,500 hygienists.

Vevay dentist Dr. Robert Findley is the current president of the ISBD and has served on the board since 2015. As ISBD president, he leads his 10 fellow ISBD members in the work of the board, guides their meetings, and works closely with a deputy attorney general and staff of the Professional Licensing Agency (PLA), the state government agency that issues, renews, and supports licensed professions across Indiana. The ISBD is comprised of nine dentists, including Dr. Findley, one hygienist member and one consumer member. In 2023, Dr. Findley was elected by his fellow ISBD members as president for a two-year term.

"I see being on the board as a way to give back to the profession and reinforce the standards of dentistry," said Dr. Findley. "I've enjoyed my years as a member and having a chance to maintain a very respected profession."

ISBD members are appointed by the governor and serve terms of three years, with no limit on terms. This is the same structure for all PLA boards. ISBD members, who are technically employees of the state, are required to undergo extensive and regular ethics training and occasional refreshers on difficult topics, such as when a member should recuse him or herself during administrative hearings. Board members are not allowed to enter into certain business ventures for up to two years after serving on the ISBD, and they are not allowed to accept gifts from other board members—to the point that the members' annual holiday gift and cookie exchange was cancelled out of concern for ethical violations.

The ISBD meets every other month. The board's meetings cover a variety of issues, but administrative hearings for dentists and hygienists occupy a large portion of each meeting's agenda. Dr. Findley explained that consumer complaints are the main instigator of administrative hearings, but other issues not directly related to patient care, such as DUIs or domestic violence arrests, can trigger an appearance before the ISBD. Medicaid billing fraud is also an issue that can land a dentist in hot water with both the state and federal government.

The Indiana Attorney General's office works with the PLA to investigate and pursue disciplinary actions against licensed professionals. For consumer complaints, the Attorney General's office works with ISBD members and its dental compliance officers to determine which complaints merit an appearance before the board. "Complaints can range from very serious quality of care issues to the frivolous," said Dr. Findley. "There are rumors that we've had complaints that someone didn't get a free toothbrush during their visit."

ISBD President Dr. Robert Findley

After serving on the ISBD for a decade, Dr. Findley is very familiar with the problems that can land dental professionals in hot water. "I've seen a lot of different things that people can do that go haywire for them," he said. "For those first few years I was amazed at the problems dentists can get into. Maybe it goes back to ethics."

Administrative hearings are run similar to a court, with the Attorney General's office serving as prosecutor, Dr. Findley as a hearing officer, which functions like a judge, and the ISBD members as the jury. For any dentist or hygienist who is required to appear at an administrative hearing, Dr. Findley has advice as a longtime ISBD member. "Take it seriously," Dr. Findley cautions. "Hire an attorney for anything serious." Each administrative hearing ends with an ISBD member vote on either a board order or a settlement agreement and can include license revocation, suspension, probation, fine, censure,

Current ISBD Members

Dr. Robert Findley - President through Oct. 2025
Dr. Annette Williamson - President Oct. 2025-Oct. 2027
Dr. Richard Nowakowski
Dr. Matthew Kolkman
Dr. Roger Sheline
Dr. Jeffrey Snoddy
Dr. Edward Sammons
Dr. Kevin Ward
Dr. Barbara "Crunchy" Thompson Wells
Twyla Rader, L.D.H., Hygienist Member
Tammera Glickman, Consumer Member

ISBD members can be contacted at pla8@.pla.in.gov

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letter of reprimand, or a combination of several of the above. Depending on the severity of the issue, a dentist or hygienist may be required to periodically appear at ISBD meetings for a designated period of time.

Other work of the ISBD includes a review of state rules governing dentistry, review of policies, approval of continuing education providers and work on Indiana administrative code. Though some state dental boards are directly involved with state legislation governing dentistry, Dr. Findley explained that Indiana doesn't have this legal structure.

One change of note for dentists is that the ISBD will be resuming its audits of continuing education hours in 2026. This was a regular practice of the board that fell by the wayside during COVID, but Dr. Findley said the audits will be taking place after the March 1, 2026 license renewal date. He has a recommendation to dentists and hygienists to protect themselves and their careers in the event they are selected for a CE audit: "Scan and keep copies of certificates and receipts for at least three years, but really I recommend keeping them for much longer," he said. "Government moves slowly and audits can take a while. Your career is worth the extra precautions." Dr. Findley added that fines for non-compliance with CE requirements can be as high as $5,000.

Another recent effort by the ISBD is the work of compliance officers. Compliance officers are dentists, often former presidents or members of the ISBD, who visit dentists or hygienists who have appeared in administrative hearings to ensure that board stipulations or instructions are being followed. Compliance officers also help review consumer complaints and offer guidance to the Attorney General's office on which complaints merit attention from the board. Dr. Findley said the concept of compliance officers for the ISBD has been in the works for years, but the visits just began in 2024.

The work of the ISBD can be time consuming and stressful, but the dedication of its board members ultimately helps reinforce professional standards, protect patients and strengthen the dental profession in Indiana.

Key Takeaways

The Indiana State Board of Dentistry licenses dentists, dental hygienists and issues permits for various dental services, establishes and enforces professional conduct and practice standards, approves continuing education courses, and investigates and resolves complaints to protect the public from unqualified or unprofessional dental care. The board also handles the administrative processes for licensure by endorsement and issues jurisprudence exams to ensure practitioners understand Indiana's laws and rules.

Key Functions

Licensing: Issues licenses and permits to practice dentistry, including dental anesthesia and dental hygiene permits, after applicants meet educational and examination requirements.

Standard setting: Adopts rules and a code of professional conduct that establish standards for competent dental and dental hygiene practice.

Enforcement: Enforces the Indiana dental laws and rules, ensuring that licensed professionals adhere to established standards.

Continuing education: Approves all continuing education (CE) providers for dentists and dental hygienists, with requirements including Basic Life Support certification and annual OSHA/Infection Control training.

Complaint resolution: Investigates and holds hearings on complaints made against licensed dental professionals.

Disciplinary action: If violations are found, the board can impose disciplinary actions such as license suspension or revocation, fines or probation.

Licensure by endorsement: Processes applications for licensure by endorsement for dentists licensed in other states with substantially equal requirements.

Jurisprudence examination: Issues a jurisprudence examination that tests knowledge of Indiana's dental statutes, rules and infection control standards.

About the Author

Kathy Walden is the IDA director of communications. She can be reached at **kathy@indental.org**.

Dental Treatment: Who Has the Final Say on Oral Health Care?

Dr. Harvi Patel
Dr. Rilee Taege
Dr. Vanchit John

IS A PATIENT'S autonomy really his or her own? Or like an onion with many skins, is it buried under layers of financial factors, insurance coverage, quality of discussion with the dentist, family obligations and emotional health, and so much more!

In the context of an individual's specific dental treatment, an adult patient generally holds the final say, assuming they are of sound mind and capable of giving informed consent. This means they have the right to accept, defer, or even refuse treatment recommendations, even if the treatment has already begun.

However, the dentist plays a crucial role in providing the patient with the necessary information to make an informed decision. This includes explaining the diagnosis, recommended treatment, its benefits, risks, alternatives (including no treatment), and potential consequences.

While patient autonomy is one of the first principles of ethics in healthcare, dentists are often unequivocally torn between autonomy, non-maleficence and beneficence. With the evolution of technology and the infamous "Dr. Google," patient autonomy has become more challenging than ever. Patients come in to see a dentist not just with their problem, but often with a differential diagnosis. Sometimes asking for very specific treatments. This leads to a conundrum for dentists. Clinicians have in many instances been faced with patients asking for extraction of teeth where the teeth are treatable, or crowns and veneers even where the tooth is non-restorable. In situations like these, do dentists comply with what the patient wants? Or do they stand their ground on decisions based on their clinical assessment?

But before dwelling into that, let's revise what ethics really means for the profession. The American Dental Association code of ethics has three major components:

- One, the principle of ethics, which are the aspirational goals of our esteemed profession to provide guidance, and offer justification for the Code of Professional Conduct and Advisory Opinions. The five fundamental principles that are the backbone of our profession are: Patient autonomy, non-maleficence, beneficence, justice and veracity.
- Two, Code of Professional Conduct, which is an expression of specific types of conduct which are either required or prohibited.
- Three, the Advisory options, which are interpretations that apply to the code of professional conduct to specific situations.[1]

These principles hold a historical record of being followed from 1866 to present.

Our profession is highly dynamic and intimately intertwined with evidence-based guidelines for our conduct, a strong code of ethics and, most important, a human patient, oftentimes in distress and looking for help. It is often the physical pain that interferes with the patients' understanding of what is being discussed by the dentist.

The aim of this article is to explore the challenges posed by following the code of ethics, as well as discuss the future directions in dentistry.

The core ethical principles in dentistry are:

1. **Autonomy:** Patient autonomy as defined by the ADA is "the dentist has a duty to respect the patient's rights to determination and confidentiality."[2] Regarding the patient's rights to determination, this means that the patient should be an equal and respected member of any treatment decisions. For the patient to participate fully as an informed member, they need to be educated on the proposed treatment as well as the risks or benefits of the treatments and any treatment alternatives. One problem that arises when informing patients on their care is a patient's lack of dental literacy. For a patient to be fully informed, care must be taken to provide the proposed information in a way that is easily understood and digested by the patient as well as allowing them to ask any follow up questions they may have to help with their understanding of the treatment options.
2. **Non-maleficence:** ADA defines this as the "duty to refrain from harming the patient."[3] This means that as a dentist, it is our moral obligation to not suggest a treatment with poor prognosis for ulterior motives or to perform a treatment which will do more harm than good.
3. **Beneficence:** This principle highlights the fact that the dentist has the duty to promote the patient's welfare.[4] As guided by this principle it is the duty of the dentist to put the patient's overall wellbeing, not just from the dental care, in front of the patient's attention.
4. **Justice:** This highlights the principle that each person is given treatment options along with access to educational resources needed, while treating every person with equal consideration and inclusion.[5] As dentists, we should not discriminate against patients based on their individuality, religion, culture, responsibilities, rights, freedom, political inclinations, etc.
5. **Veracity:** Hostiuc[7] defines veracity (or truth-telling) in healthcare ethics as a comprehensive, accurate, and objective transmission of information, and as the way the practitioner augments the understanding of the patient (in clinical/dental practice) or subject (in biomedical research).[7] This principle highlights the responsibility of the dentist to communicate all sides of truth – good and ugly to patients regarding their health and treatment

Despite the presence of evidence-based guidelines for clinical judgment and clinical decision making, are they applicable, or even appropriate for all the patients?

Dentists routinely rely primarily on patient history, clinical examination, radiographic examination, overall health condition of the patient, complexity of the case and secondarily on their knowledge, training and experience while recommending treatment plan options to a patient. Due to the imbalance of knowledge, training, and experience of the dentist versus the patient, often the latter must rely on the former for direction pertaining to dental treatment. The dentist is obligated to provide treatment recommendations that encompass all these above-mentioned factors within the bounds of code of ethics and professionalism.

The evolving involvement of patients, third party payers—insurance companies and government—in the financing, planning and delivery of health services has increased the demand for knowledge about the process of rendering care. Study findings indicate that dentist-patient interactions play an important role in treatment decision-making and that both are predicated on a variety of non-clinical factors.[7]

Some of these factors that routinely play a significant role in decision making from a patient's standpoint are desires, expectations, risk tolerance, age, dental history, clarity of communication, social circumstances, financial ability, and oral hygiene.[8]

The presence of other factors like word-of-mouth recommendations from friends and family, quality of the service provided, and the presence of mental illness, or anxiety play a huge role in a patient's decision-making process. In certain cultures, religion and family status play large roles in their healthcare decisions and which treatments may be acceptable versus forbidden.

In their study, Roing et al. concluded that the participating dentists in Sweden described three main aspects of involving patients in treatment decisions: adapting to patients, guiding them toward the "right" choice, and managing their choices. They emphasized that patients must feel secure, respected, and confident in their dentist to engage meaningfully in discussions. Dentists present treatment alternatives with explanations of benefits, risks, prognosis, and costs, while offering professional judgment to encourage acceptance of the most appropriate option. However, when patients make unreasonable demands, dentists must maintain ethical standards and refuse inappropriate requests.[9]

Every patient that walks into our offices is different. Each patient has their own unique set of past experiences, health and dental literacy levels, as well as cultural and familial influences that may play a role in their decision making. For any patient to have their right to patient autonomy preserved, there is no cookie cutter copy and paste type of way to present information to a patient. Each patient should be approached uniquely with respect to their personal views and values, as well as keeping his or her level of health literacy in mind.

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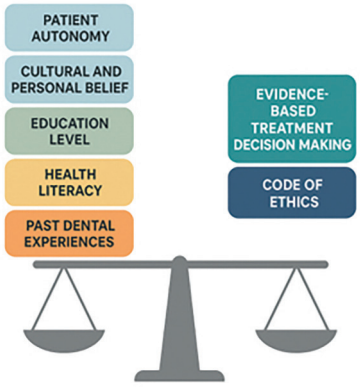

Figure 1-Evidence Based Treatment Decision Making

Figure 2- A Model for patient centered care

In such situations where a patient seeks a treatment that does not have medical indication, does one prioritize patient autonomy or the principle of beneficence? In a research article published by Kovacs and colleagues, they suggest that existing literature mentions generally prioritizing beneficence over autonomy in higher stakes dental intervention. Nevertheless, autonomy retains its importance in decisions that hold minimal impact and are preventative in nature.[10]

In an article by Reissman et al., they discuss that the best doctor-patient relationship to follow is one in which there is mutual shared decision making. Within this model it supports the patient's own expectations and past experiences while also allowing them to be informed. This allows the patient to have an equal partnership in their healthcare decisions, especially ones that are more long term and multifaceted as compared to acute urgent decisions.[11]

Having framed the challenge of preserving patient autonomy while providing ethical care for our patients, let's discuss strategies for improving the dentist-patient communication and decision-making process:

The main foundational piece is to focus on patient centered care. We start by seeing each patient as a blank canvas and filling in details about their perspectives, experiences, and expectations. This helps us build rapport with the patient, gives them confidence that we listen to them and sets up positive groundwork for all future conversations. All other factors discussed help us as practitioners achieve patient-centered care. They include enhancing communication skills, building trust, acknowledging and addressing non-clinical factors, providing clear information and using technology.

Enhance Communication Skills: To build rapport with the patient, to give them the confidence that we are listening to them, sets up positive groundwork for all future conversations.

"To listen is an effort, and just to hear is no merit. A duck hears also."
— Igor Stravinsky

- Ja Hall, in their article mention that physicians predominantly (69 percent) interrupt the patients' opening statement in about 15 to 18 seconds.[12]

Build Trust: This is essential for enabling patients to absorb information and participate in decisions.

An opinion poll conducted by Gallup on honesty and ethics among various professions of healthcare and non-healthcare indicated that a little over 60 percent of the public consider the "honesty and ethical standards of dentists to be under the category of 'very high' or 'high.'"[13] While there is enough literature to support the fact that patients trust dentists, on occasions we also stumble across social media and Google reviews of patients leaving distrust over their dentist's or dental appointments.

Acknowledge and Address Non-Clinical Factors: Recognizing the influence of patient anxiety, financial constraints and personal preferences on treatment choices also play a significant role in how the patient perceives the proposed treatment by their dentist.

The article published by JM Armfield talks about lower levels of trust being associated with negative past dental experiences, with the strongest associations being for people who had "experienced personal problems with the dentist (e.g. being criticized, treated poorly)", people who had "experienced embarrassment" and those who had "experienced fainting or feeling light-headed."[14]

Provide Clear Information: Explaining the treatment options, including risks and benefits, and encouraging the patients to ask questions before finalizing plans.

Use of Technology: AI-driven technologies and platforms designed to enhance patient engagement, comprehension and satisfaction through personalized content delivery, virtual assistants, teledentistry, immersive technologies (such as virtual reality and augmented reality), and gamification have been helpful.[15,16] These AI-enabled options offer additional solutions in patient communication, helping with language barriers, reducing dental anxiety, and catering to oral health literacy, by providing tailored educational materials, interactive experiences and remote support.

Conclusions

While these strategies provide a solid foundation to enhance the dentist–patient communication and shared decision-making process, the landscape of dentistry is far from static. Emerging clinical, technological, and societal challenges are constantly reshaping the environment in which these decisions are made, often adding new layers of complexity to the process. Involving patients in the decision-making process while presenting treatment options that are clear and easily understandable as well as affordable will enhance patient care while involving the patient and the practitioner through all the steps from the first visit to the conclusion of treatment.

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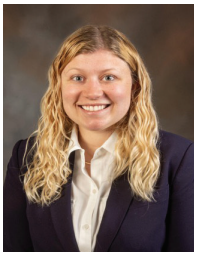
About the Authors

Dr. Harvi Patel graduated in 2024 from the Indiana University School of Dentistry. When not working, Dr. Patel focuses on calligraphy or getting lost in the world of art, creating textured floral pieces, which serve as an outlet outside of dentistry.



Dr. Rilee Taege graduated in 2025 from the Indiana University School of Dentistry and is now a first-year resident in the periodontology program at IUSD. #IUPerioPride. Dr. Taege was born and raised in Indiana and enjoys watching college sports and hanging out with family, partner, pets and friends in her spare time.

Dr. Vanchit John is the O'Leary-Hancock Endowed Professor and Chairperson of the Department of Periodontology at the Indiana University School of Dentistry.

Overview of Indiana Health Records Law

Jay Dziwlik

INQUIRIES REGARDING THE use, access, ownership, retention and disposal of health records have ranked in the top three questions from dentists, dental offices and patients over the last 25 years. As every dental office has dental health records, it is important to understand the legal and professional liability implications for properly handling and safeguarding records.

What is a Dental Health Record?

In Indiana, "health records" is a broad term defined in Indiana Code 16-18-2-168 and includes any written, electronic, or printed information maintained by a healthcare provider about a patient's diagnosis, treatment, or prognosis. The statute is very broad and covers all health records, all health care settings whether a hospital, pharmacy, physical therapy, optometry or dental practice. Each of these hold different health information and in different forms and media.

Further, all health records are also protected health information (PHI) and are subject to federal law under the Health Information Portability Accountability Act (HIPAA) of 1996. This article will focus on state statutes. Indiana health records, laws and statutes preceded the federal HIPAA legislation and required Indiana Health records to be held private and secure between patient and practitioner.

The main body of the Indiana Statutes comes from Indiana Code 16- 39 titled Health Records. This can be referenced at **https://iga.in.gov/laws/2025/ic/titles/16#16-39**

Many dentists have questions regarding what is included in a dental health record. Proper health record charting and documentation is vital to your practice and is considered a legal document. The American Dental Association provides guidance on what is included in a health record.

- Personal data, such as the patient's name, birth date, address and contact information including home, work and mobile telephone numbers
- The patient's place of employment
- Medical and dental histories, notes and updates
- Progress and treatment notes
- Recap of conversations about the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatment, including no treatment. Include conversations that took place in the office, over the phone and even calls received outside the office. Make sure that the recaps are dated and initialed.
- Diagnostic records, including charts and study models
- Medication prescriptions, including types, dose, amount, directions for use and number of refills
- Radiographs
- Photographs
- Intraoral photographs
- Treatment plan notes
- Patient complaints and resolutions
- Referral letters and consultations with referring or referral dentists and/or physicians
- Patient noncompliance and missed appointment notes
- Follow-up and periodic visit records

- Postoperative or home instructions, or a notation about any pamphlets or reference materials provided
- Informed consent/refusal forms
- Waivers and authorizations
- Correspondence, including a dismissal letter; if appropriate

Some information should **NOT** be noted in a dental record. This includes any financial information, explanation of benefits, payments and insurance claims. Financial records should not be part of clinical records and should be maintained separately. Personal opinions or criticisms, notes in margin should be avoided. If a lawsuit is filed, patients' charts are often requested and must be shared. Some offices keep personal information (family, hobbies, special interests) in a separate location from dental records.

For more information: American Dental Association **https://www.ada.org/resources/practice/practice-management/documentation-patient-records.**

Who owns the Dental Health Record?

The information in a health record is the patient's information. It's information they share to have health care workers diagnose, treat and care for a patient. Indiana and federal law both lay out a patient's right to privacy, security and access to their own health information. The State of Indiana also mandates that a dentist properly maintains these health records (IC16-39-7-1). So the answer to the question is both the patient and dentist "own" the health record. It is the patient's information with a state mandating dentist to maintain the record.

Questions or disputes arise when there is a request for health records. The only way to share that information is through a copy. The Indiana statutes do not lay out who can have the original if it's a physical chart. Electronic records are making the sharing of information easier.

Dental health records do have value and are regularly part of transitions in practices. In most dentist's transitions, there is a value assigned to health records based on valuation, estimations of the future dentistry represented in the body of dental health records and in consistency of maintenance of health records from practitioner to practitioner.

Who has access? What can I charge?

Both state and federal laws clearly outline patients have access to their health records. Offices handle requests for records in a variety of ways. Indiana statute 16-39-1, Right of Access states, "On written request and reasonable notice, a provider shall supply to a patient the health records possessed by the provider concerning the patient." A copy is to be provided within thirty (30) days after written request is made. This is both for health records and X-ray film/radiographs. Requests can be made by adults 18 years and older, parent, guardian or custodian of children or incompetent patients and by emancipated patients less than 18-year-old. Health records

Continued on page 24

of the deceased may be requested by a coroner or the estate of the deceased. All record requests should include name and address of patient, name and address of person requesting the record, description of information requested, purpose of the release and signature of patient or legal representative.

Indiana statute (16-39-1-5) allows for withholding of a record "if a provider who is a health care professional reasonably determines that the information requested…is detrimental to the physical or mental health of the patient or likely to cause the patient to harm the patient or another." A dentist cannot withhold a patient's health record because the patient has an outstanding balance on their account.

Indiana rules allow the following charges according to Indiana rules (760 IAC 1-71-3):

(a) A provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the following:

(1) One-dollar ($1) per page for the first ten (10) pages.
(2) Fifty cents ($.50) per page for pages eleven (11) through fifty (50).
(3) Twenty-five cents ($.25) per page for pages fifty-one (51) and higher.

(b) The provider or the medical records company may collect a labor fee not to exceed twenty dollars ($20). If the provider or medical records company collects a labor fee, the provider or medical records company may not charge for making and providing copies of the first ten (10) pages of a medical record.
(c) The provider or medical records company may charge the actual costs of mailing the medical record.
(d) The provider or the medical records company may collect an additional ten dollars ($10) if the request is for copies to be provided within two (2) working days.
(e) The provider or medical records company may collect a charge not to exceed twenty dollars ($20) for certifying a patient's medical record

Each dental office should have a records policy to outline how they handle records requests. Policies should include asking for patient verification to ensure records are going to the patient, or waiving charges for relocations for employment or change of life. These should reflect the practice and needs of patient base.

How long should I retain records?

Dentists have an obligation to properly maintain health records. Both health records and radiographs are included in that obligation but there is a difference in the length of time for each of these. Indiana Code IC 16-39-7 Maintenance of Health Records requires dentists maintain the original health records or microfilms of the records for at least seven (7) years. Electronic records are under the same requirements. Maintenance for Radiograph/X-ray films by providers is for at least five (5) years.

Maintenance of these records and radiographs needs to be considered in any dental transitions and or discontinuation of a practice. The obligation to maintain those records is still in effect for both and in a transition, you would want to include record maintenance and access if you are selling those records. If you are closing a practice, you will need to follow the state statutes for notifying patients and making arrangements to fulfill the seven (7) and five (5) year requirements for records and radiograph retention.

Disposal of records after the retention requirement should be done carefully and completely. Any disposal should be made with reputable companies and in a manner that removes all protected health information identifiers, whether it's shredding or incinerating. It is good to consider careful disposal of old X-ray films for its environmental impact. Any study models should be destroyed appropriately without any identifiable patient information as well.

The proper maintenance and destruction of patient records safeguards confidentiality of your patients and is crucial to your defense, should you ever find yourself in patient-related litigation. Accordingly, it stands to reason that you would want to be careful with them following all the state and federal guidelines.

About the Author

Jay Dziwlik, CAE, MBA is the IDA assistant executive director, with over 30 years of experience in the nonprofit and association management world. Jay presents regularly throughout the state and nationally through the ADA and teaches regularly in area of leadership development, associations, ethics, marketing and international business. He can be reached at jay@indental.org.

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Ethical Considerations in Cosmetic Dentistry

Dr. Jill Burns

DENTISTRY IS BOTH an art and a science. Patient care revolves around treatment for pain, missing teeth while also ensuring that appearances or the esthetic outcomes are maintained or enhanced. These two facets are not contradictory, but are intertwined for optimal, complete and customizable care for each patient. Dentists are often faced with requests from patients for a stereotypical "perfect" smile, which includes perfectly aligned teeth that are white in color resembling the image commonly conveyed by the media. As clinicians, we respond in our own way to these increasingly demanding esthetic demands. Some specialize in developing "esthetic" treatments; others focus on different parameters, such as function or disease prevention. Today, our patients are increasingly attracted to dental esthetics due to the increasing focus on the concepts of beauty, which are widely disseminated through social media platforms hyping current trends in cosmetic dentistry.[1]

So between esthetics and care, what is the place of the dental surgeon today? What ethical reflections must we focus on as a practitioner? How do we meet patient demand? What are the ethical considerations for these treatments? This article aims to discuss this conundrum that we face in our clinical practices.

Social media and its idealized model of beauty have led to unrealistic expectations and higher demands for esthetic procedures. Rostamzadeh reported[2] that social media was a primary driver of patient expectations, often prioritizing esthetic outcomes over health considerations. *The commodification of dental care, fueled by aggressive marketing strategies, has resulted in a notable increase in overtreatment, where unnecessary procedures are performed to satisfy commercial pressures and idealized beauty standards.* There are thousands of Tik Tok, Instagram, and Facebook posts by dentists highlighting their cosmetic dentistry accomplishments with before and after treatment pictures of their patients. Some have the training and experience to safely and ethically provide those services, and some do not. An additional source of aggressive marketing has revolved around 'influencers' who have no dental training or background who talk about "fabulous treatments" that engage the gullible public to perform DIY dentistry.

As dentists, we are expected to uphold the ADA Principles of Ethics and Code of Professional Conduct[3] in patient relations and treatment. There are various approaches to the ethics of these procedures in the ADA Code. While most of these treatments are well within the boundaries of our expertise as dentists, other procedures need extra training, while some could be thought to be outside of the scope of dentistry. These include Botox injections, dermal fillers and microneedling.

Both general dentists and specialists are always trying to broaden their treatment options for patients, while seeking to provide patients with the best oral care possible. Treatments can be functional in nature, cosmetic or a combination of both. A complex treatment plan can be made with the end in mind, repairing and restoring teeth and result in using various cosmetic procedures to produce the esthetic result the patient desires. But what should those offered treatments include and how do those offerings affect the dentist's upholding the ADA Principles of Ethics and Code of Professional Conduct?

The first principle to consider is *patient autonomy*. A patient has the following rights: complete disclosure of positives and negatives of any treatment, the ability to agree or say no to treatment. If a dentist proposes esthetic treatment such as Botox, derma fill, or microneedling to a patient, then they must give the patient a complete overview of treatment as well as answer any questions they might have. Their questions may include the dentist's education and qualifications in the treatment. The dentist's background should include training in these treatments both intra- and extra orally. Patient autonomy and informed consent are central to ethical practice in esthetic dentistry and must be prioritized. Informing patients of the risks, benefits, and alternatives to proposed treatments, particularly when these treatments are primarily cosmetic in nature is a challenge.

The second principle is *non-maleficence*. It means "do no harm." This is where most dentists run into issues with extra esthetic treatments. If the dentist does not take a comprehensive course or has not been educated sufficiently in the treatments, this can cause big problems. If something goes wrong and the dentist must appear before the state board, the number one question will be "Do you have the necessary training, background and experience to be performing these procedures on patients?" If the answer is no, there will be discipline and fines forthcoming. A weekend course may not be sufficient training to provide your patients with this procedure. Training and experience should be the bedrock of your practice, just like it is with any other treatment that you provide.

The third principle is *veracity*. Be truthful with yourself about what you feel comfortable with in your practice. Be truthful with your patients about the procedures that you provide. According to state law, you can provide any of the above esthetic treatments both intra and extra orally.

Using Botox and Dermal Fillers in Dentistry

Using Botox and dermal fillers in dentistry raises several ethical considerations, primarily revolving around the scope of practice, patient welfare and informed consent. While many jurisdictions allow dentists to use these injectables, typically for therapeutic or dental-related cosmetic purposes, the ethical framework requires strict adherence to training, patient well-being, and legal boundaries.

Esthetic procedures such as Botox, derma fillers and microneedling both inside and out of the mouth are within the standard and statue of dentistry in Indiana. It is crucial that dentists consider the ethicals of these procedures and preparation it takes to be able to ethically provide these services.

Scope of Practice and Competence

Legal vs. Ethical Boundaries[4]

- **Indiana regulations:** If a patient has a short upper lip, then a dermal filler may be offered. TMJ and migraine patients often benefit from Botox treatment. All of these are allowed under Indiana law, as long as the dentist is properly trained.
- **Purely cosmetic use:** Performing procedures solely for cosmetic enhancement, unrelated to dental health, is often outside the legal and ethical scope for general dentists. Dentists who perform such procedures risk professional misconduct charges and jeopardize their license.
- **Specialty vs. general practice:** While oral and maxillofacial surgeons may have a broader scope due to their advanced training, general dentists must operate within the specific, and often more limited, confines of their license.

Training and expertise

- **Adequate training:** Even when permitted, ethical practice requires the dentist to have verifiable, comprehensive training in administering these injectables, including a deep understanding of facial anatomy, pharmacology, dosage, and managing potential complications.
- **Competence and referral:** A dentist must recognize their limitations and refer patients to a qualified specialist when a procedure is beyond their training or scope of practice.

Patient Welfare and Informed Consent

Beneficence and non-maleficence

- **Patient welfare:** Dentists have a duty to promote the patient's welfare (beneficence) and "do no harm" (non-maleficence). This means only offering treatments that are beneficial and do not pose excessive or unnecessary risks.
- **Subjective "benefits":** Unlike objective dental health goals, the "benefits" of esthetic procedures are subjective and can be challenging to define. Ethical practice involves understanding the patient's goals and determining if the procedure is in their best interest.
- **Avoiding unnecessary treatment:** Excessive use of fillers can lead to unnatural "overfilled" outcomes. Ethical dentists should decline procedures that are not in the patient's best interest.

Thorough Informed Consent

- **Detailed disclosure:** Dentists must have detailed, documented, informed consent discussions with the patient. This should cover material risks, benefits, and alternatives to the proposed treatment.
- **Off-label use:** The use of Botox for dental applications is often considered "off-label" by the FDA. The dentist must explicitly inform the patient of this and that the treatment is experimental and lacks FDA approval for that purpose.
- **Managed expectations:** The dentist should manage patient expectations regarding the results, emphasizing that outcomes are not guaranteed, particularly for esthetics.

Other Critical Ethical Considerations

Advertising and marketing

- **Veracity:** Advertisements must be truthful and not misleading. A dentist cannot advertise injectables solely for cosmetic purposes if their practice is restricted to dental-related applications.
- **Avoiding guarantees:** Advertising success claims or guarantees is unethical and can expose the practice to legal and professional misconduct allegations.

Professional liability and insurance

- **Coverage risks:** Many professional liability insurance policies do not cover treatments performed outside the legal scope of dentistry. Dentists must confirm their coverage and understand that practicing outside the defined scope could leave them personally liable for any damage.

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Financial and social justice

- **Conflict of interest:** The dentist's financial interest in offering esthetic services should not override professional judgment. They should not prioritize high-paying cosmetic clients over patients with traditional dental needs.
- **Equitable access:** Offering elective cosmetic procedures can create financial barriers and a two-tiered system of care. Ethically, dentists should consider the broader societal implications of their practice.

Microneedling

Microneedling is a minimally invasive cosmetic procedure that involves using fine needles to create tiny punctures in the skin. These punctures stimulate the body's natural healing process, promoting the production of collagen and elastin. This can lead to improvements in skin texture, tone, and firmness. A sterilized device with multiple fine needles is used to gently puncture the skin. The punctures trigger a wound-healing response, leading to the production of new collagen and elastin. This process helps to improve skin elasticity, reduce wrinkles and minimize scars.

Based on state regulations, dentists in Indiana can perform microneedling if they are properly trained in facial esthetics. The depth of the procedure determines the level of training and supervision required.

Microneedling depth and regulation in Indiana

- **Up to 0.3 mm depth:** Estheticians are allowed to perform microneedling up to this depth. The state's guidance on microneedling regulations is still evolving, but this is the accepted standard.
- **Deeper than 0.3 mm depth:** If a deeper microneedling treatment is performed, it is considered a medical procedure that requires supervision by a licensed medical director (who is a physician).
- **Dentists and facial esthetics:** Dentists are medical professionals, widely trained in the anatomy of the face and experienced with sterile procedures. This qualifies them to perform microneedling and other facial esthetic procedures when they have received the proper training.

Steps to Enhance Practical Regulations for Cosmetic Dentistry[2]

1. Developing Ethical Frameworks that address the challenges that clinicians as it relates to esthetic dentistry
2. Developing training and CE Programs that focus on specific curriculum as it relates to esthetic dentistry
3. Developing resources and toolkits to help clinicians
4. Establishing reporting mechanisms that can report unethical practices
5. Developing study clubs and other groups that enhance collaboration and dialogue
6. Evaluation of compliance with clinicians as it relates to ethical guidelines.

Figure 1: Steps to Enhance Practical Regulation for Cosmetic Dentistry

Conclusions

As the number of patients who seek esthetic procedures as part of their overall dental care increases, there is need to develop well thought out ethical guidelines to help clinicians be more aware of the rules and regulations as they apply to cosmetic procedures. Emphasizing the need for ethics education in dental curricula in dental schools along with regulatory bodies that govern dentistry while creating marketing standards that ensure patient welfare is paramount going forward. Focusing on and developing a patient's first approach as it relates to cosmetic dentistry, will allow the dentists to uphold the integrity of our profession while also fulfilling patients' desires for esthetic outcomes as part of their overall dental care.

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About the Author

Dr. Jill Burns has been practicing in Richmond since 1992. Dr Burns is a past president of the IDA and provides dental services for orphaned children in Honduras every year as a member of the dental mission group, Sonrisas Siempre.


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Protecting Dentistry's Ethics: IDA's Peer Review Program

Dr. Nicolette Polite

ALL MEMBERS OF the dental profession are responsible for protecting the Principles of Ethics: *Autonomy, Nonmaleficence, Beneficence, Justice and Veracity*. Peer Review is:

- A dispute resolution program.
- Available to all Indiana patients.
- A resource for disputes for both IDA members and non-members.
- Part of what makes dentistry a profession.
- Voluntary for the subject dentist regarding participation.
- Initiated by patient complaints only.
- Not permitted to have findings entered as evidence in court.
- Not disclosed as part of dental license renewal.

When a patient submits a request for mediation, the complaint involves an alleged violation of at least one of the Principles of Ethics by the subject dentist. The statistics for the number and types of cases addressed by IDA's Peer Review Program in 2024 are attached. Over 70 percent of the 2024 cases were successfully mediated. Here are five examples of Peer Review cases and how ethics were involved:

AUTONOMY, involve the patient in treatment decisions: A minor patient was treated by an orthodontist. The case was difficult as the patient had skeletal growth issues as well as congenitally missing teeth. At the completion of the case, the parent was surprised and disappointed to see there was a space in the upper lateral incisor position. This case could not be mediated successfully and therefore went to a Panel Review where a panel of three orthodontists interviewed the patient's parent, subject dentist, and reviewed patient's records. In this case, the subject dentist had clearly documented all conversations and signed treatment plans which included that the lateral space would be a part of the finished case. Without that documentation, it would have been difficult to fairly resolve the dispute. Communicate clearly and document thoroughly.

NONMALEFICENCE, protect the patient from harm: A patient complained he had a wisdom tooth extracted by his family dentist resulting in a broken jaw. After several visits to his dentist, the patient finally sought treatment from an oral surgeon. His family dentist never took follow-up radiographs or referred him to a specialist. This subject dentist encountered a difficult case that he was not trained to treat. He should have recognized the issues and referred the patient for care by a specialist. Know your limitations and know when to refer.

BENEFICENCE, the patient's welfare must be put first: The daughter of an elderly patient filed a complaint against her father's dentist because she felt her father was never told that some of his natural teeth could be saved with root canals and crowns. Instead, her father had all his teeth removed and dentures placed. The subject dentist never offered root canals and crowns because the patient's insurance only covered extractions and dentures. Never allow a third party to dictate treatment.

JUSTICE, treat patients and colleagues fairly: A patient filed a complaint against her dentist for her "terrible" implant-supported prosthesis. This patient had gone to a different dentist for routine care and this dentist told her, "This dental work is terrible!" During mediation, it was discovered that the subject dentist had treated the patient over 10 years ago and had not seen the patient since that time. The mediator also discovered the patient had no complaints about her prosthesis but became concerned when her new dentist made this negative comment. Relationships were damaged due to one negative comment.

VERACITY, communicate truthfully: A patient filed a complaint because she never had pain with her upper molar until her dentist filled it. When she went back to the dentist, the dental assistant "ground down the tooth," but the discomfort became worse. After a third visit, the subject dentist recommended a root canal. The patient was surprised that her dentist never told her how deep the original decay was and the assistant never mentioned the possibility of a root canal. Unfortunately, there was no documentation about the extent of decay nor was there any documentation about the adjustments that had been made. Poor record keeping strikes again; if you did not document it, you did not do it!

Dentists should be guided by these principles of ethics during every aspect of practice, whether dealing with a patient, third party payor, laboratory or staff member. When ethical issues arise, Peer Review is an avenue dentists and patients can turn to for assistance when seeking answers to tough questions. The willingness of our local peer review members to step into these ethical dilemmas on a case-by-case basis is greatly appreciated.

If you are interested in having a peer review presentation at your next meeting, contact Ed Rosenbaum at **edr@indental.org**.

State Peer Review Executive Committee:

Dr. Nicolette Polite, Chair (NIDS)
Dr. Mark Mihalo (NIDS)
Dr. Katherine Patton (IDDS)
Dr. Catherine Periolat (NCDS)
Ed Rosenbaum (IDA Staff)

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Dr. Tom Kapczynski (SCDS & SIDS)
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Dr. Jason Kuester (FDDS)
Dr. Angela Burke (EIDS)
Dr. Ed Fischer (WIDS)
Dr. Gordon Green (GDDS)

About the Author

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

2024 Peer Review Case Summary

Number of Cases by Type of Dentist		
GENERAL	69	87%
ENDODONTIST	0	
ORAL SURGEON	2	
PERIODONTIST	3	
PEDIATRIC	2	
PROSTHODONTIST	1	
ORTHODONTIST	2	
TOTAL	**79**	
Types of Procedures Under Complaint		
Root Canals	2	
Crowns	14	18%
Implants	13	16%
Extractions	10	13%
Bridges	1	
Aligners	2	
Rude Staff	1	
Restorations	9	11%
Office Policy and Referrals	3	
Treatment Plan - Diagnosis	7	
Dentures	9	11%
Cleaning and Laser Periodontal Therapy	2	
Braces	2	
HIPAA Violation	1	
Partials	3	
TOTAL	**79**	
Repeat Providers	19	24%
First Time Providers	60	

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2024 Peer Review Case Summary (continued)

Graduation Year from Dental School		
2019-2023	11	14%
2014-2018	15	19%
2009-2013	18	23%
2004-2008	13	16%
1999-2003	3	
1994-1998	4	
1989-1993	3	
1984-1988	6	
1979-1983	2	
1964-1978	4	
TOTAL	79	

Resolved by Local Society	79
Ben Hur Dental Society (BHDS)	1
East Central Dental Society (ECDS)	4
Eastern Indiana Dental Society (EIDS)	1
First District Dental Society (FDDS)	9
Greene District Dental Society (GDDS)	0
Indianapolis District Dental Society (IDDS)	37
Isaac Knapp District Dental Society (IKDDS)	4
North Central Dental Society (NCDS)	6
Northwest Indiana Dental Society (NIDS)	9
South Central Dental Society (SCDS)	2
Southeastern Indiana Dental Society (SIDS)	2
West Central Dental Society (WCDS)	3
Western Indiana Dental Society (WIDS)	1

Total Resolved Cases	79	
Involving Appropriateness-of-Care	15	
Involving Quality-of-Care	54	68%
Involving Utilization Review	3	
Involving Non-Clinical Issues	7	
Cases involving non-members	28	35%
Cases involving members	51	65%
Mediated Cases – Settled	57	72%
Mediated Cases – Withdrawn	12	15%
Resolved By Hearing	10	13%
Hearing Cases – In Favor of Patient	3	30%
Hearing Cases – In Favor of Dentist	7	70%
CASES RESOLVED – Within 30 Days	4	
Within 60 Days	19	
Within 90 Days	14	
Over 90 Days	42	53%
APPEAL REQUESTED		
Reason – Decision ran counter to evidence	1	
Reason – New information after Hearing	0	
Resolved – Original resolution Upheld	1	
Resolved – Original Resolution Changed	1	
AVERAGE NUMBER OF WEEKLY CALLS	25	
MEDIATION REQUEST SENT BY OFFICE	81	
FORMS DOWNLOADED FROM WEBSITE	254	
NON-CASE CORRESPONDENCE LETTERS	43	
CASES FORMALLY OPENED	64	
CASES REFERRED TO STATE DENTAL BOARD	0	

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An Annotated Walkthrough of Dental and Dental Hygiene Professional Oaths Using AI Search Engines

Dr. Harvi Patel
Twyla Rader
Abbey Rieck
Dr. Vanchit John

MOST OF THE information contained in this article was taken using AI search engines. It is meant to be a refresher for dentists and dental hygienists as it relates to the oaths we took when we graduated from our training programs. It is also meant to be an opportunity for practitioners to reflect on their journeys since graduation as to have true they stayed to the oaths that they took. Dental assistants are not required to take a professional oath in Indiana.

Picture yourselves as new graduates, walking across that stage at your dental school or dental hygiene graduation programs with nervous excitement as you were to begin the journey on what would be the rest of your professional lives. As you stood in the long shadow of history that stretched back to ancient Greece and Hippocrates, diploma in hand, you smiled as you solemnly recited the "oath", the dental and dental hygiene oaths, that promised to echo through the centuries, binding them to a timeless code of ethics and service.

The oath is and was a moment of professional baptism, where you transitioned from student to practitioner and pledged to dedicate your life to the health of others. It is a reminder that dentistry is not merely a technical skill but an art and a science, balanced with warmth, sympathy, and understanding. For the dentist, this meant acknowledging that a patient is more than a single tooth; they are a human being with a story, a family, and an economic reality. For the dental hygienist, it meant committing to improving the oral-systemic health of the public and advancing the profession through research, education, and prevention.
The oath is not a static relic of the past. It is a living document, a "moral compass" that must be re-examined and affirmed throughout a professional's career. It provides the firm guideposts of ethics—beneficence, non-maleficence, autonomy, justice, and veracity—that anchor practitioners amid the complexities of modern practice. When faced with the pressures of business, insurance, and societal change, the oath challenges them to prioritize the patient's well-being above all else. It is a sacred contract with the public, declaring that the health of the community and the dignity of every patient are their first and highest considerations.

For dentists in Indiana, the dental oath is a solemn promise that translates into a daily professional and legal obligation to uphold core ethical principles. While often based on the traditional Hippocratic Oath, the modern dental oath is reflected in the ADA's Code of Ethics (**www.ada.org/about/principles/code-of-ethics/nonmaleficence**), which is adopted and enforced by the Indiana Dental Association and state law. It represents a binding agreement between dentists and the public, establishing a framework of integrity, service, and patient-centered care. The oath is more than a symbolic rite of passage; it is a foundational component of Indiana's dental licensing requirements and jurisprudence.

The Hippocratic Oath

The Hippocratic Oath is a traditional pledge taken by physicians and other healthcare professionals, named after the ancient Greek physician Hippocrates (often called the "Father of Medicine"). It's one of the oldest known codes of medical ethics, dating back to around the 5th century BCE.

At its core, the oath sets out principles of medical professionalism, emphasizing duties such as:

- Do no harm (non-maleficence).
- Treat the sick to the best of one's ability.
- Respect patient confidentiality.
- Pass on medical knowledge to future generations.
- Uphold ethical standards in medicine.

The original oath had references to Greek gods and specific prohibitions.

Today, most medical schools use a modernized version, which keeps the spirit of the oath—putting the welfare of patients first, practicing with integrity, and respecting human life—without the religious or outdated elements.

Modern Hippocratic Oath

- I solemnly pledge to dedicate my life to the service of humanity.
- The health and well-being of my patient will be my first consideration.
- I will respect the autonomy and dignity of my patient.
- I will maintain the utmost respect for human life.
- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient.
- I will respect the secrets confided in me, even after the patient has died.
- I will practice my profession with conscience and dignity, and in accordance with good medical practice.
- I will foster the honor and noble traditions of the medical profession.
- I will give my teachers, colleagues, and students the respect and gratitude that is their due.
- I will share my medical knowledge for the benefit of he patient and the advancement of healthcare.
- I will attend to my own health, well-being, and abilities to provide care of the highest standard.
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat.
- I make these promises solemnly, freely, and upon my honor.

The Dental Oath

The Dental Oath is very similar in spirit to the Hippocratic Oath, but it is tailored specifically for dentists. It's a pledge of professional ethics, integrity, and responsibility to patients, colleagues, and society. There isn't just one universal version—different dental schools and associations (like the American Dental Association, or dental colleges worldwide) may adapt their own wording—but the key principles are consistent:

Core elements of the Dental Oath typically include:

- Commitment to the service of humanity through oral health.
- The health and well-being of the patient is the primary concern.
- Respect for patient autonomy and dignity.
- Upholding patient confidentiality.
- Practicing dentistry with integrity, competence, and compassion.
- Avoiding harm and unethical practices.
- Continuing to learn and advance professional knowledge.
- Serving the community and advancing public health.

An example of a modern Dental Oath which is often recited at white coat ceremonies and graduation ceremonies at dental schools in the U.S.:

Dental Oath (Sample)

- I solemnly pledge to dedicate my professional life to the service of humanity through the prevention and relief of oral disease, and the promotion of health.
- The health of my patient will be my first consideration.
- I will practice dentistry with conscience and dignity, and in accordance with the high standards of the profession.
- I will maintain the honor and noble traditions of dentistry, and give to my teachers, colleagues, and students the respect and gratitude that is their due.
- I will respect the secrets that are confided in me, even after the patient has died.
- I will continually strive to increase my knowledge and skill, to share them freely, and to use them for the benefit of patients and the advancement of oral health.
- I will not permit considerations of religion, nationality, race, politics, gender, sexual orientation, or social standing to intervene between my duty and my patient.
- I make these promises solemnly, freely, and upon my honor.

The ADA's Ethical Framework (Modern Dental "Oath" Equivalent)

While the ADA doesn't use the term "Dental Oath" per se, their "Principles of Ethics and Code of Professional Conduct" serves a similar purpose—a formal ethical pledge guiding dentists throughout their careers. This framework includes aspirational principles backed by enforceable conduct standards American Dental Association: **www.ada.org/about/principles/code-of-ethics**.

Continued on page 36

Key Ethical Principles

1. Patient Autonomy ("Self-governance")
Dentists must involve patients in treatment decisions, respect their rights, and safeguard confidentiality. www.ada.org/about/principles/code-of-ethics/patient-autonomy

2. Nonmaleficence ("Do no harm")
Dentists have an obligation to avoid harming patients, stay current in knowledge and skill, and refer when specialized care is needed www.ada.org/about/principles/code-of-ethics/nonmaleficence

3. Beneficence ("Act for the patient's good")
This principle emphasizes acting with the patient's welfare in mind. Although not explicitly cited above, it's one of the five fundamental pillars defined in the ADA Code. www.ada.org/about/principles/code-of-ethics/beneficence

4. Justice ("Fairness")
Care should be provided without prejudice. Dentists should promote equitable access to oral health care for everyone www.ada.org/about/principles/code-of-ethics/justice

5. Veracity ("Truthfulness")
Dentists must be honest in communications, avoid misleading representations, and maintain intellectual integrity www.ada.org/about/principles/code-of-ethics/veracity

ADA's Approach: Principles, not a Formal Oath

The ADA does not prescribe a single, ceremonial oath akin to the Hippocratic Oath. Instead, it establishes a code of ethics built upon foundational principles.

ADA Principles of Ethics & Code of Professional Conduct

The ADA Code comprises three main components:

1. Principles of Ethics: Aspirational values guiding the profession.
2. Code of Professional Conduct: Specific required or prohibited behaviors.
3. Advisory Opinions: Guidance for real-world ethical dilemmas. American Dental Association

Five Core Ethical Principles underline the ADA Code:

- Patient autonomy
- Nonmaleficence ("do no harm")
- Beneficence
- Justice
- Veracity (truthfulness)

Preamble: "Spirit of Professional Commitment"

The ADA preamble sets the tone for ethical dental practice by emphasizing:

- The patient's benefit as the primary goal.
- The combination of technical competence and ethical character—honesty, compassion, integrity, fairness, and service to the underserved. American Dental Association

Real-World Ethical Commitments (e.g., via "MouthHealthy")

A more accessible translation of ethical principles into practice highlights five promises ADA dentists make to patients:

1. Respect the patient's wants and needs—involving them in decisions and protecting their privacy.
2. Do no harm—continuously improving skills and referring when appropriate.
3. Do good—providing thoughtful, high-quality care.
4. Be fair, treating all patients without prejudice.
5. Be truthful, maintain trust through honest diagnosis and treatment planning. MouthHealthy

Do Dentists Follow the Hippocratic Oath?

A concise answer is yes, but the oath has been modified to make sense for modern dentistry. Some of the modifications include honoring the achievements of past dental professionals, remembering that there is both art and science to dentistry and keeping in mind that a patient is more than his or her dental disease

What Is Unprofessional Conduct in Dentistry?

Unprofessional Conduct (violation): Serious violations of the Dental Practice Act or unethical business practices, such as client abandonment, failure to release or return records, or breach of confidentiality.

Dentist's Awareness of the Dental Oath in Indiana

While a specific "dental oath" like the Hippocratic Oath for physicians isn't a universally mandated or legally binding requirement for all dentists in Indiana, adherence to ethical principles, including those typically found in such oaths, is expected and promoted through various avenues.

The following is a breakdown of the awareness of dental ethics and professional responsibility in Indiana:

Side-by Side: Traditional Oath vs. ADA Ethical Framework

Aspect	Traditional Dental Oath (e.g., School Ceremonies)	ADA Principles of Ethics & Code of Conduct
Structure	Single pledge in ceremonial form	Multi-part document: Principles + Conduct + Opinions
Tone	Inspirational, solemn	Formal, structured and enforceable
Core Ideals	Service, confidentiality, integrity, ongoing learning, respect	Autonomy, nonmaleficence, beneficence, justice, veracity
Enforceability	Honor-based (often symbolic)	Binding for ADA members, with disciplinary measures for violations

1. Professional organizations

The Indiana Dental Association (IDA), aligned with the American Dental Association (ADA), emphasizes ethical conduct and professionalism for its members. The IDA promotes the ADA's Principles of Ethics and Code of Professional Conduct, which is founded on five core principles:

- Patient Autonomy: Respecting patients' rights to self-determination and confidentiality.
- Non-maleficence: The duty to "do no harm" to patients.
- Beneficence: The duty to act for the benefit of patients and the public at large.
- Justice: Being fair in treatment and not discriminating.
- Veracity: Being truthful and honest in communication with patients.

2. Continuing education

- Indiana dentists are required to complete 20 hours of continuing education every two years to maintain their license. Dental hygienists are required to complete 19 hours of CE and are also required to have the 2 hours of Indiana Ethics just like dentists.
- A minimum of 2 hours of this continuing education must be in ethics, professional responsibility, and Indiana statutes and administrative rules relating to dentistry. This ensures ongoing exposure to and understanding of the ethical obligations of the profession.

3. Licensure and jurisprudence

Applicants for dental licensure in Indiana are required to pass a jurisprudence examination. This examination covers the Statute and Rules of Indiana related to the practice of dentistry and dental hygiene, universal precautions, and infectious wastes. This ensures that dentists are aware of the legal and regulatory framework that governs their practice, which often overlaps with ethical considerations.

The Dental Hygiene Oath

The Dental Hygiene Oath is a pledge recited by dental hygiene programs around the country at graduation that connects a dental hygienist to practice, ethics and patient care.
"I affirm my personal and professional commitment to improve the oral health of the public, to advance the art and science of dental hygiene, and to promote high standards of quality care. I pledge continually to improve my professional knowledge and skills, to render a full measure of service to each patient entrusted to my care, and to uphold the highest standards of professional competence and personal conduct in the interest of the dental hygiene profession and the public it serves".

"In my practice as a dental hygienist, I affirm my personal and professional commitment to improve the oral health of the public" acknowledges that hygienists have a dual responsibility to personal commitment. Hygienists are to act with integrity, empathy and dedication in their patient interactions. Hygienists are also expected to display professional commitment by following professional standards and aligning with the ADHA Code of Ethics to improve the community's oral health.
The next phrase of the oath states "to advance the art and science of dental hygiene…" which reflects a duty to stay engaged with current research, products and innovation. Hygienists have an "art" of building trust, motivating patients and using patient-centered approaches to improving their patient's oral health. The "science" aspect of the phrase implies that hygienists apply current evidence-based practices and clinical methods to achieve the best clinical outcomes.

Promoting high standards of quality care means more than providing correct treatment-it requires a holistic commitment to patient well-being. A dental hygienist isn't just a clinician

but also serves as an advocate, educator and ethical decision-maker daily. Hygienists advocate for their patients' best interests, even where financial pressures, scheduling conflicts or institutional policies might push for shortcuts. We are held accountable to a consistent, ethical standard of care to protect patients from harm by following infection control standards, correct radiographic procedures, ergonomic practice and medication safety. We also use evidence-based treatment strategies to determine proper periodontal therapies and fluoride therapies that are supported by current scientific research rather than outdated traditions. Hygienists respect patient autonomy and tailor care to meet individual needs while making sure that treatment isn't delayed.

Pledging to continually improve professional knowledge and skills reflects a commitment to lifelong learning which recognizes that graduation isn't the endpoint of education. New diseases, technologies and treatment modalities emerge, and a hygienist must adapt to remain competent and effective. While continuing education is required for licensure, this is also an essential way to maintain clinical excellence in areas such as periodontal therapy, caries management strategies, laser use, guided biofilm therapy, pharmacology updates and medical-dental integration. Continuing education should go beyond the minimum requirements, which reflects a genuine drive to provide the best patient care. Lifelong learning could also encompass the pursuit of additional credentials or degrees which would broaden the hygienist's ability to contribute to education, research, leadership or advocacy roles. Engaging in professional organizations such as ADHA, ADEA or state associations will keep hygienists connected to evolving standards and provide networking opportunities.

A skilled dental hygienist will continually evaluate their strengths and weaknesses and identify areas for improvement. Seeking mentorship or training to close gaps displays professional maturity and self-assessment with foster technical growth. Constructive feedback from colleagues can highlight blind spots that self-assessment alone might miss. Mature practitioners see themselves not only as care providers but as contributors to the growth of their professions and the health of the community.

The Dental Hygiene Oath also has a legal and ethical concept of "standard of care" which evolves as science advances. Ethically, the hygienist is bound to practice in alignment with best available evidence, not simply "the way it's always been done." Patients expect honesty and competence and a hygienist who neglects education risks betraying patient trust. Promoting high standards means refusing to compromise care for convenience or profit which includes not over-treating or under-treating, maintaining complete accurate records, upholding confidentiality and advocating for referrals when care is outside the hygienist's scope of practice.

By consistently promoting high standards, that are indicated in the Dental Hygiene Oath, the public will have trust in the profession leading to improvements in oral healthcare that will ensure patient receive not just treatment, but care that improves their overall health and quality of life.

The Critical Role in Emergency Medical Care

Emergencies can arise in the everyday clinical practice of dentistry. Emergencies can range from syncope to allergic reactions to swallowing crowns or implant parts along with cardiac events to name a few emergencies that can happen in dental offices. The whole dental team plays a pivotal role as first responders when emergencies arise.

How does the Oath get applied in Dental/Medical Emergencies?

Beneficence: The main concern is the patient's well-being. Well-coordinated and immediate actions are key when it comes to potentially life-threatening situations.

Non-Maleficence: Upholding the principle of "do no harm" in emergency interventions. Dental teams must be trained to handle emergencies while also practicing monthly or quarterly drills in the office using a wide variety of emergency scenarios.

Confidentiality: Patient confidentiality is important. Discussing patient specific emergency situations while identifying patients is taboo. Discussions must be limited to the dental team and other first emergency management personnel.

Autonomy: Always involve the patient when he or she is conscious and able to communicate. Communicating the plan with the patient whenever possible is important.

Justice: Consistent emergency response protocols for all patients in practice is the foundation of good patient care.

The Importance of Emergency Preparedness

In making sure that the dental team is aligned with the principles of the Hippocratic Oath, dental practices must prioritize emergency preparedness in their offices. The steps in making sure that the office is prepared would include:

Training: Team members should seek out and maintain their basic life support training with ACLS also included especially if conscious sedation is part of the office treatment protocol.

Equipment: A team member must be assigned to ensure that emergency medical equipment, AEDs, oxygen cylinders, and medications, follow state regulations and they are readily accessible.

Communication: Establishing clear and concise communication protocols to help ensure that the dental team is prepared for medical and dental emergencies and in coordinating responses with other members of the team as well as with EMS if required.

Documentation: Careful documentation of the events taking place during the emergency. This should include actions taken, medications used and patient responses. These are important for patient care and legal purposes.

Review and Improvement: A post-emergency debrief that includes assessment of the team responses while identifying areas for improvement is vital.

Conclusion

While there might not be a specific "dental oath" that every Indiana dentist formally recites, the profession, through organizations like the Indiana Dental Association and the state's licensing board, actively promotes and mandates awareness of ethical principles and professional responsibilities through various mechanisms like codes of conduct, continuing education, and jurisprudence examinations. This fosters a strong culture of ethical practice among Indiana dentists.

The oath taken by dental hygienists helps in creating trust in the public in the profession and helps ensure that patients receive care, that can improve their overall health and the quality of their lives.

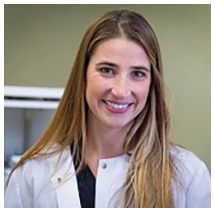
Epilogue

The information contained in this article is not original. Most of the information was derived using Generative AI search engines. It is meant to be a refresher for dentists and dental hygienists as it relates to the oaths taken when we joined the dental profession upon graduation. It is also meant to be an opportunity for practitioners to reflect on their journeys as they relate to the oaths that were made at the graduation ceremony.

About the Authors

Dr. Harvi Patel graduated in 2024 from the Indiana University School of Dentistry. When not working, Dr. Patel focuses on calligraphy or getting lost in the world of art, creating textured floral pieces, which serve as an outlet outside of dentistry.

Twyla Rader, LDH, M.Ed., clinical associate professor, is the Dental Hygiene Program Director at the Indiana University School of Dentistry in Indianapolis and currently serves as the appointed dental hygienist on the Indiana State Board of Dentistry.



Abbey Rieck, LDH, B.S., MS. Ed., is an assistant professor in dental hygiene at the Indiana University School of Dentistry. A 2010 graduate of IU, Abbey spent a decade in clinical practice before transitioning to full-time academia.

Dr. Vanchit John is the O'Leary-Hancock Endowed Professor and Chairperson of the Department of Periodontology at the Indiana University School of Dentistry.

Radiation Safety in Dental Offices: Where Do We Stand in 2025?

Dr. Erica Chhokar
Dr. Vanchit John

DENTAL X-RAYS WERE first invented in 1896.[1] Dr. Otto Walkhoff, a German dentist, who is credited with taking the first dental radiograph, used himself as the subject and required a 25-minute exposure time for that first blurry radiographic image to be seen.

However, X-ray images were created the year before in 1895 by Wilhelm Roentgen. Of the early pioneering researchers in radioactivity, Marie Curie, who was directly involved in the development and operation of mobile radiography units to support field hospitals during World War I, was the most famous. These mobile units led to their subsequent use in almost every dental practice across the world. The first committee that investigated the negative effects of X-rays was formed in 1898.

The first paper published on the risks of radiation was written by William Herbert Rollins who was a dentist and a physician. He suffered radiation burns during the development of his pioneering dental X-ray unit and accordingly was an early advocate using lead shielding to protect against X-rays.

From those early origins, X-ray machines have become smaller, more practical to use and safer. It was not until the 1950s that radiographs became a regular tool used by dentists.

More recently, standard X-ray machines have been supplemented by OPG systems (a type of 'focal plane tomography' more correctly called a panoramic radiograph). The first experiments to create an image of the whole dentition used an intra-oral radiation source in the very early 20th Century. Safer and more effective technology emerged in the 1920s, but a practical commercial system was not marketed until the 1960s.

Where We Are Today

Digital detectors have essentially replaced films to provide images instantly with no additional film processing. They are also being supplemented with digital light scanners that create 3-D images of teeth and soft tissues. These innovations have led improved and quicker diagnosis, and to digitized appliance manufacturing. Cone Beam Computed Tomography (CBCT) which are 3D imaging techniques have now become almost routinely used in dentistry to image the maxillofacial region. The image quality offered using this technology is superior to traditional 2D X-rays. CBCT images aid in diagnosis, treatment planning, and assessment in implant dentistry, orthodontics, oral surgery, and endodontics.

Use of Lead Vests

Lead vests and thyroid collars have been worn and used during dental X-rays for about a century. The heavy lead lined apron-like shields are placed over sensitive areas, including the chest and neck, before the X-rays are taken.

What Has Changed About Dental X-rays?

The use of lead vests and thyroid collars were first recommended as X-ray technology was not as precise as it is today. However, changes over the last few decades have significantly improved patient safety. Some of the changes include:

Digital Radiography, which has enabled smaller radiation doses, reducing radiation exposure and the risks associated with higher doses. The doses used in dental radiology are very small today. The total exposure time is approximately five seconds, compared to many minutes of exposure about a hundred or so years ago.

The small size: There is significantly less "scatter" that restricts and focuses the beam size to the area being imaged. This has enabled significant protection for patients.

A practical reason that presents itself when using lead vests is that lead vests and thyroid collars can get in the way of the images on the screen necessitating additional exposures of radiation. This can lead to repeat imaging with additional exposure to radiation.

In September 2023, the *Journal of the American Dental Association* had an article titled "Patient shielding during dentomaxillofacial radiography"[2] which included research and guidelines with recommendations from the American Academy of Oral and Maxillofacial Radiology to discontinue shielding in dental radiography based on their research. The ADA also updated its own recommendation language on dental imaging safety with a similar article, "Optimizing radiation safety in dentistry."[3]

When Did Lead Aprons Stop Being Used?

As indicated, the American Dental Association (ADA) changed its lead apron guidelines in February 2024. The new ADA Lead Apron Recommendations[4] state that lead aprons aren't needed for dental X-rays if facilities use updated machines with the proper calibration.

That said, lead aprons are still necessary in other medical settings. C-arms and fluoroscopy emit much higher doses of radiation than dental X-rays since this equipment is involved in more intensive diagnostic and interventional processes. In dental offices, currently the use of lead aprons and thyroid collars is no longer routinely recommended for dental X-rays.

As dental X-ray equipment and techniques significantly minimize radiation exposure, lead shielding appears to be unnecessary. This updated recommendation is supported by the ADA and the American Academy of Oral and Maxillofacial Radiology (AAOMR).

A More Detailed Analysis

Reduction in exposure to radiation: Modern dental X-ray machines, digital sensors, and optimized beam filtration deliver significantly lower radiation doses compared to older equipment.

Lead shields effectiveness: Lead aprons and thyroid shields are not very effective at blocking internal scatter radiation. This does not shield the body from the radiation that results in an effective manner.

Routine use no longer recommended. As previously noted, the ADA and AAOMR no longer recommend the routine use of lead aprons and thyroid collars for all patients during dental X-rays.

Shielding for specific patients: Patients with certain medical conditions or those who express concern about exposure to radiation to other parts of their body, may choose to have a lead apron used when taking dental X-rays.

Good communication: It is important for dentists to explain the updated recommendations while addressing any concerns they may have about radiation safety.

While these are big recommendations, it is important to note that these will have to be reviewed within the context of state law and rules. **Indiana still requires protection of "five tenths (0.5) mm lead equivalent" protection during radiographic exposure** according to 410 IAC 5-6.118(t) of Indiana Administrative Code. Some key takeaways to remember will include:

- Recommendations from reputable sources have changed and we are recommending no shielding with proper technique and equipment for dental radiography.
- Research is continuing and will still be ongoing.
- Guidelines from ADA, state health departments, school curriculum will all need to undergo review.
- Indiana State rules still require shielding.
- Patient expectations and education take time to change.

Indiana Rules 410 IAC 5-6.118 (t):

Except for patients who cannot be moved out of the room, only the staff and ancillary personnel required for the medical procedure or training shall be in the room during the radiographic exposure. In addition to the patient being examined, others will be protected in the following manner:

1. All individuals shall be positioned such that no part of the body will be struck by the useful beam unless protected by five tenths (0.5) mm lead equivalent.

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2. Staff and ancillary personnel shall be protected from direct scattered radiation by protective aprons or whole-body protective barriers of not less than twenty-five hundredths (0.25) mm lead equivalent.

3. Patients who cannot be removed from the room shall be protected from direct scattered radiation by whole body protective barriers of twenty-five hundredths (0.25) mm lead equivalent or shall be positioned so that portion of the body nearest to the tube head is at least two (2) meters from both the tube head and the nearest edge of the image receptor

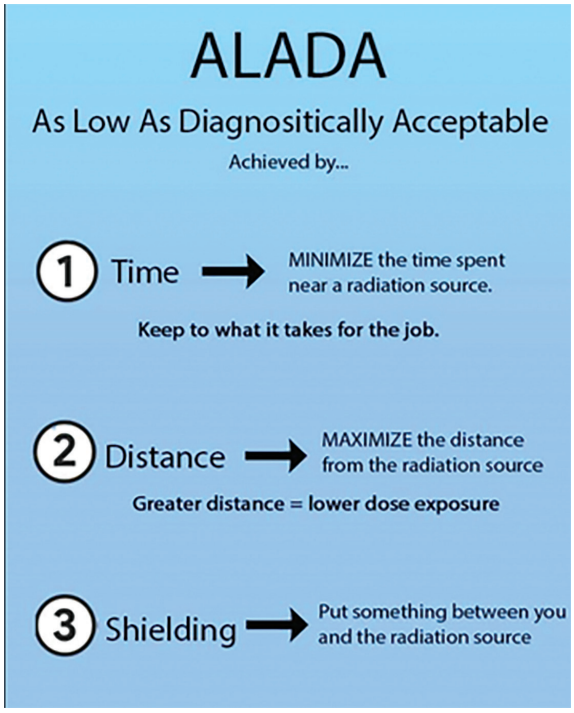
ALARA and ALADA

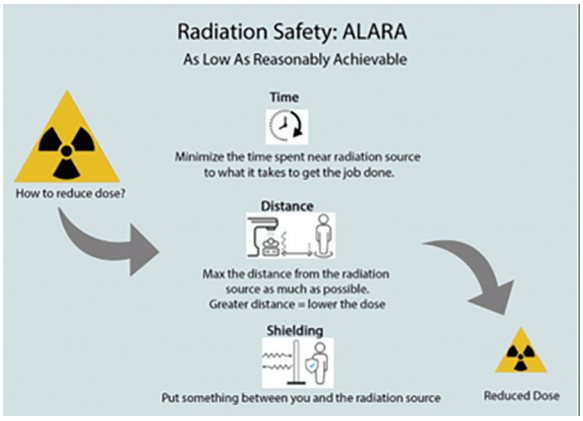
ALARA and ALADA are both radiation safety principles, but they differ in their focus. ALARA, which stands for "As Low As Reasonably Achievable," focuses on minimizing radiation exposure in all situations where radiation is used, with the goal of reducing risk to individuals.

ALADA, or "As Low As Diagnostically Acceptable," focuses on optimizing radiation exposure specifically for medical imaging, ensuring the lowest possible dose while still obtaining a diagnostically useful image.

ALARA is a broader concept, while ALADA is a more targeted approach within medical imaging.

ALARA is the global principle of radiation safety, while ALADA is a specialized application of ALARA within the context of medical imaging. It has also been proposed to use ALADAIP, which is "Indication-oriented and Patient-specific" to ALADA.





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About the Authors

Dr. Erica Chhokar graduated from IU School of Dentistry in 2022 and currently is a first-year resident in the Department of Periodontology at IUSD.

Dr. Vanchit John is Chairperson of the Department of Periodontology at Indiana University School of Dentistry.

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Sexual Harassment in Dentistry: Understanding the Issue and Steps to Prevent it from Happening

Dr. Monica Gibson
Dr. Celine Joyce Cornelius Timothius
Dr. Vanchit John

THE #METOO MOVEMENT in 2017 shone a light on how widespread sexual abuse and sexual harassment were in the workplace.[1] A survey completed in 2020 reported that 38 percent of women experienced different forms of sexual harassment in the workplace, while approximately 15 percent of men reported similar experiences.[2] The data indicate, that sexual harassment was not unique to women as men, as well as nonbinary people also reported facing sexual harassment.

Sexual harassment in dental practices in the U.S. is a serious issue, with a significant number of dental professionals, especially hygienists, reporting instances of inappropriate behavior. Many cases go unreported due to fear of retaliation or lack of awareness about reporting procedures.

Title VII of the Civil Rights Act of 1964 made it illegal to discriminate against a person based on sex, race, religion, color, and national origin with hiring, firing, promotions training, harassment, benefits, or wage discussions.[4] Dental offices must follow the established law. In addition, each state has its own laws regarding sexual harassment in the workplace. Indiana law prohibits sexual harassment in the workplace under the Indiana Civil Rights Act, which makes it unlawful for employers to engage in sexual harassment or to allow it to occur on their premises.

In comparison, as noted by one of the authors of the article, the State of Georgia enforced a statewide Sexual Harassment Prevention Policy to ensure a safe and respective workplace under the Executive Order 01.14.19.02, authorized by O.C.G.A. § 45-20-4 and the Fair Employment Practices Act of 1978. The policy prohibits sexual harassment and retaliation while mandating consistent reporting, investigation and training procedures across all executive branch agencies.

What is Sexual Harassment?

According to the U.S. Equal Employment Opportunity Commission (EEOC), the legal definition of sexual harassment is “unwelcome sexual advances, requests for sexual favors or other verbal and physical conduct of a sexual nature when this conduct explicitly or implicitly affects an individual’s employment, unreasonably interferes with an individual’s work performance or creates an intimidating, hostile or offensive work environment.[5]

What is Sexual Harassment in a Dental Practice?

Sexual harassment in a dental practice (Table 1) can range from unwelcome physical contact and inappropriate comments to discriminatory practices and creating a hostile work environment. It’s crucial for dental professionals to understand what constitutes sexual harassment and how to address it, as both patients and staff can be affected.

Unwelcome physical contact: This includes touching, patting or rubbing that is not related to dental treatment.

Inappropriate comments or jokes: Sexual innuendos, offensive remarks, or conversations that make someone uncomfortable.

Discriminatory practices: Treating employees differently based on gender, sexual orientation, or other protected characteristics.

Creating a hostile work environment: Any behavior that makes someone feel uncomfortable, intimidated, or unsafe at work.

Retaliation for reporting harassment: Taking adverse action against someone who has reported sexual harassment.

Patient-initiated harassment: Dental professionals can also experience sexual harassment from patients, including verbal advances, inappropriate touching or other unwanted behavior.

Colleague-initiated: Dental hygienists also report experiencing harassment from dentists and other staff members, including gender discrimination, bullying and sexual harassment.

Verbal and physical: Harassment can range from verbal comments and jokes to physical actions like groping or following someone into a closed room.

Hostile work environment: Sexual harassment can create a hostile work environment, impacting the well-being and job satisfaction of dental professionals.

A larger percentage of dental hygienists experience unwanted sexual conduct from patients, including staring at body parts, overt sexual remarks, and purposeful touching.

CATEGORY	Examples of Sexual Harassment in Dental Practices
Verbal Harassment	Sexual jokes, suggestive remarks, offensive comments, patient innuendos
Physical Harassment	Unwelcome touching, groping, invasion of personal space not linked to treatment
Non-verbal Harassment	Staring, gestures, displaying sexually explicit material
Discrimination	Gender based exclusion from opportunities, unequal pay or workload
Retaliation	Punishing, demoting or ostracizing individuals who report harassment

Table 1: Examples of Sexual Harassment in Dental Practice

Hunt et al.[6] in their study of sexual harassment among dental hygienists in Virginia had 161 dental hygienists complete the survey using the Sexual Experiences Questionnaire (SEQ-W). 27 percent of the respondents reported at least one experience of sexual harassment in the previous 24 months. They measured three different constructs and found that 27.3 percent of participants reported gender harassment, 18.6 percent unwanted sexual attention, and 6.8 percent sexual coercion. The most reported items were being told offensive sexual jokes or stories (21 percent) and hearing someone make crude and offensive sexual remarks (18 percent). The authors concluded that sexual harassment is a contemporary problem in dental hygiene employment settings in the state of Virginia.

Why is it Important to Address Sexual Harassment in Dental Practices?

Legal and ethical obligations

Dental practices and their owners have a responsibility to provide a safe and respectful workplace for their employees while ensuring that patients that they provide care for are treated with dignity. Sexual harassment can undermine trust between patients and the dental professionals while leading to their reluctance to seek care. Additionally, sexual harassment can lead to significant emotional distress, anxiety, and reduced job satisfaction for its victims. Finally, offices with a reputation for harassment, sexual or otherwise can suffer damage to their reputation while having challenges retaining staff and attracting new patients.

What Steps Can Dental Practices Take to Prevent Sexual Harassment?

Develop and implement a clear policy

Dental practices should have a written policy that defines sexual harassment, outlines prohibited behaviors and provides a clear reporting procedure.

Provide regular training

All staff members, including dentists, hygienists, assistants, and administrative staff, should receive training on sexual harassment prevention and reporting procedures.

Foster a culture of respect

Dental practice leaders should set a positive example by demonstrating respect and professionalism in their interactions with all staff and patients.

Establish clear reporting procedures

Employees should know who to report to if they experience or witness sexual harassment, and they should be confident that their concerns will be taken seriously and addressed appropriately.

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Take all complaints seriously

Dental practices should investigate all complaints of sexual harassment promptly and thoroughly.

Consider engaging an independent party to review complaints

In larger practices, it may be helpful to have an independent party to handle sexual harassment complaints.

What to do if you experience or witness sexual harassment

Report it

Follow the established reporting procedures within the dental practice. It is crucial for dental professionals to understand the reporting procedures for sexual harassment, both within the practice and through external channels like state dental boards or legal professionals.

Document the incident

Keep a record of the date, time, location, what happened, and any witnesses.

Seek support

If needed, seek support from a trusted colleague, friend, family member, or professional counselor.

Consider legal options

Depending on the severity and nature of harassment, you may want to consult with an attorney or contact the Equal Employment Opportunity Commission (EEOC) or the Indiana Department of Labor. Additionally, dental malpractice lawyers can be helpful.

Dental professionals have ethical obligations to create a safe and respectful work environment for all staff members. By taking proactive steps to prevent sexual harassment and addressing it seriously when it occurs, dental practices can create a safe, respectful, and professional environment for everyone.

Are dental offices doing enough to prevent sexual harassment?

The following questions can help focus your offices policies as they apply to the prevention of sexual harassment.[7]

1. Does your office and the personnel in charge know the applicable federal and state laws regarding sexual harassment?
2. Does your office have a written policy as it applies to sexual harassment?
3. Do new employee's receive training in sexual harassment prevention and are they informed about office policies that apply to sexual harassment?
4. Is annual training provided for employees regarding sexual harassment prevention?
5. Has the training been updated in the last three years?
6. Does your office have protocols that can help employees when it comes to reporting incidents of sexual harassment?
7. Has your office engaged an outside human resources (HR) professional to review office harassment prevention training protocols?

Dentists are responsible and liable for the activities that occur within their offices. If sufficient training was not provided and documented, the liability for the practice in case of an accusation of sexual harassment. The dentist could be held liable for the actions of others that occur within the practice, if an incident was not documented and addressed formally. Accordingly, every dental office must include sexual harassment prevention training as a priority expectation for all personnel. Making sure that the training program is reviewed and approved by an HR professional or a labor law attorney is in the best interest of the dentist and/or practice owner.

More recently, dental practices across England, Wales and Scotland have been legally required under the Worker Protection Act 2023 falling under the Amendment of Equality Act 2010, to implement proactive measures aimed at preventing sexual harassment. This marks a significant shift from a reactive to a preventative approach to workplace culture prompted by dental teams and highlights the importance of familiarizing staff with updated Equality and Human Rights Commission (EHRC) guidance.

The new legal duty thus presents both a compliance requirement and an opportunity to uphold higher standards of professionalism and care[8]

Conclusions

In conclusion, sexual harassment is a serious problem in dental practices, impacting the well-being of professionals and potentially leading to legal and professional consequences.

Open communication, clear policies, and proactive measures are essential to create a safe and respectful work environment in dental offices.

Table 2: Framework for Addressing Sexual Harassment

Component	Key Actions	Objectives
Policy Development	Establish a clear, written sexual harassment policy. Define unacceptable behaviors and provide examples. Outline rights, responsibilities, and consequences. Ensure compliance with legal standards.	Provide clarity, consistency, and a formal standard for workplace conduct.
Training and Awareness	Conduct mandatory training for all employees and managers. Include bystander intervention strategies. Use interactive and scenario-based learning. Refresh training regularly.	Build awareness, promote respect, and prevent harassment through education.
Safe Reporting Channels	Provide multiple confidential reporting options (e.g., hotline, HR contact, anonymous online form). Protect whistleblowers from retaliation. Communicate reporting procedures clearly.	Encourage victims and witnesses to come forward without fear.
Investigations and Accountability	Investigate all reports promptly, fairly, and impartially. Maintain confidentiality throughout the process. Apply consistent disciplinary actions when necessary. Hold managers accountable for enforcing standards.	Ensure fairness, transparency, and trust in the process.
Support and Follow-Up	Offer counseling, legal, or medical support to affected individuals. Monitor workplace climate after resolution. Provide updates to those who reported issues. Reinforce a culture of respect and inclusion.	Promote healing, rebuild trust, and prevent recurrence.

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About the Authors

Dr. Monica Gibson, BDS, PhD, MS, FRCDC is the Graduate Program Director in the Department of Periodontology at the Indiana University School of Dentistry.

Dr. Celine Joyce Cornelius Timothius BDS, M.Sc, M.S, MSD, is an Assistant Professor and the Predoctoral Program Director in the Department of Periodontics, at the Dental College of Georgia, Augusta University.

Dr. Vanchit John is the O'Leary-Hancock Endowed Professor and Chairperson of the Department of Periodontology at the Indiana University School of Dentistry.

What Success in Dentistry Is and Isn't!

Dr. Tony Ratliff

(Adapted and Re-written from an old Zig Ziglar book)

Success is waking up each morning and choosing to have a positive attitude about life. It's about arriving at your dental office with a smile on your face, with a feeling of gratitude and having the desire and enthusiasm to help as many people as possible.

Success isn't about being negative and/or depressed. It's not about dragging yourself into the office each morning, feeling unappreciated and tired. It's not fun being stressed out and maxed out. Success isn't about doing one more crown today – so you can pay your bills tomorrow.

Success is working with a dental team that stands behind you during good times and bad. It's having a team that respects you as their leader and believes in your vision. It's about having a practice that runs smoothly, and a team that's aligned with your core values and understands they are helping to make a difference in this world.

Success isn't working with people who hate their jobs and can't stand their boss. It's not about having employees that don't get along. It's not about working with people that don't believe in your cause, and who only care about themselves.

Success is leaving the office with a feeling of contentment, knowing that you did the best dentistry you could possibly do, knowing that you treated people in a way you would want to be treated, and knowing that your patients are proud to call you their dentist. It's the realization that you are not only changing smiles, but changing lives.

Success isn't having your patients come back three or four times for adjustments. It's not about over diagnosing. It's not about treating patients you can't stand or doing procedures you hate to do. It's not about selling more dentistry just so you can buy more things. It's not about rushing through your day, so you can get away from the office earlier.

Success is coming home and being welcomed by the people you love. Kissing your family and giving them hugs. Sharing yourself and your time with your kids. It's knowing that your family is your first priority and dentistry comes second. It's a personal commitment to accept responsibility for everything that happens in your life and in your practice.

Success isn't coming home late and complaining to your spouse about how difficult your day was, or blaming others for your problems. Success isn't about being financially strapped and emotionally drained. It's not about staying late after work to avoid going home. It's not about accusing others and making excuses when things go wrong.

Success is understanding the importance of health and living a healthy lifestyle. It's about respecting your body and nourishing your mind. It's about getting regular exercise and plenty of rest. It's about understanding balance and those things that are the most important in life.

Success isn't about putting dangerous chemicals into your body to cope with your problems. It is not about excessive eating, drinking or sitting on the couch. It's not about staying up late at night and being late for work the next morning. It's not about helping others and forgetting to take care of yourself.

Success is lying in bed every night and thanking God for all your blessings: Your Health, Your Happiness. Your Wealth. Your Wife. Your Husband. Your Life. Your Family, Your Friends and Jesus. It's about being a good husband or wife, father or mother, son or daughter, brother or sister, friend, leader and the best PERSON you can be.

About the Author

Dr. Tony Ratliff, a longtime member of the ADA and IDA, practiced general dentistry in Noblesville for more than 30 years. After retiring in March of 2025, he now dedicates his time to managing his other business ventures. This was an article he wrote over 25 years ago to remind himself of the what true Success was in Dentistry.