Part I

Ethics

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Ethics in Aesthetic Dentistry

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Principles

Ethics could be considered to be a moral code, giving a set of principles to guide behaviour. All of us who belong to the healing or caring professions are expected to look after our patients in their best interests, at all times. This is the obligation that society places on us, in return for the trust it places in our hands.

The doctor/patient relationship is underpinned by some fundamental principles, the first of these being 'beneficence' – that is, doing good and acting in the patient's best interests – and 'non-maleficence' – that is, doing no harm. This principle dates back to the Hippocratic oath, which also includes the exhortation *Primum est non nocere*, 'First and most importantly, do no harm'. This is further supported by a secondary principle of reserving more extreme measures to treat the more extreme conditions.

The two words 'aesthetic' and 'cosmetic' appear to be very commonly used in surgery and dentistry and are often interchangeable. 'Cosmetic' comes from the Greek word *cosmeticos* and generally implies temporary, superficial or reversible. 'Aesthetic' comes from the Greek word *aestheticos* and is concerned with the perception, the philosophy or the structure of beauty. With its deeper meaning, the term 'aesthetic' may appear to be favoured by the medical profession.

We live in an age where various cultural and social expectations associate beauty and appearance with attractiveness, youth, success and status.[1] Added to this, in the presence of a rapidly increasing amount of readily available information, the people who are seeking cosmetic procedures have rising demands and expectations. They may also see themselves more as consumers than as patients. Because aesthetic dentistry may be perceived as an issue to do with their 'wellness', they see it as their 'right' to have it done.

Procedures

As dentists we have a problem and an ethical dilemma when faced with patients requesting cosmetic treatments that are purely elective and optional, merely in order to enhance the smile or appearance. This is especially the case when it is in the absence of any disease or functional disability or deficiency. The fact is that many procedures may involve considerable and irreversible harm to the existing biological tissues. It has been shown[2] that up to 30% of sound hard tissue may be removed for a porcelain veneer

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preparation, and between 62% and 73% of sound tooth structure may be removed during preparation for full ceramic crowns in anterior teeth.

There are several questions to ask of ourselves. First, do have we the required competence to perform the procedure? Competence may be considered as the sum total of knowledge (which must be up to date in terms of materials, techniques and methods as well as being evidence based) and skills (which consist of appropriate training and adequate experience).

Secondly, in terms of treatment planning, are there any other, less invasive options that would achieve almost the same or a similar objective and could be considered instead? Is the plan based on what is safe and appropriate for this particular patient? What will work and last the longest? What will cause minimal problems in the future? How can these problems be dealt with if and when they arise? Is the whole procedure to be done with minimally invasive measures and methods?[3]

When a patient is demanding a certain type of treatment, consent is a complex issue. Has the patient the mental capacity and the maturity to absorb, comprehend, analyse and assess all the information we offer? Did the patient give their consent freely, without any subconscious or subtle coercion on our part? As professional people we then have to ask some pertinent questions of ourselves. Did I give all the relevant options and facts with regard to the risks/benefits and failure/success and potential harm, in step with current acceptable professional standards? Where do I stand if a patient who is a bruxist, for whom I know gold would be the most conservative and long-lasting suitable material with which to restore the posterior teeth, refuses it?

The reality is that dentistry is a business too for many of us. Therefore there are further questions to ask. Did I or any of my team do anything by any form of communication (including any advertising in all its forms) to embellish or promote my qualifications or ability to encourage uptake of the treatment plan offered? Am I comfortable that I have no financial conflict of interest in the advice I have given? Would I be able to justify it to my peers? Would I be able to defend it to my profession's regulatory body? Would I be willing to carry out the proposed treatment on any member of my own immediate family?

In parallel with our patients' increased dental knowledge, intelligence and expectations, we have moved in medicine from the age of paternalism to one of collaboration. So it behoves us to work in a spirit of cooperation with our patients to help guide them and enable them to reach a proper and suitable decision, while at the same time respecting their autonomy.

However, if after having presented all the information honestly and fully, the patient still insists on having inappropriate or harmful work carried out, which we as the dentist disagree with and are uncomfortable undertaking, then not only are we professionally entitled to refuse, we should also feel at liberty to do so. It should be remembered that just as their culture and social environment influence patients, dentists also have our personal judgement coloured by our upbringing and family background. This is of the utmost relevance when facing a professional dilemma, because attitudes and behaviour go beyond education and competence. Therefore, our level in possibly engaging with aesthetic work with any downsides must be judged on each individual case and particularly in the patient's best interests. This ultimately becomes a matter for our individual conscience, guided by our internal moral compass. This is vital, as we need to retain the proper respect and trust of those we look after and care for, to belong and remain part of a worthy and noble profession.

Tips

- Make sure you have covered all the treatment options, even those you may not consider within your area of expertise.
- Be prepared to refer the patient on if the option chosen is beyond your area of expertise or experience.
- Make sure to list the advantages and disadvantages of all the treatment options.
- It is good practice to have a consultation with your patient, follow it up with a written treatment plan and then allow the patient to have the opportunity to discuss that plan.
- It is good practice for the patient to be informed of all the likely costs not only of providing the treatment but also of any maintenance required over a period of time.

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