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The Journal of Dental Humanities is dedicated to presenting thought provoking material connecting dentistry to the humanities, and the social sciences. The journal places a priority on publishing quality material that supports the objective of dental professionals who seek to provide a patient-centered approach to health care. The mission purpose of the Journal of Dental Humanities aligns with the position that a functional democracy requires ethical, highly skilled professionals who are engaged, active members within their community and the larger society.

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EDITORIAL

A DENTAL STUDENT AND THE PATIENT FIRST PROMISE

ROBERT P. IOVINO, D.D.S., M.A.

Dental educators derive a distinct sense of satisfaction when a student demonstrates the understanding that moral and clinical competency go mutually hand-in-hand. Dental students are faced with unique combination of pressures. A list of clinical requirements, time constraints, tuition, and the ever-looming anticipated graduate date can, unfortunately, at times, combine to promote questionable professional behavior. How satisfying it is when such pitfalls are avoided. The following anecdote is a brief example of how one student abided by the American Dental Association's "patient first promise" [1] (Names and details have been altered to protect confidentiality).

In a typical day there can be multiple undergraduate oral surgical cases scheduled in our oral surgery clinic. Despite the constant flow of cases, both students and their patient patients, at times, can wait weeks for a desired appointment. As a result, on the day of the appointment, all parties involved have a strong desire to go forward with the planned treatment.

Maureen, a fourth-year dental student, has been providing comprehensive care for Mary, a 80+ year-old disabled elderly woman. The scheduled treatment plan today includes the extraction of three asymptomatic non-restorable teeth in preparation for a removable denture. Mary's, dutiful, daughter has taken time out of her busy day to transport her mother to the oral surgery clinic.

[1] American Dental Association. "Ethics: The 5 promises ADA dentists make to their patients." <https://www.mouthhealthy.org/en/az-topics/e/ethics-and-dentistry> Accessed 1 December 2018.

Maureen, prior to seating her patient, notifies me that on the day prior to this her patient Mary had fallen. Maureen states her patients has assured her that she is OK and would like to proceed with the day's planned surgery. However, upon being seated, Mary's marked facial ecchymosis bears testimony to the extent of her recent accident. Immediately, I understand what the situation calls for; but I silently wonder: Does Maureen? Maureen immediately provides me with the answer. She advises me that today's surgery best be postponed, and that a facial trauma evaluation is called for. Maureen politely assures her patient that this is in Mary's best interest; the extractions will be rescheduled.

I cannot help but inwardly smile as I instruct, and, together, we conduct a thorough, thankfully essentially negative, facial trauma exam. No clinical requirements are checked off Maureen's official list today. However, the most important requirement isn't so easily measured – in the clinic that day, Maureen successfully demonstrated the moral/clinical competence and determination to live and abide by the ADA's patient first promise.

ETHICAL CONSIDERATIONS OF THE CLINICAL DENTAL EXAMINATION FOR LICENSURE

JOHN M. IACONO, D.D.S.[1]

Many professions and occupations require competency testing prior to working in their respective fields. Almost always when public safety is involved a license is required. Obtaining an automobile driver's license requires an actual demonstration of competency before a DMV examiner. An airplane pilot after training must perform a solo flight in an airplane which demonstrates his/her ability to fly safely and competently. The lives and well-being of the passengers are directly related to his/her competence. A passenger train engineer must demonstrate the knowledge and experience that he/she can safely start and stop the train and obey the signals that are necessary to transport the passengers to their desired destinations. The engineer must annually demonstrate his/her continued competence. In all these examinations simulators are not used. The "hands on" test is the actual performance of the task.

Medicine and dentistry are licensed for the same reason: the protection of the public. The Medical Licensing process includes a three step exam given by the USMLE taken at various points in the training of a physician. At present the final examination in the USLME series is given after the start of his/her residency which includes 13 patient case simulations. In most states the Dental Licensure examination includes a clinical exercise on a patient in the final year of their pre-doctoral training.

This paper is not going to address the similarities and differences between dental and medical licensure because that subject is too large and contentious to be covered in this essay.

[1] F.A.C.D., F.I.C.D.; Private Practice, General Dentistry, Manhasset, N.Y.

The history of dental licensure exams in the United States goes back over one hundred years and always used human subjects for part of the licensure exams. Until the creation of the North East Board of Dental Examiners the candidate had to travel, with the necessary patients, to the state where he or she desires to practice and take the exam appropriate for that state. This meant that the candidate for licensure had to incur great expense in order to be tested. Today a candidate only has to take one examination that will cover almost all states and jurisdictions. The Commission on Dental Competency Assessments (CDCA) is an agency that administers the ADEX clinical examination that is accepted in 46 different US states/jurisdictions and the country of Jamaica. The CDCA develops, administers, scores, and reports the results of the ADEX examinations in Dentistry and Dental Hygiene.

The CDCA remains committed to serving boards of dentistry by designing and administering assessments that are based on sound principles of testing and measurement. It is pledged to excellence, integrity and fairness and strives to be a preeminent resource in the development, innovation and administration of competency assessments for the oral health professions.

Before we go any further the accepted definition of ethics must be stated: Ethics is based on well-founded standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues.

Before a candidate is allowed to take a licensure exam the dean of his/her respective dental school must certify that he/she is competent to treat patients independently. That satisfies the ethical requirement that the candidate has been deemed properly trained to provide the necessary tasks required for the successful completion of the examination.

An ethical examination must be fair, valid and reliable. A fair clinical exam tests the candidate's ability to perform certain basic procedures that he/she would be required to perform every day. Periodically the examination community conducts a task analysis survey to determine the most common procedures that are performed by the new graduate dentist within the first five years of practice. The results of that study will determine the content of the exam. Presently procedures such

as gold foil, gold inlay restorations, and setting up of complete dentures were found not to be done very often or not at all by the new graduate. It would be unfair to test the candidates on these procedures. Therefore procedures such as these have been removed from the exam. Anterior and posterior composite restorations have been added because they are most often performed by the new dentist. Therefore testing the competency in the most often performed tasks demonstrates the fairness of the exam.

Validity of the examination is important and requires the use of a patient. If one is successful then it can be said that the candidate is competent to treat a patient. If only a typodont mounted in a manikin is used for the exam and the candidate is successful then one can only say that the candidate is competent treating a lifeless typodont. Likewise if the exam requires the candidate only to identify items on a laboratory bench the examination cannot certify that this individual is competent to treat a patient. The reason is that the typodont or lab bench lack all the conditions and problems that a living breathing human being will present at the examination. Therefore use of a human being in the examination is valid because it certifies that the dentist is competent in treating a patient. In the future, if a manikin can be made to simulate all the conditions of a living, breathing human being and the state licensing boards accept the simulated manikin exercise then the testing agencies would be happy to develop criteria for such an exam. At present we will have to be content with using a patient in order to attest to the validity of the examination.

A reliable examination is efficient in determining who is minimally competent and who does not meet the level competency required to practice independently. The exam criteria are constantly studied and refined by a cadre of educators, dental examiners and psychometricians. The education community provides a vast amount of knowledge and support in the development of a valid exam.

A reliable examination requires that someone not possessing minimal competency will not be successful. It also requires that someone who does possess the minimal competency requirements pass the examination. The exam must consistently be able to discern the difference. The results should always be consistent. Incompetence should not succeed but competence will succeed.

In addition, to eliminate the variation in grading all examiners are required to be knowledgeable of the test criteria and procedures of the exam. Prior to every examination the examiners must pass a calibration examination based on the criteria and procedures in order to be permitted to grade the candidates' performance. Statistics are kept of all examiners and all must fall within an acceptable area near the standard of deviation. If outliers are discovered they are prohibited from grading until remediated.

Ethics in the licensure process also involves who (what entity or agency) is giving the licensure examination. It is important that an independent third party, one that is not affiliated with a dental school or any dental benevolent association or society, be involved in the licensure process. Dental schools have a conflict of interest administering a licensure examination because can be used as an evaluation of their educational outcomes. In like manner how could a benevolent association with its goal to provide benefits and services to dentists avoid the taint of the conflict of interest if it administers a licensure exam designed to protect the public? Who comes first, the public or the members? The independent state boards are the logical independent third parties that should give the examination. Therefore, if a dental school or a dental organization develops and administers a licensure exam how would it avoid the taint of the conflict of interest issue? Isn't that unethical?

In the past the candidate for licensure was required to successfully complete a number of restorative and periodontal exercises on a patient. Restorations included a posterior gold inlay and amalgam or a gold foil and an amalgam restoration or any combination thereof. The main problem for the candidate was obtaining a patient that required the necessary conditions in their mouth that corresponded to the requirements of the exam. As one can see this was conducive to ethical problems in pursuit of the appropriate lesion for the exam. The lesions required for the exercises were not necessarily in the best interest of the patient. This lead to the development of abuses and possibly the unethical criticisms were valid. Critics sited unethical practices such as warehousing patients lesions (delaying treatment) until the board exam, restoring teeth that had questionable decay, treating only the board lesion and ignoring the rest of the patient's oral health, trading patients, paying patients and paying unscrupulous people to provide patients for board lesions. The schools

also had their issues such as the patients that were used for the examination were not registered at the schools' clinic. This may have placed the schools in a libelous position by a candidate if an undesirable outcome developed as the result of the clinical examination. The testing agency addressed this issue by informing the candidate that he/she was unsuccessful and follow up treatment was necessary for the patient. Many times the proper follow up care fell to the dental school.

Today the ADEX exam is administered by the CDCA (commission on Dental Competency Assessments) and by CIRTA. It was CDCA that pioneered and administered the first patient centered ADEX examination. Pilot exams were administered at the SUNY Buffalo, School of Dentistry. The development took all ethical considerations concerning the treatment of the patients. The issues of patient procurement, the treatment of the patients, the overall oral health of the patient and the follow up treatment if the candidate was unsuccessful was addressed. I will explain how this is put into practice:

- The patient is registered at the dental school and has been diagnosed as to his/her condition and a treatment plan has been developed by the student and approved by the faculty.
- The lesion required must be part of his/her treatment plan which has also been approved by the faculty.
- The examiners review the lesion presented for the examination and will accept or reject it based on whether or not it meets the criteria of the exam. The faculty is calibrated [informed] of the criteria.
- The test criteria are spelled out in the candidate's manual which is available on the internet.
- The examination is anonymous. The patient's treatment is graded in a neutral area (examination station). All candidates are assigned numbers and names are not used. Graders do not come in contact with the candidates eliminating any subjectivity in the evaluations.
- The candidate will perform the necessary treatment and will be graded by the dental examiners in the evaluation station according to the published criteria. If the candidate is successful, the patient has received the necessary treatment for his/her oral health and the candidate has fulfilled the requirements for licensure.

- All treatment is graded independently by three examiners. This eliminates any influence one examiner can have on another. If two examiners agree then that will be the grade.
- The graders are randomly assigned by computer to evaluate a candidate's treatment eliminating the domination by any one examiner.
- The captain will review a case when the welfare of a patient is involved. Instructions are sent to the candidate and supervised by a clinic floor examiner when corrective action is required.
- If a candidate is unsuccessful with either the preparation or the restoration the patient is referred back to the candidate. The faculty personnel are present to instruct the candidate concerning corrective treatment. Almost always the issues are resolved at that time. The goal is to have the patient leave the clinic with a permanent restoration.

The results have been favorable with the educators. The school's faculty is happy with the exam because it solves the procurement of lesions issue and eliminates the problems associated with the treatment of unregistered and undiagnosed clinic patients. The treatment rendered is appropriate for the patient. There is less stress for the candidates because they are treating their own patients. Patients aren't warehoused. Almost all patients leave the clinic with a final restoration.

The patient centered examination is a giant step forward in the ethical board examination. The examination addresses the needs of the patient not the other way around. Unnecessary treatment is eliminated. Any follow up treatment is immediately addressed and resolved.

I have reviewed the procedures and protocol of the patient centered examination. It is my opinion that all ethical objections have been addressed without compromising the goals of the examination. This new format has been very well received by the dental community.

THE WAYS THAT DENTISTS DO THINGS HAVE CHANGED: WHAT ABOUT THE ETHICS OF DENTAL PRACTICE?

A COMMENTARY.

H. BARRY WALDMAN, D.D.S., M.P.H., PH.D.[1] AND STEVEN P. PERLMAN, D.D.S., M.SC.D., D.H.L.(HON.)[2]

Some history

Almost forty years ago, one of us (HBW) published the following commentary on the training of dentists in the late 1970s and early 1980s.

> "The selection process and the training of dentists emphasize a particular orientation of dental services which virtually eliminates a 'prevention attitude.' As long as emphasis is placed on the 'things' that dentists do, as long as the behavioral science and motivational psychology component of the curriculum is played down, there is little opportunity to change the dentist's attraction for, and the veneration of the fixed bridge and similar repair 'things.'"[3] (The Dental Orgasm – 1980) 1
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> "Picture for a moment the glow of exaltation as the dentist

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[1] SUNY Distinguished Teaching Professor, Department of General Dentistry, Stony Brook University.

[2] Global Clinical Director, Special Olympics, Special Smiles, Clinical Professor of Pediatric Dentistry, the Boston University Goldman School of Dental Medicine.

[3] Waldman H.B. and M.H. Schoen. "The dental orgasm." *Journal of Preventive Dentistry*, 1980; 6(October): 333-335.

deftly checks each of the margins of the eight or ten unit bridge with multiple abutments. The hours of planning, preparation, impressions, try-ins, and esthetic determinations are climaxed by a perfect fit and most important, the patient and practitioner are united in euphoria when the technical accomplishments are surpassed by the resultant esthetic transformation."[4]

By the 1990s, the era of "esthetic or cosmetic dentistry" was in vogue and full swing. For most patients, the glare of "golden oral appliances" was just unacceptable. Cosmetic dentistry was aimed at creating a positive change to the patient's teeth, general facial appearance and smile.

As the years passed, it became evident that the rate of edentulism was decreasing. No longer would our mother's be faced with the old adage of "the inevitable loss of a tooth for each pregnancy."

> "The inevitability of this (the loss of teeth) was recognized (before the establishment of the [British] National Health Service) and in many industrial towns of the North, people made the pragmatic decision not to put off the evil day, and so the extraction of all teeth and the fitting of dentures became a recognized twenty-first birthday, or wedding present."[5]

The technological advancements into the 21st century of bonding, porcelain, veneers, laminates and digital dentistry (e.g. CEREC® CAD/Cam Dentistry) and other devices that incorporate digital or computer-assisted components are in sharp contrast to that of mechanical or electrical items. The new technologies permit major advancement in the era of "picket-fence dentistry competition" (e.g.

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[4] Waldman H.B. and M.H. Schoen. "The dental orgasm." *Journal of Preventive Dentistry*, 1980; 6(October): 333-335.

[5] Smith, D. "Dental hygiene." *The New York Times*, September 5, 1978; Waldman, H.B. "Dentistry within the British National Health Service." *Journal of the American Dental Assocation*, 1979(9):439-447.

the replacement of missing single teeth with titanium implants – carried out by oral surgeons, periodontists, prosthodontists and general practitioners who have received training during their dental school years or completed continuing education courses). These developments have drawn increasing number of seniors seeking the services of dentists. In many dental practices, this increase counter balances the economic reality that the 18-64 population is reported to have the lowest usage pattern for all groups less than 65 years of age.[6]

Indeed, the veneration of the "roundhouse golden bridge" has been relegated to the "dust bin history of dentistry" and has been replaced by a list of **new things** (e.g. sleep apnea) that dentists do. Advances in technology have moved far beyond the time, more than 60 years ago, when one of us (HBW) first trained in dental school using pulley-driven hand pieces with burs that reached the unheard of speed of 7,500 rpm (which unfortunately could not cut through enamel).

But what of ethics?

Most often one speaks of ethics in terms of an individual's behavior. Ethics, however, also reflects upon a group's actions or moral performance in a range of evolving circumstances. A profession is defined as an occupation requiring long and specialized course of higher education, and one that is governed by a special code of ethics.[7] Professions serve the public good. A prerequisite for membership in the American Dental Association (ADA) is an individual's voluntary willingness to abide by the ADA Principles of Ethics and Code of Professional Conduct.[8] The code is a written expression of the

[6] National Center for Health Statistics. Health, United States, 2016: With Chartbook on Long-term Trends in Health. Hyattsville, MD. 2017. <https://www.cdc.gov/nchs/data/hus/hus16.pdf> Accessed 16 May 2018.
[7] Gurley, J.E. *The Evolution of Professional Ethics in Dentistry*. St. Louis: American College of Dentists, 1961.
[8] Advisory opinion to the ADA Principles of Ethics and Code of Professional Conduct. Council on Bylaws and Judicial Affairs. *Journal of the American Dental Association*, 1981:103:253.

obligations arising from the implied contract between the dental profession and society.[9]

Question: The profession has made significant strides in the development and use of **dental things**. In line with the Code of Professional Conduct, how is the profession responding to:

- The forecasted increasing numbers of dentists?

"We project the supply of dentists in the U.S. by modeling various sources of outflows from and inflows to the dentist workforce... Under what we consider to be the most probable scenario, the per capita supply of dentists in the United States is projected to increase through 2033. Total inflows to the dentist workforce are expected to exceed total outflows, and the net gain is expected to exceed the growth in the U.S. population." (emphasis added) (ADA Health Policy Institute Research Brief)[10]

- The need to expand the scope of dental practice to provide care beyond the traditional population that served as the bulwark of many dental practices; i.e. white middle and higher income populations?

The U.S. Census Bureau recently reported that between 2010 and 2016 there was a population increase (in rounded numbers) of:

Hispanics – 6,991,000
Asians – 3,742,000
Blacks – 3,561,000
Whites (alone) – 643,000

[9] Waldman H.B and Steven P. Perlman. "Lobbying for the oral health care of individuals with disabilities." *Journal of Dental Humanities*, 2018; 2(1,2):17-26.
[10] Munson B.A. and M Vujicic. "Supply of Dentists in the United States is Likely to Grow." ADA Health Policy Institute Research Brief: 2014. <http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_1.ashx> Accessed 18 May 2018.

In addition there were:

Hispanics – 5.3 million more births than deaths
Whites (alone) – 400,000 more deaths than births[11]

- The services required by individuals with special needs?

In the United States, there are 57 million, men, women and children with intellectual disabilities, physical and/or sensory impairment (including more than 38 million with severe disabilities.)[12] While many practitioners do provide care for individuals with disabilities, the challenge is for the dental profession to expand services beyond the traditional roster of patients.

The reality is that in the past, particularly limited dental and dental hygiene school training opportunities were provided to prepare students upon graduation to provide care to individuals with special needs. Despite the endorsement by the House of Delegate of the American Dental Association to support the establishment of needed training requirements for school accreditation, the Commission on Dental Accreditation (CODA) refused to accept our plea to modify its standards, citing costs, lack of experienced personnel, and other related issues. As a consequence, one of us (HBW), adopted a somewhat nefarious approach by informing one of our colleagues, who worked with CODA, of the fictional idea that a noted national columnist and television commentator (who has a son with Down syndrome) had heard of our efforts and refusal by CODA to modify standards. He was going to go public about this confrontation with a column in a national magazine. We can't be certain that this ploy was the catalyst, but

[11] U.S. Census Bureau. Estimates of the components of resident population change by race and Hispanic origin for the U.S.: April 1, 2010 to July 1, 2016. <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> Accessed 16 May 2018.
[12] Brault, M.W. Americans with Disabilities: 2010. Current Population Reports. P70-131. <https://www2.census.gov/library/publications/2012/demo/p70-131.pdf> Accessed 18 May 2018.

new standard requiring dental and dental hygiene schools to prepare students for the care of individuals with special needs.[13]

A further complication in providing needed care for individuals with special needs is the fact that there are virtually no continuing education courses or requirements that mandate such opportunities for current practitioners during their periodic licensure renewal.[14]

Yes, the ways in which dentists do things have changed. The need now is for the education and practice of the next generations of dentists to come to terms with the major increase in the number of practitioners, evolving demographics of our country and requirements of growing numbers of residents with special health care needs.

It seems to us that this is what the ADA Principles of Ethics and Code of Professional Conduct is all about!

[13] Waldman, H.B. "I'm a lair & proud of it. (Or, my introduction to reality)." *Exceptional Parent Magazine*, 2012;42(12):20-21.
[14] Waldman, H.B., A. Wong, K. Raposa, and Steven P. Perlman. "Preparing current Massachusetts dentists to provide care for individuals with disabilities." *Journal of the Massachusetts Dental Society*, 2017; 66(Summer):24-26.

BROKEN TOOTH

JACK COULEHAN, M.D., M.P.H.[1]

The first time the tip
of a lower incisor
cracked in a bowl of granola
I charged to my dentist
in panic, for previous
shadows of aging
had dimmed my body
less quickly, at the same pace
my eyes had blurred—

my paunch,
my puffy eyes, my vein-
sketched skin, the fungal
thickening of my nails,
wounds of time,
became a part of me.

The dentist, whirring
his instrument
with zeal and detachment,
capped the incisor
with a slather of plastic
that promised
to redeem it.

How simple, I thought—
for a week, until the rim
collapsed again
into a bowl of bran.

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