Ethical Moment

Ethical care is good dentistry

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We will typically judge our peers' care as being either good dentistry or bad dentistry. But what is meant by good dentistry, or, in other words, quality oral health care? Some may think a well-seated dental crown on a mandibular first molar with ideal tripod occlusion and perfectly adapted margins reflects good dentistry. But when performed on a tooth that did not clinically need a crown, it is not quality care but harmful dentistry.

In 2001, the Institute of Medicine (now the National Academy of Medicine), took on the challenge of defining quality health care (that is, good dentistry) at the patient level as the "degree to which healthcare services for individuals increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1]

The National Academy of Medicine[1] described 6 standard components, or domains, of health care quality that should characterize all quality health care outcomes. Specifically, quality health care should be safe, effective, efficient, patient centered, timely, and equitable.

Enshrined in these 6 domains are the 4 basic principles of biomedical ethics, as described by Beauchamp and Childress[2]: nonmaleficence, beneficence, autonomy, and justice.

Biomedical ethics refers to the ethical implications and applications of morality that govern a clinician's behavior and conduct.[2]

The nonmaleficence principle, like the precautionary principle, is addressed in the quality domain of safety. The precautionary principle (for example, the Hippocratic Oath) requires that, in the absence of sound scientific evidence, health care decisions must err on the side of caution.[3] The principle of beneficence implies that health care should be effective and efficient. Autonomy encompasses the broad area of patient-centered care, and the principle of justice requires timeliness and accessibility.

Furthermore, contained in the domains of safety, effectiveness, efficiency, and, to some extent, patient-centeredness are the 3 core values of evidence-based dentistry defined by the FDI World Dental Federation[4]: clinical expertise, scientific evidence, and patient preference and values.

In patient-centered care, the patient's specific health needs and desired health outcomes drive all health care decisions.[5] The Picker Institute highlights 8 principles of patient-centered health care delivery:

- respect for patient's preference
- coordination and integration of care
- information and education
- physical comfort
- emotional support
- involvement of family and friends
- continuation and transition of care
- access to care[6]

The figure shows how the principles of biomedical ethics enshrines precaution, evidence-based dentistry, and patient-centeredness to achieve the goal of delivering quality oral health care to our patients. In other words, the mission of every dentist must be to get the right care to the right person at the right time.[7]

However, in a world of imperfect information, uncertainty, and choice, the mission to deliver quality oral health care to patients is easier said than done. To quote the 36th President of the United States, Lyndon B. Johnson, "[The] hardest task is not to do what is right, but to know what is right."[8]

Balancing our decisions against the 4 biomedical ethics principles enshrined in the 6 domains of quality health care, the 3 domains of evidence-based dentistry, and the 8 factors of patient-centered care is a good start. Sometimes decisions cannot satisfy all the domains, factors, and principles, resulting in a clinical dilemma. Resolving a dilemma requires that the clinician find the higher good based on which ethical principle holds the highest preponderance of rightness in the uniqueness of the clinical context.

For example, deciding how to best manage a caries lesion places the clinician in an ethical dilemma between nonmaleficence and beneficence. Preparing a relatively large restoration will indeed compromise the tooth's strength, putting it at risk of fracturing in the future (maleficence). However, the beneficence of eradicating further spread of the carious infection into the tooth's endodontic complex, hence reducing the immediate risk of the patient experiencing pain and costly treatment in the future, may justify the surgical procedure.

Clinical practice guidelines (CPGs) have been developed to assist clinicians with standard clinical questions. The National Academy of Medicine defines CPGs as "statements that include recommendations intended to optimize patient care. These statements are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[9] The seminal 2011 publication *Clinical Practice Guidelines We Can Trust* set standards on CPG development that are evidence-based.[9] To be trustworthy, the guidelines should be developed by a multidisciplinary panel of experts and stakeholders with full disclosure of any potential conflicts of interest and transparency of its developmental process. The CPGs must be based on a clear, specific clinical question considering all reasonable alternative care options. It is essential that the analysis be based on a comprehensive systematic review of all the available evidence. It must consider the patient's experience, including risks, harms, benefits, and costs associated with each care option. Finally,

Bioethics	Quality health care	Patient-centered care		Evidence-based dentistry		Precaution
Nonmaleficence	Safe	Physical comfort	Emotional support	Scientific evidence	Dentist expertise	Precautionary principle
Beneficence	Effective					
	Efficient	Coordination of care				
Autonomy	Patient-centered care	Respect patient preferences		Patient preferences		
		Involve family and friends				
		Information and education				
Justice	Timely	Continuation of care				
	Equitable	Access to care				

Figure. Enshrined in biomedical ethics are the principles of quality health care, patient-centered care, evidence-based dentistry, and precaution.[1-4,6]

the CPGs must grade the strength of the evidence on the basis of an acceptable approach, like Grading of Recommendations Assessment, Development and Evaluation.[10] Carrasco-Labra and colleagues[11] described in detail the process of developing dental CPGs.

CPGs are not just a summary of the gathered research, but a rigorous and costly endeavour of critically appraising results and conclusions of all available evidence on the basis of their validity, precision, and generalizability to the specific clinical context in question.[11,12]

Think of CPGs as a tool that transfers scientific knowledge to clinical practice, intending to optimize patient care. High-quality CPGs are considered "the strongest resources to aid dental professionals in clinical decision-making"[13] because they are developed by a panel of experts who systematically incorporate relevant evidence gained through scientific investigation into patient care.

A good start is the American Dental Association's Clinical Practice Guidelines and Dental Evidence.[13] Although CPG development is an ongoing process that continues to gain momentum in dentistry, there remain many clinical questions where well-conducted systematic reviews or CPGs do not meet the standard set by the National Academy of Medicine or are not yet available.[11,14,15] This leaves the clinician needing to make clinical decisions with limited available quality evidence. In this case, the clinician must rationally work through the systematic process of critically appraising the limited available evidence on the basis of its validity, clinical significance, risk, and benefits to the patient.

Our patients are counting on us to help them make the right decision. ■

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