State and regional board examinations of dental students

Rating performance, ethics and professionalism

By Jonathan Shouhed, fourth-year dental student, Ostrow School of Dentistry, University of Southern California

Do dental students treat patients holistically and humanely during dental competency examinations? As student dentists progress through their education, clinical skills are learned and then challenged during competency and licensure exams to make certain that the student is prepared to practice dentistry independently.

State and regional board examiners detail the requirements and percentage value for caries preparation form, restoration anatomy and integrity and the maximum length of time allowed to complete any procedure (including periodontal, endodontic and operative treatment) in order to achieve a passing grade. Unfortunately, the emphasis on ethical and professional behavior during these exams is far less specific. Beauchamp and Childress (2001) agree that dentists fulfill the criteria of professionals because they are specially trained and licensed, and they are committed to the provision of important health care services to their patients. As Tartakow (2010, p. 96) reported “Certosimo cited five principles of ADA codes that included: non-malfeasance, beneficence, justice, veracity, and patient autonomy, [suggesting] that these were the obligations for all health-care providers to make available in order to address the needs of patients and the profession.”

As defined by Rule and Veatch (2004, p. 45-46), patient autonomy, or the “pa-

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Studying oral health in the United States vs. foreign countries

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Abstract

The aim of this study was to compare the oral health status of underserved individuals in the United States with underserved individuals in two other countries, Colombia and Kenya. Each year, dental students from the Ostrow School of Dentistry of University of Southern California (USC), Dental Humanitarian Outreach Program (DHOP) travel overseas to countries where residents with untreated dental problems have no access to dental care. The 2011 and 2012 locations visited were Cartagena, Colombia, and Nairobi, Kenya, both are considered third-world countries.

Inhabitants in these locations were compared to Los Angeles residents who also had untreated dental problems with no access to dental care. All patients at each of the three dental clinic locations were treatment planned by student dentists, obtaining approval for proceeding with dental care from USC dental school volunteer faculty.

Once formal and appropriate data were collected, specific dental needs were determined as low, moderate or severe. Dental treatment was limited to prophylaxis, restorative treatment and extractions. Final analysis of dental care from each of the three clinics showed that the individuals from both third-world communities as well as Los Angeles had varying degrees of dental needs. Regardless of whether patients treated lived in third-world countries or in the United States, their needs for dental care were emergent and crucial to bettering their general and oral health condition.

Introduction

The DHOP dental students travel overseas each year to countries where residents are underserved with respect to their dental needs. Dental treatment and procedures completed included (a) periodontal cleanings, (b) restorative dentistry, i.e., caries cleanout followed by amalgam or composite-
Teaching residents to act morally in the presence of risk

By Dennis J. Tartakow, DMD, MED, EdD, PhD, Editor in Chief

As Rushworth Kidder (2006) suggested, moral courage bridges talking ethically and performing ethically. Although Kidder’s book is meant for everyone, it is a must for physicians and dentists. Performing ethically is not always easy and is therefore important to be stressed during formal educational programs. Dental students must recognize that moral courage is frequently needed to address ethical issues in order to take action to do the right thing when questionable issues arise with patients that place the clinician in an uncomfortable position.

Health-care professionals often face complex ethical dilemmas in the workplace; some clinicians tackle ethical issues directly while others turn away. Regardless of whether a doctor is involved with private clinical practice, education, research, or administration, they are not immune to facing moral dilemmas or experiencing unethical behavior. Moral courage takes into account the principles of ethics and the courage to act accordingly. Courage is not the absence of fear; it is doing what’s right even in the presence of fear.

Educators and scholars have disputed the diverse meaning of moral courage over the centuries. Ancient Greek philosophers Plato and Aristotle repeatedly used this term in reference to character on the battlefield, discussing courage as a trait set aside for situations where individuals feared death. Aristotle specifically discussed moral courage in the context of being able to wage war while being mindful of the possibility of injury or death. To Aristotle, bravery was a virtue that enabled Greek soldiers to respond appropriately to the fear of the battle.

How a doctor responds to ethical dilemmas depends on his or her (a) previ- ous experiences with unethical behavior, (b) individual personality traits, (c) moral values, and (d) knowledge of social justice principles, for which moral courage is required. Moral courage is required to confront unethical behaviors. As a result of cost control procedures, inadequate staff levels, shortage of clinicians in some areas delivering patient care, merging of health-care organizations, and ineffective leadership, there is an increase of ethical dilemmas in the health-care milieu today and it directly affects all doctors.

The AAO’s Principles of Ethics and Professional Code of Conduct, Section VI, states, “Members may exercise discretion in selecting a patient into their practice, provided they shall not refuse to accept the patient because of the patient’s race, creed, color, sex, national origin, disability, HIV seropositive status or other legally recognized protected class.”

Although dental schools and hospital clinics often accept fee reimbursement from federal funding, most private practitioners do not. It is considered discriminatory for a dental school or hospital faculty to reject a patient based on a disability, even though a “contract” between the clinic and the patient at a screening evaluation might not yet have been established.

It would also be unwise to refuse a patient from your private practice if the reason is based on discrimination, including any of the reasons listed in the AAO’s Principles of Ethics and Professional Code of Conduct.

Even though there is no universally accepted Hippocratic oath for dentists, it should be stressed to our dental students that they must adhere to affirmations such as:

• I may not always do what’s right, but I will always try to do what’s right.
• It is sometimes hard to do the right thing and sometimes hard to know what the right thing is, but once you know what that is, do it!

A temperamental tolerance of courage over timidity is needed when facing risk management issues. The tenets of decision-making are related to ethics and social justice principles, which directly begs the clinician’s ability to serve the (a) individual, and (b) community needs (educational services, outreach programs, welfare agencies, public service, etc.), are risk management issues (Wal- zer, 1983). Such concerns are becoming increasingly more critical for the profession as well as society.

According to Wren (1993), “Since the function of leadership is to produce change, setting the direction of that change is fundamental to leadership.” Setting direction and planning are two separate activities—activities that co-occur with teaching and which directly relate to teaching our dental students how to ethically and morally cope with adversity and risk.

References

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‘Even though there is no universally accepted Hippocratic oath for dentists, it should be stressed to our dental students that they must adhere to affirmations...’

Image courtesy of Dr. Earl Broker.
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tient’s right to make decisions based on his or her best interest or values, principles or ide- als,” can only be upheld if “the health-care provider respects the patient’s rights to be adequately informed and acts ac- cordingly.” But the idea that the patient’s needs are the utmost concern, as the AMA (Rule and Veatch, 2004) urges an individual to act honestly and without concealment regardless of ben- efit promised or harm encountered. These principles of social justice create a unique environment of honesty and re- spect in which fair treatment of patients is contextualized.

During dental competency examina- tions such as state boards, circumstances arise that can jeopardize these principles of justice. Not only are honest experienc- es and witnessed accounts of misconduct during practical exams, it is clear that ethics violations occur when a student is not mindful of his or her responsibility as a professional.

For example, the WREB Candidate Guide outlines the assessment of point deductions if a student fails to finish the procedure in the allotted time, completion more than 15 minutes later garners a score of “0.” As a result, student doc- tors may use improper isolation, etch- ing time and instrumentation as ways to complete exams when time becomes limited. They may also ask patients to limit their treatment, or the treatment being received during the appointment, failing to follow proper protocol regard- ing informed consent in an effort to gain more “working time.” Under these cir- cumstances, standard care can occur.

This quandary, though, is not the only ethical gray-area on test day.

During the preparation and restaura- tion process, both patient and student assess students’ work and may lower a score for any technical errors found during these checkpoints. This risk of losing valua- ble points on the exam, in addition to the fear of forthright communication, which would directly result in error detection. For in-

stance, a student may be aware of a void in a composite restoration or an open margin on a provisional crown, but fail to recognize the inherent danger of an uncorrected margin. A restora- tion can be “corrected” by removing sound tooth structure or being “built-up” with adhesive resin. Continued use of errors leads to a situation where a risk as a student can instruct a patient to “tap lightly” when occlusion is being checked. These examples encompass the inherent conflict of interest involving the student’s desire to pass an exam and his or her obligatory honesty to the patient and the examination process it- self. Unfounded and endangering ethical boundary- lines that are vital to the concept of being a professional.

While these examples may present complex scenarios, the response should not be to eliminate time constraints dur- ing exams or the examination process as a whole. Instead, ethical virtue can be as- sured during exam day with proper planning and execution. For example, by explain- ing the risks and benefits of treatment to patients during a prior appointment, with the ability to describe the procedure, a patient’s true informed con- sent can be gained without pressure to do so during an exam. A patient’s rights to not place unreasonable re- strictions are unalienable. No amount of time saved or advantage gained by a student justifies the failure to deliver a patient these basic rights.

A student must show preparation and confidence in clinical skills during an exam but must not attempt a compe- titive edge by cheating. For which he or she is un- qualified. Proper case selection is vital to this concept. An example of this is the attempt of a potential graduate to com- plete a gold complete veneer crowns prep- aration on a second molar with no visual contact and a gingival overgrowth in the area for a test.

Independent of skill and experience, a satisfactory crown preparation, gingival reduction, final impression and provi- sional restoration fabrication would be an ambitious task for any dental stu- dent. This multiple-step treatment exam- ination and brings about the potential for (1) excessive patient discomfort, (2) poor treatment execution and (3) irreversible place pulp trauma. Had this patient’s treatment needs been assessed for clinical exam appropriateness with a faculty member prior to test day, the student may have been advised against performing a procedure that is not in the best interest of the patient. As involving procedural responsibility, there are also personal obligations of the student doc- tor to professional behavior that protect the value of society.

Above all other extrinsic factors, a stu- dent must value and protect his her integrity as a doctor. He or she should al- ways portray this decorum, that is, to pass exams based on merit and capability, not good fortune and concealment. The hon- esty with which doctors act engenders a trust between patient and physician, hon- esty that has not been corrupted by self- ishness and self-interest, the way Allan Bloom (1987) suggested modern honesty has, is central to this trust. Bloom’s ap- parent for a review of contemporary “hon- esty” during a time in which moral code is being eroded by knowledge of popular greed, is of particular importance to the medical field. A doctor’s commitment to selflessness displays profound strength of character, and makes him or her worth- while as a professional.


Western Regional Examination Board. (2012). Dental Exam Candidate Guide. Phoenix, Ariz.

About the author


Western Regional Examination Board. (2012). Dental Exam Candidate Guide. Phoenix, Ariz.

Results

Data analysis from each of the three den- tals showed that individuals in undervaried, third-world communities had varying degrees of dental needs, but generally greater than did U.S. citizens. Dental needs were determined by (a) limited power supply, (b) supply of water, (c) tooth extraction due to caries or infec- tion. Dental needs were determined by (a) limited power supply, (b) supply of water, (c) tooth extraction due to caries or infec- tion.

The severity of decay and restorability of teeth were also evaluated. Dental treat- ments were categorized to (a) scale and plan- ning, (b) restorative treatment, and (c) tooth extractions due to constraints such as time, financial resources and volume of patients. Need for dental care was measured by the following parameters:

Low: Prophylaxis treatment and no carious teeth

Moderate: Prophylaxis treatment and 1–3 carious teeth

High: Prophylaxis treatment, three or more carious teeth and/or one or more unrestorable teeth due to caries or infec- tion.

Discussion

Proportionally, more prophylaxes than restorative treatments were completed in Cartagena, suggesting that many pa- tients had previous dental treatment and/ or better oral hygiene. In Kenya, dental prophylaxis and restorative treatments were found to be equal, with patient records of previous dental treatment. The decreased numbers of patients treated in Kenya compared to Colombia were affect- ed by (a) lower access to care, (b) lower supply, (c) tooth extraction due to caries or infec- tion.