UNIVERSITY "Ss. CYRIL AND METHODIUS" – SKOPJE
FACULTY OF DENTISTRY - SKOPJE

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ETHICS IN DENTISTRY

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PREFACE

The system of moral values, their origin and functioning, interpersonal relations, relations among colleagues and employees, the criteria for establishing a code of conduct, the development of responsibility and ethical action, as well as the influence of moral norms on the formation of social relations, the relationship between the individual and society, and all issues arising from such relations—these and numerous other matters constitute the subject of ethics.

Ethics is most commonly linked to the standards governing a specific profession, occupation, institution, or social group. This concept is referred to as professional ethics and encompasses, inter alia, medical ethics, business ethics, ethics in dental practice, sports ethics, and related fields.

An individual entering the practice of a particular profession is required to comply with the standards applicable to that profession.

While everyday dental practice presents numerous challenges and ethical dilemmas that every doctor of dental medicine may encounter, the resolution of which must consistently be guided by ethical principles and respect for patients' rights.

The application of ethical norms in everyday dental practice is presented in the textbook *Ethics in Dentistry,* which consists of three chapters, accompanied by an introduction, annexes, and a selected bibliography. Each chapter is divided into several subchapters, ensuring greater clarity of the content and a well-structured systematic organization.

The first chapter (Basic Concepts) is divided into seven subchapters. It provides a concise yet precise overview of the most important concepts and theories in ethics. The prevailing views on the notions of ethics and morality are presented. This is followed

by a presentation of issues directly related to the history of medical ethics, as well as its relationship with bioethics. Subsequently, the dominant ethical theories are functionally explained. The preceding content culminates and finds its practical application in the subsequent subchapters, which address the fundamental issues of the deontology of healthcare professionals. These subchapters also examine the doctor–patient relationship.

The second part of the textbook is dedicated to professional ethics in dental medicine through a practical explanation of communication skills and principles applied in everyday clinical practice. Special attention is given to the specific characteristics of dental medicine, with particular emphasis on the code of conduct and ethical standards to be applied in dental practice. The benefits of these insights are intended for healthcare professionals. They provide clear and precise guidance on appropriate professional behavior toward patients, with the aim of fostering trust and enhancing personal integrity and professional reputation in the eyes of patients.

The third part of the textbook *Ethics in Dentistry* addresses ethics and dentistry, dentistry and society, and also focuses on patients' rights. Of particular importance and topical relevance is the ethics of scientific research conducted under laboratory conditions (so-called in vitro research) and research involving patients, i.e., in vivo research. In these types of research, it is especially critical to observe ethical norms and standards that every researcher must know, in order to ensure confidentiality and safeguard the personal integrity of the patient.

At the conclusion of this chapter, the ethical responsibilities of students and professors at dental faculties are presented.

Following the third part, *the Annexes* provide several codes and declarations on ethical conduct in medicine and dentistry, through which healthcare professionals can acquire guidance on the appropriate application of ethical norms in everyday practical work with patients.

The textbook *Ethics in Dentistry* is intended for students, dental nurses, dental technicians, and professionals throughout the healthcare system

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INTRODUCTION

Professional education in dentistry ensures the training of personnel who will practise dentistry on a professional basis and contribute to the advancement of oral health worldwide. In order to achieve this objective, students of dental medicine, professional dental assistants–oral hygienists, and professional dental technicians must acquire comprehensive theoretical knowledge in the field of dentistry, as well as highly developed manual skills.

However, the knowledge and skills acquired in clinical practice are not, in themselves, sufficient to guarantee the provision of high-quality dental healthcare. Additional expectations placed upon doctors of dental medicine are closely associated with the demands of contemporary society, namely the obligation to provide high-quality dental care that serves the best interests of patients.

Furthermore, the international ethical principles of the World Dental Federation (FDI) emphasize that dentists must practise in accordance with their acquired knowledge and technical and artistic skills, as well as with the principles of humanity, while safeguarding patients' oral health irrespective of their individual status, race, or ethnic origin.

More than 2,000 years ago, Hippocrates underscored the importance of ethics in the medical profession. Today, as oral health is recognized as an integral component of overall human health, the importance of ethics and the application of ethical principles in the dental profession become increasingly evident.

Care for oral health is guided by the same fundamental norms and values as general healthcare and should therefore be accorded equal importance.

Contemporary stressful living conditions, the struggle for survival, and modern technology on the one hand, and cultural tradition on the other, may give rise to various forms of intolerance and conflict among individuals. Such circumstances may also extend to dental practices and result in strained relationships among the doctor of dental medicine, their associates, and patients. Hence, there is a need for every student at faculties of dentistry to be educated in an ethical spirit, and for every doctor of dental medicine to remain aware of the obligation to engage in careful reflection and to make prudent, ethical decisions that serve the best interests of patients. Furthermore, they should demonstrate respect toward all individuals, provide patients with appropriate information, and involve them in decision-making concerning their oral health. Ultimately, through their professional conduct in diverse situations, the clinician must maintain patients' trust.

Ethics constitutes an integral component of dental practice, and the study of ethics equips students to identify ethical issues and to act in a rational and principled manner in their interactions with patients, society, colleagues, and collaborators, as well as in the conduct of scientific research in dentistry.

Chapter 1

BASIC CONCEPTS

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I

BASIC CONCEPTS

1. THE MEANING OF ETHICS AND MORALITY

All individuals, whether in everyday life or in professional practice, frequently encounter dilemmas regarding what ought to be done, what is necessary, what is ethically right or wrong, and how one should conduct oneself in specific situations. In many cases, insufficient attention is given to such dilemmas. Nevertheless, in these circumstances, individuals engage in personal assessment and, guided by their convictions, make determinations concerning their course of action. Consequently, the question arises as to whether such decisions are invariably "correct" or whether one has acted in an appropriate manner.

Reflection on these questions invariably gives rise to further dilemmas, as the decisions made may serve one's own interests, those of others, or may result in intentional or unintentional harm. This, in essence, is what differentiates one individual from another. It is impossible to ascertain in advance whether a particular decision will be the correct one or whether it will yield a specific "benefit." What must consistently be borne in mind, however, is that in every situation, conduct should be moral, that is, informed and guided by ethical principles.

The terms ethics and *morality* are frequently employed interchangeably, yet in everyday discourse their meanings diverge.

The term **ethics** is derived from the Greek word *ethos*, meaning character or conduct. This term is frequently associated with the word morality, which originates from the Latin word *mos* (moris), meaning custom or habit. What these terms share is that both pertain to moral obligations rather than to mandates imposed by law.

Morality is a concept used to differentiate actions, behaviors, and intentions as good or right versus bad or wrong. Morality represents a set of shared values that justify conduct when individuals interact with one another or encounter particular problems. The concept of morality is reflected in fundamental beliefs and views regarding what is right, encompassing honesty, ethical conduct, and truthfulness. Conversely, actions or intentions that are dishonest, false, or harmful are considered wrong.

Morality may be understood as a set of unwritten social norms on the basis of which individuals form their opinions and behaviors toward others within the social group to which they belong.

Moral norms may be described as having a dual binding nature:

- Social (external) – society imposes certain rules of conduct on its members, and specific sanctions follow in cases of non-compliance;
- Individual (internal) – each person experiences a moral obligation independently, without external influence.

Morality is usually associated with an individual's social, personal, and sexual behavior, whereas the term ethics primarily refers to professional conduct and the evaluation of such behavior.

As a discipline, **ethics** constitutes a philosophical doctrine concerning human behavior under specific socio-economic conditions. It elucidates the rationale for moral conduct and evaluation, as well as the assessment of certain accepted attitudes.

Philosophical reflection does not concentrate on what an individual ought to do or how they should behave in particular situations, but rather on how they actually behave.

Norms of conduct may be specific to certain professions, yet ethical principles remain universal. While legal rights are grounded in written law, ethical rights are founded upon principles and values.

For the medical and dental professions, ethics holds essential significance; without a robust ethical foundation in these health disciplines, one cannot truly be regarded as a professional.

2. HISTORY OF MEDICAL ETHICS

The earliest records regulating the work of physicians are found in the Code of Hammurabi in Babylon (2100 BCE), which contained provisions concerning fees for individual surgical procedures, as well as penalties in cases of unsuccessful treatment. Historical data from that period indicate that extremely severe punishments were imposed on physicians when treatment was unsuccessful. Penalties depended on whether the patient was a slave or a free person. For unsuccessful treatment of a slave, a monetary fine was imposed, whereas for a free person the physician was punished by amputation of the hand. In cases of loss of vision or death of the patient, the physician could even be sentenced to death.

Numerous scholars and thinkers have left their mark and contributed to the foundations of medical ethics.

Auroleus Philippus Theostratus Bombastus von Hohenheim, known as *PARACELSUS*, born in 1493 in Switzerland, made a significant contribution to medical science. He held physicians in high regard primarily for their competence and their love for people. According to him, these characteristics represented the strongest motivation and were essential for those professionally engaged in medicine. His view corresponds with the well-known saying attributed to Hippocrates:

“Only a good person can be a good physician,” or, “Where there is love for humanity, there is also love for the art of medicine.”

With the development of modern scientific medicine in the nineteenth century, the foundations of medical ethics were established on the basis of the ethical principles of the Hippocratic Oath.

Hippocrates (460–377 BCE) is regarded as a pioneer of the scientific approach in medical practice. He grounded his medical practice in careful observation of the human body and sought rational explanations for disease, rather than, as his contemporaries did, attributing illness to evil spirits or superstitions. Hippocrates was the first to emphasize that medical examination begins with the collection of information from the patient based on recollection (anamnesis).

As early as ancient Greece, physicians were required to take an oath prior to commencing their medical careers. This oath remains relevant today and is known as the Hippocratic Oath, preserved in the collected works attributed to Hippocrates. Physicians in many countries throughout the progressive world solemnly pledge to uphold its principles and values upon entering the medical profession.

The text of the Hippocratic Oath has been modernized, and in 1948 certain modifications were adopted in Geneva, rendering it obligatory worldwide. In response to numerous medical crimes and inhumane experiments conducted during the Second World War, the World Health Organization initiated the adoption of the Geneva Declaration in 1948, which was subsequently supplemented in 1968 and 1983. In this Declaration, medicine is defined not only as a natural science but also as a social science. For these reasons, medical ethics underwent significant development in the post-war period.

A landmark advancement in medical ethics, following centuries of neglect, occurred after the Second World War, when the Allied forces uncovered the horrific reality of sadistic experiments conducted on humans in German concentration camps. During the so-called “Doctors’ Trial”, twenty-four physicians from Nazi Germany were brought before the International Military Tribunal. They were charged with organizing and participating in war crimes and crimes against humanity through atrocious medical experiments on prisoners and civilians of various nationalities, carried out in concentration camps under the guise of “scientific research.” These crimes encompassed murder, brutality, cruelty, starvation, torture, and other inhumane acts. The extremely dangerous studies were conducted without the consent of participants. Subjects were treated as experimental guinea pigs, subjected to suffering, torture, and unimaginable mental and physical pain, often resulting in death. This starkly illustrates that the human toll exacted in the name of “scientific research” can reach terrifying proportions.

History records numerous instances in which physicians, guided by national obligation and utilitarian reasoning, forfeited their moral responsibility as both human beings and professionals. Nevertheless, it is incomprehensible how a physician could abandon personal integrity and professional identity in the service of an ideological cause. Blinded by career-driven motives, the

physician becomes incapable of properly evaluating the gravity of ill-considered decisions, the consequences of which are borne by the patient.

In such circumstances, it is particularly shocking that these physicians sought to justify their actions by claiming that they were conducting military-medical research. Such conduct constitutes a grave violation of the Hippocratic Oath, despite claims that the experiments were undertaken for the benefit of humanity and to acquire knowledge intended to save other human lives.

With the Nuremberg Trials, which marked the inception of modern international law, the necessity arose to identify within medical ethics an area that had previously received little attention. From that point onward, a distinction was established between the ethics of medical care and the ethics of medical experimentation involving human subjects. The Hippocratic Oath emphasizes the physician and their provision of medical care to the patient, establishing foundational ethical principles for the doctor–patient relationship; however, it does not address the conduct of experimentation on humans. The unprecedented crimes, human experimentation, and genocide perpetrated in Nazi Germany revealed one of the most specific and pressing issues in medical ethics—human experimentation—highlighting both the limitations of the Hippocratic Oath and its potential susceptibility to misuse.

In response to these atrocities, the Nuremberg Code was formulated in 1947 as one of the most significant documents in the history of medical ethics, alongside the Hippocratic Oath. This Code marked the beginning of a new era in biomedical research involving human participants and sparked extensive debate regarding the ethical treatment of research subjects. It is universally acknowledged that the primary duty of every physician is to safeguard human health, as mandated by the Geneva Declaration and the International Code of Medical Ethics of the World Medical Association, which require physicians to place the health of their patients *above all else and act in their best interest. Conversely, the principal objective of biomedical research involving humans is to advance preventive, diagnostic, and therapeutic interventions, as well as to enhance understanding of the etiology, pathogenesis, and effects of diseases. Such interventions inherently involve risk, as medical progress is ultimately predicated on research that necessarily includes studies with human participants. Consequently, the critical*

distinction between clinical practice and research was firmly established.

Despite these developments, unethical medical research involving human subjects persisted after the Second World War. In 1957, an experiment conducted in a New York hospital involved infecting children with disabilities with the hepatitis virus to study the course of the disease.

In 1966, a hospital in New Zealand conducted a study on women with carcinoma in situ of the cervix, observing the course of the disease without surgical treatment and without informing the participants that surgery was an available treatment option. In response to such practices, and in the interest of advancing scientific knowledge while simultaneously protecting human subjects, the World Medical Association adopted the *Declaration of Helsinki* at its 18th World Medical Assembly in 1964 in Helsinki, Finland. The Declaration of Helsinki constitutes a foundational document in the field of biomedical research ethics, exerting significant influence on international legislation and codes of conduct for research. It establishes ethical standards for scientific research in healthcare and recommends their integration into legislative frameworks and professional ethical-medical guidelines worldwide.

The Declaration of Helsinki addresses ethical considerations in biomedical research involving human participants and encompasses principles relating to:

- *the special protection of vulnerable research participants (including children, pregnant women and their fetuses, prisoners, terminally ill patients, and unconscious or mentally ill individuals), for whom informed consent is provided by a legally authorized representative;*

- *the use of results obtained from animal experiments;*

- *the preparation of an appropriate research protocol, including analysis, evaluation, commentary, and approval by an independent research ethics committee prior to study initiation;*

- *adequate research and ethical training of the physician-researcher leading the project;*

- *assignment of overall responsibility for the study to the physician-researcher;*

- *the necessity of careful prior risk assessment and comparison with potential benefits for participants and society;*

- *the obligation to terminate the study if risks outweigh potential benefits (as the welfare of research participants must never be subordinated to the interests of science or society);*

- *obtaining written informed consent incorporating all elements of the Nuremberg Code;*

- *maximal protection of participants' privacy and confidentiality of personal data;*

- *the obligation to publish research results regardless of outcome, with full disclosure of funding sources, participating institutions, collaborators, and any conflicts of interest.*

The Declaration emphasizes the distinction between healthcare from which the patient derives direct benefit and research from which the patient may or may not benefit directly. This distinction underpins ongoing debates regarding placebo-controlled trials, particularly in studies concerning HIV infection, malignancies, and other idiopathic diseases with unpredictable prognoses.

In principle, upon the completion of a study, participants should be informed of its outcomes and share in any resulting benefits.

Since 1964, several revisions of the Declaration of Helsinki have been adopted, the most recent at the 59th General Assembly of the World Medical Association in 2008 in Seoul. Moreover, numerous international organizations have issued ethical recommendations for clinical and biomedical research.

Following the public disclosure of the Tuskegee study in the United States (1932–1972), conducted by the U.S. Public Health Service, which observed the natural course of syphilis in 400 impoverished African American men from Alabama without informing them or providing appropriate treatment, the U.S. Congress formally adopted the principles of the Declaration of Helsinki into law in 1974. In 1979, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research published *the Belmont Report, establishing three fundamental ethical principles: respect for persons (autonomy, with informed consent as central), beneficence, and justice.* These principles underpin U.S.

federal regulations for the protection of human research subjects. The Tuskegee study represents a profound political and ethical failure, prompting President Clinton in 1997 to issue a public apology to the participants and their families.

International ethical guidelines and revisions of the Declaration of Helsinki aim to ensure the effective application of ethical principles in biomedical research involving human participants, particularly in developing countries, while taking into account local socio-economic conditions, legal frameworks, and participation in international and national research projects.

The emergence of new diseases, shifts in disease patterns, rapid advances in medicine and biotechnology, increasing financial influence of powerful pharmaceutical corporations, the HIV/AIDS pandemic of the 1980s, and the urgent need for extensive studies to develop vaccines and test treatments have generated new ethical questions and dilemmas.

All of these factors necessitate the adoption of new ethical guidelines or the revision of existing ones to clarify, address, and regulate emerging ethical challenges.

3. MEDICAL ETHICS AND BIOETHICS

Medical ethics constitutes a branch of applied ethics that prescribes standards of conduct for health professionals—a body of norms governing the relationship of healthcare professionals toward patients, colleagues, and society as a whole.

Medical ethics represents a system of moral principles pertaining to values and perspectives arising from medical practice.

Owing to the specific nature of the medical profession, medical ethics is of exceptional importance and provides guidance in addressing numerous questions and dilemmas encountered in everyday clinical practice. This field likewise encompasses mid-level healthcare personnel, social workers, psychologists, students in secondary medical schools, medical students, patients, their relatives, and members of the broader community.

Medical ethics fosters ethical awareness among health professionals and encourages principled reflection in resolving the many problems and dilemmas encountered in clinical practice.

Medicine concerns human health and life; therefore, the immense responsibility borne by physicians must always be borne in mind. At the same time, patients occupy a subordinate position, as they are, in a certain sense, dependent upon the physician or the team of healthcare professionals directly responsible for establishing the diagnosis, determining the prognosis, and prescribing therapy. The fact that medical practice concerns human health—sometimes compromised to the extent that the patient stands at the threshold between life and death—renders the physician's knowledge, experience, and competence exceptionally significant. Patients, as a rule, exhibit heightened sensitivity in their responses when their health is at stake.

All of the foregoing indicates that the ethical principles upon which medicine is founded are indispensable, as they guide the making of complex and difficult decisions concerning fundamental human rights.

Owing to the specific nature of the physician–patient relationship, the establishment of effective external control is inherently challenging, since possibility of abuse cannot be excluded.

What serves as a regulatory mechanism in such relationships is, in essence, the consistent application of ethical principles in order to safeguard the rights and interests not only of patients but also of the community as a whole.

Medical ethics fundamentally represents a set of principles and rules by which health professionals should be guided when making decisions—decisions that may, at times, conflict with particular ethical norms. Such circumstances give rise to ethical dilemmas that may be especially difficult to resolve.

One fundamental ethical obligation is the protection of the patient's interests and the preservation of medical confidentiality. However, the physician is also required to safeguard the interests of other patients and of society at large. In certain situations, the protection of a particular patient's interests may pose a risk to the health and lives of others—for example, when a physician seeks to protect the interests of a patient who is HIV-positive.

Until the twentieth century, comparatively little attention was devoted to the physician–patient relationship. However, as a consequence of rapid technological advances in medicine and the development of new therapeutic possibilities in recent decades, interest in medical ethics has increased, giving rise to numerous questions and moral dilemmas.

The purpose of these rules and principles is to ensure that users of health services have access to the highest attainable standards of prevention, treatment, and care—namely, to prevent potential abuses by physicians or other health professionals.

The same rules apply to health professionals engaged in scientific research. They are required to respect human life and autonomy. The standards governing research are comparable to those applied in everyday clinical practice and relate to principles or codes of conduct for health professionals, aimed at protecting patients from inappropriate actions by clinicians.

Medical ethics assists health professionals in identifying and resolving ethically relevant problems. It is closely related to bioethics; however, whereas medical ethics addresses issues arising from medical practice, bioethics constitutes a broader concept encompassing moral questions associated with the development of the biological sciences as a whole.

Bioethics (Greek *bios*—life, *ethos*—conduct) is an interdisciplinary field that examines human conduct in relation to life in its entirety, including the individual. It may be understood, in a certain sense, as an expanded form of medical ethics that elaborates upon topics drawn from various domains of contemporary life.

Bioethics encompasses reflection on topics related to:

- The origin and birth of human beings (assisted reproduction, contraception, sterilization);
- Genetics (the genome, cloning, stem cells);
- Issues concerning the human embryo (abortion, prenatal diagnosis, experimentation on embryos);
- Aging (euthanasia, palliative medicine, pain management);
- Death (suicide, capital punishment, self-defense in war, homicide);
- Relationships with the environment and animal rights.

Bioethics may be defined as a multi perspective field of inquiry in which the moral and broader civilizational dimensions of life are examined.

Potter (1971) sought for a considerable period to identify an appropriate term that would express the need to balance the scientific orientation of medicine with fundamental human values. According to this author, bioethics constitutes a discipline that integrates scientific knowledge with an understanding of human norms and value systems—that is, a *science concerned with the ethical dimensions of medicine and the biological sciences.*

4. ETHICAL THEORIES AND THEIR APPLICATION

How to live a moral life, and how the term "moral" may best be defined, constitutes one of the fundamental questions of general ethics and philosophy.

Moral philosophers (ethicists) have formulated numerous theories intended to assist individuals in making the most appropriate moral—that is, ethical—decisions.

Aristotle's *approach to ethics is grounded in practical reasoning and in the existence of virtue, and it generally does not separate moral reasoning from other forms of practical deliberation.* Ethical philosophy represents an attempt to provide a rational answer to the question of how human beings should live in the best possible manner. Aristotle follows Socrates and Plato, who regarded virtue as the essential characteristic of "living well." Like Plato, he values the ethical virtues (justice, courage, temperance, etc.) as complex rational, emotional, and social capacities. To live well, one must be educated and develop the habit of responding appropriately in diverse situations, guided by the best logical reasons for a suitable course of action.

Aristotle emphasizes the importance of cultivating an excellent character (virtue) as the true path toward attaining what is ultimately most significant. Aristotle further stresses that virtue must be practiced, not merely understood—that is, it is insufficient simply to know that one ought to act well. Despite the central importance of practical decision-making, the final conclusion in the original responses of Aristotle and Socrates to the question "How should one live as the best human being?" is that one should live "philosophically."

The Kantian approach *is based on the existence of duties—that is, obligations—and their fulfillment,* and it is most commonly associated with formal ethical reasoning. The ethics of the German philosopher Immanuel Kant belong to deontological ethics, which is founded on the view that the moral fulfillment of duties is possible primarily through the possession of a good will, and that an action can be considered morally good only if it is grounded in principles and duties in accordance with moral law.

4.1. VIRTUE ETHICS

The origins of virtue ethics can be traced back to Aristotle and his work *Nicomachean Ethics.* He maintains that a person of excellent character performs the right actions, at the appropriate time, and in the proper manner.

Advocates of virtue ethics, in addition to conduct, emphasize the significance of personal character. The term *virtue* denotes a positive quality in individuals, particularly in relation to their character. Certain virtues are especially relevant when comparing individuals - for example, dentists and other professionals.

Virtue ethics constitutes a branch of normative ethics that seeks to identify and classify what may be regarded as moral character and to apply such character as the foundation for personal conduct.

The general premise of this theory is that individuals should concentrate on the development of their character, irrespective of legal regulations.

Virtue ethics is one of three principal perspectives within the *Normative ethics* that focus on character rather than on the nature of actions themselves or their consequences. This perspective stands in contrast to *deontology,* which emphasizes duties and the rules that ought to guide conduct, and to *consequentialism,* which assigns primary importance to the outcomes of actions. The differences among these three perspectives relate more to their approaches to moral dilemmas than to the derivation of specific moral conclusions. For example, a consequentialist argues that lying is wrong because of its negative consequences, although it may sometimes be justified (a “white lie”). A deontologist maintains that lying is always wrong, regardless of any potential benefit that may result. The virtue ethicist focuses less on the act of lying itself and more on character and moral disposition. Accordingly, the morality of lying depends on the particular circumstances and factors such as personal benefit, collective benefit, and similar considerations.

Virtue ethics holds that only morally good individuals are capable of making sound moral decisions. Therefore, the most effective way for a person to adhere to moral values—and simultaneously remain moral—is to strive for continuous self-improvement. Virtue ethics encompasses a set of qualities that an individual

should cultivate in order to be regarded as moral. These qualities are considered universal and are valued across many cultures: wisdom, loyalty, honesty, patience, courage, generosity, justice, and prudence.

Virtue ethics maintains that if a person endeavors to cultivate the values included in this list, they will be able, at all times, to make ethical decisions and to be recognized as a moral individual.

4.2. UTILITARIAN THEORY

Utilitarian theory was first popularized in the nineteenth century.According to this approach, *the most appropriate way to reach a moral decision is to assess the potential risks and consequences of each available option and to choose the one that produces the greatest happiness and the least suffering—namely, the greatest good for the greatest number of people.*

The term *utilitarian* derives from the French word *utilitaire ("useful"),* referring to practical application; therefore, utilitarian ethical theory is also known as the ethics of utility.

One of the most prominent representatives of this theory is the English philosopher Jeremy Bentham (1748–1832).

Utilitarianism is regarded as a clear and logically structured theory, maintaining that right and wrong that is, the good and the bad, can be evaluated through a systematic analysis of potential risks and benefits. Before selecting a course of action, all positive and negative aspects must be carefully considered, and the option that yields the most favorable overall outcome should be chosen. Supporters of this theory argue that what produces the greatest overall benefit is right, whereas what produces the greatest harm is wrong. Classical utilitarians consider happiness to be intrinsically good and suffering to be intrinsically bad; accordingly, "an action is deemed good if it produces more beneficial consequences than any alternative."

It is important to distinguish between correct actions and correct moral decisions. If we wish to determine, according to this theory, whether something is morally right—that is, ethical—we must first ask whether it leads to greater good and less harm than alternative solutions. If the answer is affirmative, then it is considered a morally acceptable solution.

An example often used to illustrate utilitarian reasoning is the following:*A wealthy man loses a wallet containing money, which is found by a poor man who struggles with alcoholism. He deliberates whether to keep the wallet or return it. If he keeps it, he will experience pleasure from gaining the money but also discomfort due to guilt. His pleasure may be substantial and long-lasting, enabling him to purchase necessities or desired items, whereas the wealthy man's loss may cause comparatively minor and short-lived distress.*

Conversely, if he returns the wallet, the wealthy man's satisfaction may be relatively small in comparison to the poor man's disappointment. According to strict utilitarian reasoning, keeping the wallet might therefore not be considered immoral, since it appears to generate more pleasure than pain.

Criticism of utilitarianism: this theory tells us to do what is best for most people, but this may cause disregard for others. For example, is it ethical to sacrifice one person in order to save five others by transplanting that person's organs?

From a purely utilitarian standpoint, the action could be justified because it maximizes overall benefit and minimizes harm only to one person, which is the right thing to do.

However, contemporary ethical thought generally affirms that certain actions remain wrong regardless of how many people support or benefit from them. As William Penn stated: "What is wrong is wrong even if everyone does it. What is right is right even if no one does it."

In medicine, the utilitarian approach has traditionally influenced clinical reasoning; however, it is often criticized for insufficient respect for patient autonomy. It may encourage paternalism within the physician–patient relationship, emphasizing the physician's responsibility to determine what is best.

Although numerous ethical theories exist, most analyses identify five ***principal theories that are particularly relevant to the dental profession***. Each of these provides a framework of principles, guidelines, and standards intended to define and guide ethical conduct in professional practice. These include deontological theory, teleological theory, motivational theory, natural law theory, and transcultural theory.

4.3. DEONTOLOGICAL THEORY

This theory incorporates one of the fundamental ethical principles found in virtually every religion, commonly referred to as the "Golden Rule," or the ethics of reciprocity: "Do unto others what you would have others do unto you." In deontological ethics, an ethical decision is not merely a question of morality, but above all a matter of duty and justice, which are regarded as core moral principles in decision-making. Every individual practicing as a dentist has accepted an obligation to fulfill professional duties. An example of the application of deontological theory in dentistry may arise in an ethical dilemma where a dental procedure that is clinically ideal for a patient could potentially result in unfavorable consequences. Deontological theory maintains that, in analyzing ethical dilemmas related to treatment, the dentist must adhere to established obligations and duties. In doing so, the dentist fulfills responsibilities toward both the patient and society, while acting in accordance with ethical principles.

The most prominent representative of deontological theory is undoubtedly the philosopher Immanuel Kant.

4.4. TELEOLOGICAL THEORY

Teleological theory derives from the term *teleology* (Greek *teleos*—goal, *logos*—study). According to idealist philosophy, everything in nature is predetermined, and every process of development fulfills goals that have been established in advance. Teleological theory, often referred to as the "ethics of consequences," is understood as an outcome-based theory. Within this framework, motivation is not regarded as the basis of ethical conduct; rather, the determining criterion of whether conduct is good or bad lies in its final result. If an action produces a satisfactory outcome, it is considered ethical. In essence, individuals are not guided by fixed external standards, codes of conduct, laws, or traditions; instead, decision-making depends on what is considered, at a given moment, to be the most beneficial option for all parties involved. In dentistry, this theory relates to what either the dentist or the patient believes to be the most appropriate treatment in order to achieve the desired outcome. If consensus between the two parties cannot be reached, an alternative ethical approach becomes necessary in determining the course of treatment.

4.5. MOTIVATIONAL THEORY

Motivational theory is based on the attempt to uncover motives of which individuals may not be consciously aware. This theory is not guided by absolute values, but rather by underlying initiatives or motives. It asserts that the motive for undertaking a particular action should serve as the basis for determining whether that action is ethical, and when it is not.

According to motivational theory, the intention underlying specific conduct constitutes the primary criterion for assessing its ethical nature. It is generally accepted that motives do not necessarily have to be ethical for the resulting behavior to prove beneficial to the patient.

4.6. NATURAL LAW THEORY

Natural law theory, regarded as a robust ethical framework, holds that the moral standards governing human conduct are largely derived from the nature of living beings. As a method of ethical decision-making, individuals act ethically if they behave in accordance with the ultimate purpose of human nature and the overarching goals of humanity. In this respect, natural law theory is closely aligned with deontological theory. The key distinction is that natural law theory emphasizes the final outcome of actions, whereas deontological theory emphasizes reciprocity and adheres to more generalized principles. Ethical decision-making is understood to depend on the individual's character, intellect, moral sensibility, and spiritual orientation, which guide the dentist in applying natural law principles when making ethical judgments.

4.7. TRANSCULTURAL ETHICAL THEORY

In contemporary society, given the diversity of ethical values, it is essential to incorporate cultural factors into the process of resolving ethical dilemmas. The principal advantage of the transcultural ethical framework is that it extends beyond the scope of other ethical theories, taking into account variations in ethical decision-making in dentistry across different cultural contexts.

Nonetheless, it is important to recognize that ethical theories remain theoretical constructs and do not provide absolute solutions for every ethical dilemma a dentist may encounter in

clinical practice. Ethical theories offer a structured framework for decision-making in situations where critical information is obtained from a patient requiring dental care. In practical application, most dentists integrate a combination of theoretical ethical principles tailored to the patient's specific circumstances and needs.

5. DEONTOLOGY OF HEALTH PROFESSIONALS

Deontology derives from the Greek words *deon* (duty) and *logos* (study). The term was first employed by the English philosopher *Jeremy Bentham* (1834) and denotes the systematic study of duties.

Medical deontology is the discipline that examines and defines the professional duties of health professionals, their moral conduct, and the ethical reasoning that guides their performance in medical practice.

By its definition, deontology largely coincides with medical ethics; nevertheless, medical deontology encompasses a broader scope. Deontology is understood *as the science of rights, obligations, and duties.*

When the term medical—or dental—is applied, the concept is narrowed to the doctrine of professional ethics for physicians, including doctors of dental medicine, specifically addressing ethical conduct in all procedures related to patients and health personnel.

Dental deontology represents a system of ethical norms establishing mutual obligations between the dental profession and society, aimed at improving population oral health. It is founded upon professional conduct in patient care, safeguarding the personal integrity of patients, and upholding the integrity of every dental professional.

In addition to ethical principles, medical deontology encompasses positive legal (statutory) provisions regulating practice in medicine. Accordingly, medical deontology covers both the moral and legal duties of health professionals, with noncompliance potentially resulting in moral and/or legal accountability. This underscores the critical importance of medical deontology for the profession as a whole and for individual health professionals.

Some authors assert that medical deontology rests on two pillars: medical ethics, on the one hand, and legal regulations governing activities aimed at protecting and promoting health,

on the other.

Other scholars contend that medical deontology comprises three areas:

- Medical law—jurisprudence;
- Rules of conduct—medical ethics;
- Guidelines for the study of medicine—medical hodegetics.

The duties of health professionals toward society are defined by the Law on Health Care, whose articles may be supplemented and amended. Such laws are enacted for the benefit of citizens, primarily to protect their rights and interests. Ethics plays a significant role in shaping these laws and influences their interpretation in specific circumstances. Conversely, legal provisions related to medicine appear across almost every branch of law: criminal, civil, obligations law, administrative, international, and others.

In everyday clinical practice, physicians encounter situations where decisions may lie at the boundary of legal provisions or ethical standards, that is, be unethical. Consequently, medicine includes rules delineating what a physician may and may not do—that is, what is permitted and what is prohibited.

Ethical and legal norms are closely related, yet they remain distinct. Legal solutions aim to reflect ethical principles, but they cannot fully enforce them; thus, ethical norms are frequently more stringent than legal requirements.

The period of "transition," characterized by the rationalization of health services, fostered a form of medicine focused on self-protection and limitation of liability through the performance of numerous often unnecessary examinations and tests.

Under such conditions, inappropriate practices may occur, increasing the likelihood of errors in clinical work. This contributes to a rise in both justified and unjustified lawsuits related to medical errors. For these reasons, medical law and medical ethics warrant particular attention.

6. ETHICAL PRINCIPLES

In everyday clinical practice, physicians encounter a large number of patients, each of whom should be treated as a distinct individual in order to determine the needs and demands related to their general and/or oral health.

The fundamental ethical principles that complement the professional attributes of the doctor of dental medicine are: patient autonomy, nonmaleficence, beneficence and professional integrity, and justice.

Patient autonomy

Patient autonomy denotes the patient's right to decide on the treatment they should receive. In contemporary practice, the patient makes the final decision, in contrast to the past when the clinician held exclusive authority. The patient decides independently, but only after receiving all necessary explanations regarding available treatment options and their expected outcomes, as provided by the treating clinician. The patient should be informed about their oral health status, the course of the proposed intervention, and their entitlements to health insurance within the scope of dental care. Considering all circumstances, the clinician should offer the optimal solution to the patient's problem, while the patient retains the right to accept or refuse a particular intervention. This right may only be limited when justified by the patient's health condition or if the patient is a minor.

All of this indicates a mutual relationship—*an equal partnership* between dentist and patient in the decision-making process. In this way, respect is achieved between the two parties, each of whom has value. *A partnership of equals essentially represents the contemporary ethical perspective on the professional–patient relationship.*

Historically, the clinician alone made decisions and applied what they believed was best, even though the patient was not informed about certain procedures. Such treatment, in a sense, discredited the patient as a person. In these cases, it involved so-called *paternalistic physicians,* characterized by making decisions on behalf of others based on their own experience. Decisions

made in this manner were not always acceptable to patients and, under certain circumstances, could even be harmful.

Nonmaleficence (primum non nocere)

This principle emphasizes that the doctor of dental medicine must avoid causing unnecessary harm through treatment. In clinical practice, a clinician may encounter situations that exceed their experience or competence, particularly early in their career. In such cases, it is preferable to seek guidance from more experienced colleagues or specialists rather than risk harming the patient. For patients with chronic conditions under specific therapy, consultation with the managing specialist—most informed about the patient's general health—is required prior to any dental intervention. Written confirmation from the specialist may be necessary to verify that the patient's condition permits a particular procedure (e.g., tooth extraction, apicoectomy).

Pain during dental intervention may also constitute "harm," although it may indicate that the desired outcome is being achieved. Acceptable pain levels should be determined by the patient, in accordance with their tolerance. Dentists must recognize the limits of their competence and ensure that procedures are conducted without causing avoidable harm.

Exposure to potentially infectious material obliges the dentist to inform the patient and refer them to appropriate professional care. Similarly, dentists must refrain from treating patients when they themselves carry transmissible diseases that could pose a risk.

This ethical principle also includes the dentist's ethical obligation to avoid personal relationships with patients, as such relationships may lead to decisions influenced by emotional reasons rather than the most professionally beneficial choice, thereby undermining the patient's trust.

Beneficence and professional integrity

This principle represents professional honesty and benevolence. Professionalism is grounded in ethical principles and encompasses the conduct, goals, and qualities characterizing the profession. Central to dentistry is promoting the patient's well-being, which requires effective teamwork among the dentist, dental assistant, and dental technician, founded upon mutual respect and trust.

Quality dental care demands professionalism, including adherence to institutional hierarchy, respect for colleagues, and compliance with standards of care for specific oral diseases. Within any health institution, whether private or public, hierarchical order must be respected.

Justice

Dentists bear the responsibility of acting justly in communication with patients, colleagues, and society. This principle includes promoting equitable access to dental care for all citizens. Social norms may evolve, and the dentist must remain attuned to such changes to ensure ethical compliance.

This also applies to discrimination when referring a patient to another colleague or specialist. The dentist should provide care or offer an opinion without negative comments about previous treatments or opinions. When called upon to provide a professional opinion or serve as an expert witness, it is essential to provide a professional, not personal opinion.

The contemporary approach to dental care encompasses five modern ethical principles:

- Providing dental services that are in the best interest of the patient, ensuring the patient recognizes the clinician's selfless intent to assist using all knowledge and technical capabilities;

- Employing evidence-based dentistry, ensuring that interventions for specific oral diseases are scientifically validated;

- Providing patients with accurate information about the state of their oral health, the course of the intervention, expected results and potential complications, as well as all possible solutions in planning prosthetic therapy—always fairly and with the sole intention of helping the patient, without being guided by personal interest or gain;

- Respecting the wishes and suggestions of the patient and enabling the patient's active participation in decision-making about treatment; the patient is at the center of attention, and final decisions must be joint, based on a partnership between dentist and patient;

- Ensuring high-quality teamwork founded on mutual understanding and trust.

The application of these principles in everyday practice—where the patient is central—upholds the dignity of the dental profession and protects the professional. Concurrently, such practice aligns with the spirit of the Hippocratic Oath, reflecting the ethical commitment inherent in the profession.

7. PHYSICIAN–PATIENT RELATIONSHIP

According to contemporary understandings of medical clinical practice, the role of the patient and their active participation in decision-making concerning health is increasingly emphasized—from establishing an accurate diagnosis to determining appropriate therapy. Proper conduct is essential for both parties. Mutual respect and trust significantly influence diagnostic accuracy and the patient's comprehension of their condition. When this relationship is inadequate, the physician's ability to assess the disease is compromised, and the patient may distrust the physician's recommendations. Under such circumstances, patients often seek a second opinion or consultation with another physician.

From the perspective of treatment efficacy, the physician–patient relationship may appear to have a minor influence; however, it exerts a highly significant impact on the outcome of care.

The physician–patient relationship is among the essential factors and key conditions for delivering high-quality health care, particularly due to the patient's inherently personal and vulnerable starting position. This subordinate position underscores the necessity for the physician to exercise mindful conduct—not adopting dominance but fully respecting the patient as a person. Hence the maxim: "the patient is always right."

Patients should feel privileged to be understood and to encounter a clinician who approaches them with empathy and a genuine desire to help. This reflects the humanistic aspect of the dental profession, where the imperative to assist the patient is central.

However, if this approach is imposed superficially that is, if the clinician lacks genuine commitment, the patient may experience feelings of rejection and even additional resentment.

7.1. ESSENTIAL ELEMENTS IN THE PHYSICIAN–PATIENT RELATIONSHIP

In the physician–patient relationship, several key elements are important and should be integral to their interaction:

- **being informed**;
- **confidentiality**;
- **truthfulness**.

Being informed

Today, under conditions in which patients actively participate in their care and autonomy is one of the four basic ethical principles, being informed, both for the patient and for the physician, is undoubtedly of great importance. From the moment the patient presents to the physician they have chosen to help resolve a health problem, it is necessary to establish appropriate communication at the very first contact. Through communication, the patient will openly inform the physician about problems related to their illness, and on that basis, the physician will later communicate their observations, reasoning, and possible solutions.

In the process of informing, honesty is crucial and replaces the paternalistic approach in which, in the past, physicians told patients very little, or nothing, about their diagnosis, especially when the patient had cancer or was in a terminal stage of disease. Physicians made all treatment decisions without involving or informing the patient.

Physicians' opinions are often communicated without difficulty, but problems may arise when a diagnosis must be communicated that does not always have a favorable prognosis. In such cases, a series of dilemmas arises: "How much, what, and whether anything should be said to the patient? Should the patient be informed that they have a serious illness?" The answers cannot be generalized and differ across societies, primarily due to differences in tradition and culture.

Nevertheless, the patient should be encouraged to seek and receive information about their health or illness and its treatment. Only with appropriate information and inclusion in decision-making do patients simultaneously assume greater responsibility.

If the illness is severe, the physician should inform the patient's family about the disease that is, consult with them regarding when and how it is most appropriate to communicate the truth.

Confidentiality

Confidentiality is one of the fundamental duties in medical practice. Providers of health care have a duty to safeguard information they possess about patients' health or illnesses.

By establishing a climate of trust while respecting the patient's privacy, the physician will be able to obtain and convey sensitive information, which is of great importance for treatment outcomes. In situations in which patients may be stigmatized or judged because of their condition, such as certain psychiatric conditions, sexual problems, reproductive problems, and others, ensuring confidentiality is crucial for obtaining an accurate picture of the patient's health status. However, the question arises: must the physician always keep secret the health problem the patient has? What if the patient is HIV-positive? Is it ethical not to tell the truth to the patient's partner or family? What if pregnancy is diagnosed in a minor? Should abuse of a child—psychological, physical, sexual, or through neglect—remain undisclosed? Should a young woman not be warned that her boyfriend has a psychiatric illness and might one day kill her?

The question thus becomes: "Is it ethical in all these cases to keep the information confidential?" *Breaching confidentiality is justified only when the purpose is to protect someone else.*

In most countries, standards exist regarding confidentiality related to adolescents' health. These standards state that certain conditions may not be treated without a parent's presence and permission, such as pregnancy, sexually transmitted infections, mental health, or substance misuse.

In other situations, when the patient is not a minor and there is no threat of spreading a disease, disclosure of information about the patient's illness to the family is also a matter for discussion. If the patient does not grant the physician permission to share the patient's health status with the family, it is not ethical for the physician to do so, except when family members are at direct risk due to the patient's diagnosis.

Confidentiality is a very important component in building the physician–patient relationship. Health care, that is, obtaining anamnestic information that is often quite intimate, and examining someone's body to establish the best possible diagnosis and therapy, by its nature involves intrusion into the patient's privacy. For these reasons, the use of information is possible only with the patient's permission.

The right to privacy is one of the fundamental guaranteed human rights and is regulated by the European Convention on Human Rights.

Electronic medical records (medical history, test findings, diagnosis, therapy, etc.) are also subject to confidentiality and must not be shared without the patient's permission.

Truthfulness

Ethics is a state of mind, and ethical sensitivity is directly related to honesty and truthfulness.

The ethical duty of honesty toward patients is based on three arguments. First, honesty is grounded in respect for others. Second, it is closely linked to fidelity and promise-keeping: in contact with patients, the physician implicitly promises not to deceive them. Finally, the physician–patient relationship is founded on truthfulness.

Although the physician–patient relationship represents a kind of partnership, it is highly specific, above all because the patient is in need of help, which makes the relationship unequal and the patient vulnerable.

Disclosing the truth to the patient is debatable in situations where a diagnosis must be communicated, especially when a severe illness has been diagnosed. In the past, in most countries, the truth was not communicated in such cases. In contemporary medical practice, however, this is one of the ethical–deontological dilemmas. One-sided acceptance of either view has both positive and negative aspects. According to the principles of jurists and moralists, "not telling the truth" is unacceptable, even if for noble purposes. Many physicians share this view, believing that withholding the truth about the patient's illness lacks moral justification and that the patient has a moral right to know the truth about their illness. The patient is a person with individuality and is self-aware regarding health, illness, and death. This applies especially

to the contemporary, medically well-informed patient, who more often wishes to know the truth in order to participate actively in treatment, sometimes seeking alternative medical solutions.

It may be said that judicial practice also supports the view that the patient should be told the truth, yet the physician must decide whether to do so. It is ethical not to lie; however, if it is in the patient's interest, this moral rule may be broken - especially if the physician believes that concealing the truth about the illness will psychologically contribute to coping with it. In everyday clinical practice, physicians often face situations in which legal, ethical, and deontological principles provide little concrete guidance. Thus, the decision whether to tell the truth to the patient is left to the physician's discretion, tact, and conscience.

The duty to tell patients the complete truth is not absolute; a physician is not obliged to disclose the entire truth. In clinical cases where the patient is in the terminal phase of disease, while respecting patient autonomy, the physician does not have to disclose a fatal diagnosis immediately. There are also situations in which one does not lie but does not state the truth if the patient does not insist.

The process of sharing bad news depends on the individual relationship between physician and patient and on the patient's personal views regarding the health problem. Ultimately, each physician determines how to act and what position to adopt with respect to this ethical duty.

In the Geneva Declaration, as a modernized version of the Hippocratic Oath, it is stated: "The health of my patient will be my first consideration." The document also states: "My colleagues will be my brothers." Although the primary duty of physicians is toward patients rather than colleagues, relationships with colleagues and other medical personnel can indirectly have a significant impact on the physician–patient relationship.

In clinical practice, cases occur in which physicians protect one another after a professional error, whether the colleague is from the same institution or another, which is certainly not in the patient's interest.

However, today there are also increasingly frequent cases in which colleagues speak against one another, adopting a critical stance regarding the competence of their peers. Such situations create even greater confusion and insecurity among patients,

which may significantly affect trust and the physician–patient relationship.

We must always bear in mind that gossiping against colleagues as persons or against their professional competence is profoundly unethical and uncollegial and may have negative consequences for patients' health. In addition, in everyday clinical practice, conflicting opinions from different specialists, within the same or different specialties, may be encountered, which can adversely affect the patient's health.

On the basis of the above, it may be stated that *collegial relations indirectly influence the physician–patient relationship.*

Relationships among health professionals must be based on mutual respect, support, and sincere, constructive criticism.

7.2. BIOETHICAL MODELS OF THE PHYSICIAN–PATIENT RELATIONSHIP

The patient is more than a collection of symptoms or diseased organs; rather a living being who suffers and seeks help, necessitating a unique physician–patient relationship.

The historical framework of the physician–patient relationship was delineated by Thomas Szasz and Marc Hollender in 1956. They posited that this relationship is contingent upon two principal variables: the medical condition and the social climate. The term "medical condition" denotes the capacities of both the patient and the physician for self-regulation and effective communication, whereas the social climate is determined by the prevailing socio-political and intellectual-scientific context. Cultural factors exert a profound influence on the individual characteristics of both physician and patient, particularly with respect to their knowledge of diseases, therapeutic interventions, healthcare practices, and the overall physician–patient dynamic.

These authors identified three fundamental models of the physician–patient relationship:

- **The activity–passivity model;**
- **The guided cooperation model;**
- **The mutual participation model.**

The activity–passivity model does not constitute a genuine interaction, as it is characterized by the physician acting upon the patient, who remains entirely passive. This model is clinically applicable in scenarios where the patient is incapable of communication, such as in coma, under anesthesia, during acute trauma, or in states of delirium, wherein the physician assumes full responsibility for performing the necessary interventions.

The guided cooperation model represents an interaction in which the patient, experiencing the burden of symptoms, actively seeks the physician's assistance. In this model, the physician provides directives, and the patient consents and adheres to the guidance provided. The patient is neither expected to question nor to challenge the medical advice. While both parties are engaged, the principal distinction lies in the distribution of authority and decision-making power. Clinically, this model is applicable, for instance, in the management of acute infectious conditions.

The mutual participation model characterizes a relationship in which the physician and patient share roughly equal roles in collaboration, maintain a partnership, and jointly strive toward consensus on therapeutic goals. Within this framework, the physician facilitates the patient's capacity for self-care and informed decision-making. This model is particularly relevant for managing chronic diseases, psychoanalytic interventions, and certain adaptations of psychoanalytic therapy.

Model	Role of the physician	Role of the patient	Clinical applicability of the model	Model prototype
The activity–passivity model	Physician acting upon the patient	Recipient (not in the state to react in any way)	anesthesia, during acute trauma, or in states of delirium, cola etc.	Parent-newborn
The guided cooperation model	Instructs the patient	Executes	Acute infectious conditions	Parent-adolescent child
The mutual participation model	Facilitates the patient's capacity for self-care	Participates in a partner-relation	Number of chronic diseases, psychoanalytic interventions,	Adult-adult

Table 1. Three basic models in reference to the doctor-patient relationship (Szasz u Hollender, 1956)

Over the past two decades, discourse has persisted regarding the patient's role in medical decision-making, reflecting the inherent tension between patient autonomy and health outcomes, as well as between the patient's values and those of the physician. This ongoing debate raises the pivotal question: "What constitutes the ideal physician–patient relationship?"

In 1992, Ezekiel and Linda Emanuel delineated four models of the physician–patient relationship: paternalistic, informative, interpretive, and deliberative.

Paternalistic model

The paternalistic model is designed to ensure that patients receive interventions deemed most beneficial to their health and overall well-being. Within this framework, the physician exercises comprehensive expertise to assess the patient's health status and selectively presents information that encourages acceptance of the intervention considered optimal. When an intervention is required, the physician may simply inform the patient of its implementation schedule.

In this model, the physician assumes the role of the patient's guardian, acting in accordance with the principle of *primum non nocere,* which constitutes the central ethical tenet governing the

physician–patient relationship in this context. Hellin (2002) analogizes the paternalistic physician–patient relationship to that of a parent and a newborn, wherein the patient is entirely dependent on the physician's decisions.

In the paternalistic model, the physician is ethically obliged to prioritize the patient's interests above their own and makes healthcare decisions grounded solely in their professional expertise and clinical judgment, without seeking the patient's input. In this framework, patient autonomy and informed consent are not fully acknowledged or respected.

Informative model

The informative model, also referred to as the consumer model, emphasizes the physician's role in providing the patient with comprehensive, relevant information, enabling the patient to make independent decisions regarding their care. The physician explains the nature and status of the disease, outlines possible diagnostic and therapeutic interventions, and communicates the associated risks and benefits, without explicitly addressing the patient's individual values or assessing their understanding of the information. Once fully informed, the patient exercises personal judgment to select the interventions they consider most appropriate.

This model establishes a clear distinction between objective facts and personal values. The patient's values are assumed to be established and coherent, while the physician's responsibility is to supply all pertinent medical facts. The ultimate treatment decisions are left to the patient, who integrates these facts with their own values to determine the appropriate course of action.

Interpretative model

In the interpretive model, the physician–patient relationship is oriented toward clarifying the patient's values, elucidating their true preferences, and assisting them in selecting among available therapeutic options. Similar to the informative model, the interpretive physician provides detailed information regarding the patient's condition, as well as the risks and benefits of potential interventions. However, beyond mere information provision, the interpretive physician actively facilitates the patient's comprehension of their health status and guides them in evaluating which medical interventions best correspond to their personal goals and identity (it is not based only on the personally values of the

patients, that is how they comprehend).

In this model, patients' values are often underdeveloped, and they may only partially understand the information provided. Consequently, the physician engages collaboratively with the patient to interpret, clarify, and contextualize medical information according to the patient's cognitive and emotional capacities. Success requires the physician to have a deep understanding of the patient's goals, priorities, and character. Crucially, the physician does not impose decisions; the patient independently determines which values and interventions align with their identity.

In the interpretive model, the physician's obligations are similar to those in the informative model, but the patient is further engaged in a collaborative process of understanding. In this context, patient autonomy is conceived as self-understanding—that is, the patient should gain a clearer sense of who they are and how different treatment options may impact their identity.

Deliberative model

The deliberative (also referred to as the advisory) model is designed to assist the patient in determining and selecting the most appropriate health-related therapeutic options. The physician provides proposals and explanations regarding why certain interventions are more valuable and toward which options the patient should orient their decisions.

Within the advisory model, the physician assumes the role of a teacher or mentor, fostering comprehensive communication with the patient about the optimal course of action and the most suitable treatment decisions. The patient evaluates all available therapeutic alternatives and their implications in light of their personal values.

Table 2 presents a comparative overview of the four physician–patient relationship models described by Ezekiel and Linda Emanuel.

Depending on the clinical scenario, different models may be more appropriate and applicable.

	Paternalistic model	Informative model	Informative model	Deliberative model
Patient's values	Objective and shared accordingly	Defined, fixed and known to the patient	Underdeveloped, confusing, requires clarification	Open for development and review through a moral conversation
Physician's liability	Prioritizing patient's interests above their own privileges as physicians	Provides relevant, clear information and applies the intervention preferred by the patient	Clarification and interpretation of the values relevant for the patient and applying the intervention preferred by them	Fostering communication in reference to the most significant values, applying the selected intervention by choice of the patient and providing information for the latter
Opinion about patient's autonomy	In compli-ance with the objective values	Choice and control over the medical care	Self-reflection relevant for the medical care	Moral self-development relevant to the medical care
Opinion on physician's role	Guardian	Competent technical expert	Advisor	Friend, teacher or mentor

Table 2. Comparison among four models of the physician–patient relationship (Emanuel, 1992)

Ezekiel and Linda Emanuel advocate for the deliberative model, supporting their preference with several arguments:

- The deliberative model most fully reflects the concept of patient autonomy;
- Society's expectation of an ideal physician extends beyond knowledge and communication skills; the physician must continuously update medical expertise, provide informed recommenda-

tions, and competently execute interventions;

- The deliberative model does not constitute a covert form of paternalism;

- The physician's values are considered appropriate for guiding patient care, and when disagreements arise, discussion clarifies which perspective is more relevant; in such cases, referral to another physician may be warranted;

- Physicians should address not only treatment-related issues but also promote broader health-related values (e.g., caries prevention in children, safe sexual practices for patients with HIV, moderation or abstinence from alcohol);

- Some physicians may lack adequate specialization or the ability to effectively communicate and persuade patients regarding recommended interventions.

The deliberative model embodies the principle that physicians have a duty of care toward patients. It also serves to educate patients about the relevant legal frameworks and insurance regulations governing the physician–patient relationship.

The principal factor distinguishing the four physician–patient relationship models is their conceptualization of patient autonomy. Even when patients are fully informed, individual circumstances may hinder comprehension; consequently, patient engagement in decision-making may involve a degree of "conditional" or "negotiated" autonomy. Accordingly, physicians should exercise meticulous attention in the communication of information, adopt a patient-specific approach, and allocate time in accordance with each patient's values, prior knowledge, and cognitive capacity.

Beyond robust clinical training, physicians are expected to demonstrate exceptional communication proficiency and possess both the insight and sensitivity necessary to understand human behavior and psychology.

Over the past two decades, numerous professional associations have promoted the adoption of a **patient-centered approach** in both medical and dental practice.

Patient-centered care prioritizes the personal and interpersonal dimensions of the physician–patient relationship. Professional conduct should be guided by empathy, unconditional

positive regard, and collaborative engagement with patients.

A physician's exhibition of a courteous, respectful, and supportive demeanor can markedly enhance patient adherence to recommended therapeutic interventions. Conversely, negative emotional responses or interpersonal discord between physician and patient may impair clinical judgment and increase the likelihood of diagnostic or therapeutic errors.

Mead and Bower (2000) identify several factors that may influence the efficacy of the patient-centered model. Behavioral interactions within the physician–patient relationship may be disrupted due to:

- physician-related factors (behavior, values, knowledge, character, sex, age, ethnicity, and familiarity with the patient);

- patient-related factors (behavior, expectations, knowledge, character, sex, age, ethnicity, nature of health issues, and familiarity with the physician);

- professional influences (norms, implementation of initiatives and objectives, accreditation, and insurance requirements);

- negotiation-level influences (communication barriers, physical barriers, interruptions, presence of third parties, time constraints, and work pressures);

- contextual influences (cultural norms, social expectations, socio-economic background, formal and informal education, personal experience, and clinical training of the physician).

Contemporary practice recommends a partnership-based physician–patient relationship founded on unconditional cooperation, wherein the physician regards each patient as a distinct and *autonomous living individual.*

Within this patient-centered framework, the physician's role is to mediate between the scientific realm of medicine and the patient's personal experience, thereby aligning clinical care with the patient's individual needs and preferences.

Chapter 2

DENTISTRY AS A PROFESSION

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DENTISTRY AS A PROFESSION

1. PROFESSIONAL ETHICS

All professional disciplines possess their own systems of professional ethics; however, in professions that directly concern human health, professional ethics assumes paramount importance. **Professional ethics** governs the conduct of members of a given profession, including their relationships with service recipients and the activities they undertake. Professional morality entails an additional level of responsibility inherent to the profession, while upholding the fundamental moral values shared across professions and regulating broader social interactions.

Members of a profession undertake a commitment to conduct that aligns with established ethical rules and principles. Ethical principles shape and are reflected in professional and scientific achievements within the discipline, while simultaneously responding to societal expectations and demands.

A profession may be defined as an occupation requiring prolonged and specialized higher education, regulated by a codified ethical framework. The foundational purpose of every profession is to serve the public good; in this respect, dentistry is unequivocally recognized as a profession.

Dentistry is a profession that offers concurrent opportunities for intellectual development and practical proficiency, with the objective of advancing oral health and, consequently, the overall health of the population. Oral health constitutes an integral and highly significant component of general health.

The dental profession is characterized by a high degree of autonomy, affording substantial discretion in the selection of methods within professional practice. Doctors of dental medicine primarily deliver their services through direct and

individualized interactions with patients. In the provision of care, whether during treatment, consultation, teaching, or the exercise of legal responsibilities, they maintain close contact with patients; consequently, professionalism is often accompanied by approachability and courtesy, yet professionalism must at all times remain the governing standard.

Doctors of dental medicine are healthcare professionals with expertise in the diagnosis and treatment of diseases affecting the teeth and the soft tissues of the oral cavity. This role requires the integration of diagnostic, clinical, and social competencies. They may practice as educators in secondary schools or universities, within the public health sector, in commercial dental institutions, or, most commonly, in private practice, typically within general dentistry. In leading and coordinating a dental team, they are also required to demonstrate well-developed administrative and managerial capabilities.

Patients are entitled to freely choose the dentist who will perform dental procedures. In doing so, they often disclose personal information that they may not wish to share with others, relying on the trust that the selected dentist will act in their best interests.

Doctors of dental medicine should be primarily concerned with the welfare of people, possess an aesthetic sense, and have manual dexterity or readiness to develop it. As professionals, they should possess the following characteristics:

1. Professional competence, consisting of knowledge and manual skills for applying knowledge in practice;
2. The competence of doctors of dental medicine is the most significant benefit for those who require their assistance (patients);
3. Owing to their competence, doctors of dental medicine are granted broad autonomy in matters related to dental practice;
4. Doctors of dental medicine have additional responsibility toward society—to do everything necessary and appropriate for the proper functioning of the profession.

The primary role of the doctor of dental medicine is to be a professional. To be recognized by the public and patients as such,

adherence to ethical norms and rules is required. However, not every participant in a profession is simultaneously a professional in the true sense of the word.

A professional is a member of a profession characterized by four fundamental qualities:

1. respect for people;
2. competence;
3. integrity;
4. a primary focus on work itself, rather than prestige or profit.

Health care professionals, by the nature of their work with people, have specific obligations. They must:

- respect patients for their individual needs and values and place these as the primary focus of their interests;
- adopt a “service-oriented” role while maintaining personal integrity and respect for patients;
- be tactful and instinctively know when to speak and when to listen;
- recognize the non-reciprocal nature of the relationship and therefore provide assistance and respect even when the patient is discourteous;
- treat patients with understanding and decency, demonstrate empathy, and refrain from judging patients or their behaviors.

In the Republic of North Macedonia, the professional duties of health workers and their associates are regulated by the Law on Health Care.

Professional duty entails the voluntary acceptance of availability and responsibility toward the patient, the assumption of risks inherent in patient care, the recognition and understanding of patients’ needs, and the provision of the highest possible standard of health care within existing conditions and the framework of health insurance coverage. The Law on Health Care, inter alia, provides that:

- Health professionals and health associates are required to

perform their duties conscientiously, professionally, efficiently, properly, and in a timely manner, in accordance with the Constitution, the applicable legislation, and ratified international agreements.

• Health professionals and health associates must carry out their work impartially, refrain from being influenced by personal financial interests, avoid any abuse of authority or position, and safeguard both their personal reputation and that of the institution in which they are employed.

• Physicians are required to apply diagnostic methods and appropriate therapeutic interventions that are recognized and validated in health care practice. They are expected to perform their professional duties in accordance with contemporary standards, conscientiously, with due diligence, and with full respect for the patient. Failure to perform legally prescribed duties constitutes nonperformance. Physicians must practice within established safety parameters and obtain all necessary information required to form sound professional judgments. This includes conducting a comprehensive clinical examination and applying all necessary diagnostic procedures in order to establish an accurate diagnosis and implement the most up-to-date therapeutic interventions.

• Contemporary medical practice recognizes Evidence-Based Medicine (EBM) as one of its most widely accepted standards, which entails the application of evidence derived from scientifically sound methods within specific fields of clinical practice.

• EBM provides high-quality evidence regarding the risks and benefits associated with medical treatment.

• EBM involves the conscientious, explicit, and judicious use of the best available current evidence in making decisions concerning the care of individual patients.

• The foundation of EBM lies in the systematic review of evidence relating to specific treatments, primarily through randomized controlled trials, with the Cochrane Library assuming a leading role as an international, non-profit organization that provides information on the effects of health care interventions.

Contemporary dental practice must be founded on evidence derived from scientific research in clinical dentistry that is, Evidence-Based Dentistry (EBD). This entails the systematic application of the best available scientific evidence when making

decisions regarding dental treatment and patient care.

To practice dentistry as true professionals, practitioners must demonstrate *integrity within their chosen profession; they must act with honesty, sincerity, and transparency toward themselves, their colleagues, their teams, the patients who entrust them with their health, and the society in which they practice.* Professionalism further requires competence, continuous professional development, and a commitment to advancement and innovation within the field.

Only the professional's conscience can safeguard patients against the misuse of trust; therefore, ethics holds fundamental importance in dentistry. Dental ethics encompasses the moral principles and standards governing dental practice. A consistent emphasis on ethical conduct and ethically grounded decision-making distinguishes the professional from the non-professional. Without a firm ethical foundation, the attainment of true professional excellence is not possible.

1.1 COMMUNICATION SKILLS: PRINCIPLES OF PROFESSIONAL COMMUNICATION IN EVERYDAY CLINICAL PRACTICE

Communication represents one of the most sensitive domains of human interaction, through which problems may both be resolved and generated. Interpersonal communication is universal and unavoidable, arising from the inherent human need to exchange information and share experiences. *It constitutes a continuous process of transmitting and receiving information and serves as a powerful means of assessing the interlocutor's character, emotional state, and psychological disposition at the time of interaction.*

The totality of all forms of human communication within a given time, space, and society constitutes the social communication network, which comprises both formalized and informal segments. The formalized (institutionalized) segments of the social communication network operate through numerous subsystems of the broader social system. Informal communications take place on a daily basis across all spheres of social life.

The quality of communication between patient and physician exerts a substantial influence on their relationship; in particular, the physician's effectiveness in this regard depends on well-developed communication skills. Numerous so-called "ethical misunderstandings" in dental ethics originate from inadequate communication. Communication failures result in misunderstandings between the patient and the health care team or among health professionals themselves.

Communication between physician and patient directly affects the quality and completeness of the information obtained and comprehended. A patient who lacks full trust in the physician may withhold relevant information; similarly, an impatient patient may not adequately understand the information provided.

Insufficient or unclear communication, leading to inadequate patient understanding of their disease, treatment options, and prognosis, constitutes a frequent cause of patient dissatisfaction. Consequently, ineffective communication is a common antecedent of complaints submitted to health care management. In recent years, there has been increasing recognition of the importance of communication skills within health care practice.

While all health professionals engage in patient communication, the primary responsibility for its effectiveness, and for failures therein, rests with physicians. Accordingly, communication skills are particularly critical for physicians and must be integrated with professional competence, empathy, and adherence to ethical standards.

Multiple perspectives exist regarding physician–patient communication, generally grounded in a combination of empirically validated techniques and individual professional attitudes.

From the initial patient encounter, the physician is expected to obtain a thorough medical history, an endeavor that demands effective communication. Empathy and active listening are fundamental components essential to establishing a positive physician–patient relationship, which benefits both the patient and the physician.

Active listening, one of the key communication tools, is essential for effective communication and involves accurately identifying the interlocutor's needs.

In professional communication within dentistry, several essential elements characterize the physician–patient relationship. Through communication, the parties should:

- determine and monitor the nature of the problem;
- establish an appropriate diagnosis;
- educate the patient and implement a treatment plan;
- identify and overcome communication barriers;
- agree on treatment priorities.

In communicating with patients, it is important that the physician:

- listens attentively and with interest;
- maintains eye contact when asking questions;
- encourages the patient through gestures and facial expressions;
- observes nonverbal cues;
- demonstrates understanding, support, and empathy;
- allows the patient to ask questions.

Communication may be verbal or nonverbal. Verbal communication involves not only the formulation of questions but also the ability to listen effectively. Nonverbal communication is equally significant, often accompanying verbal interaction by conveying meanings that words alone cannot express and, in some instances, replacing verbal messages entirely. In certain situations, verbal and nonverbal signals may even be contradictory.

Verbal communication refers to the exchange of messages through spoken language. Speech is used to transmit information and to express ideas, attitudes, emotions, and beliefs. It also serves functions such as requesting information, posing questions, and providing instructions.

Words and dialogue constitute the primary form of verbal communication. Effective verbal communication relies on two fundamental skills: listening and speaking. These skills include active listening, respect, empathy, reflection, paraphrasing, summarisation, clarification, inquiry, the use of “I-messages” instead

of “you-messages,” and constructive feedback.

Successful verbal communication requires the use of appropriate words, delivered in an appropriate manner and at an appropriate time. This process represents both a skill and an art. Effective verbal communication depends on adherence to linguistic rules, particularly grammar, as well as social and cultural norms, in order to ensure that the intended message is transmitted successfully in both oral and written forms.

Research indicates that in the workplace, individuals spend the greatest proportion of their time listening, followed by speaking, while relatively less time is devoted to reading and writing.

Nonverbal communication refers to the transmission of meaning without the use of words. It encompasses various signals, including gestures, facial expressions, body posture, eye contact, vocal tone, clothing choice, spatial behaviour, and timing. Nonverbal cues significantly influence verbal communication and may modify or even contradict its original meaning. Individuals are generally less conscious of their nonverbal behaviour than of verbal expression, and interpretation of nonverbal signals often occurs unconsciously. Consequently, impressions of others are frequently formed based largely on nonverbal behaviour and overall appearance.

In certain situations, nonverbal messages may substitute for words. For example, a parent may soothe a child with a single stern glance. Attention can be communicated nonverbally by orienting the body toward another person, maintaining eye contact, and demonstrating active listening. Simple gestures, such as pointing toward an individual, may grant that person the opportunity to speak. Similarly, emotions such as anger may be expressed through hand movements, tightened lips, or clenched teeth.

In some cases, nonverbal signals may contradict verbal messages and reveal underlying intentions that differ from formally expressed attitudes. When verbal and nonverbal communication are inconsistent, communication difficulties may arise.

For analytical purposes, nonverbal communication is commonly classified into several principal categories: facial expression, body language, vocal characteristics, tactile communication, and spatial–temporal communication. Facial expression encompasses various movements of the facial muscles in different combina-

tions, including eyebrow positioning, eye movement, nasal flaring, mouth configuration, and other muscular expressions.

Avoiding eye contact, even when delivering a positive verbal message, may impart a negative connotation. Nonverbal signals may also be subject to intentional manipulation, as individuals can simulate emotions they do not genuinely experience or conceal their true feelings.

This reflects both the strength and the potential risk associated with insufficient awareness of nonverbal communication. Facial expressions, as with other forms of nonverbal behaviour, may be ambiguous, and their interpretation is strongly influenced by cultural context.

Through bodily movements, individuals transmit messages that may be either conscious or unconscious. Certain gestures, such as waving, carry conventional meanings such as “greeting” or “farewell.” Other bodily signals are often unintentional: an upright posture may suggest confidence and professionalism; a relaxed posture may indicate disengagement or low interest; leaning forward may signal attentiveness and friendliness; crossed arms may imply defensiveness or lack of openness; and open, visible palms may convey sincerity and honesty.

Practical experience demonstrates that vocal tone does not always correspond to the literal meaning of spoken words. Even without understanding a particular language, emotional states such as excitement, anger, joy, or pain can often be recognized. Similar to body language, the human voice conveys meaningful information, whether intentionally or unintentionally expressed.

Emphasising certain words through variations in intonation, as well as changes in vocal volume, can significantly influence how a message is perceived by the interlocutor.

In some cultures, prolonged direct eye contact may create communication difficulties, as it can be interpreted as impolite or intrusive. However, research indicates that sustained direct eye contact—when it does not cause discomfort—generally conveys mutual respect and positive social engagement. Conversely, if the interlocutor experiences discomfort and avoids eye contact, such behaviour may be interpreted as a sign of hostility, suspicion, or aggression.

An important characteristic of nonverbal communication is that individuals are often unaware of its actual influence. Even when consciously attempting to control nonverbal signals, people may unintentionally transmit them. Nonverbal cues frequently reveal a speaker's authentic attitudes and intentions, even when verbal expressions convey a different message. In situations of inconsistency between verbal and nonverbal communication, greater credibility is commonly attributed to nonverbal signals.

Both verbal and nonverbal communication may be expressed in either explicit or implicit forms. Explicit communication is open and directly observable, most commonly conveyed through spoken language. Implicit communication is less visible and more indirect; it may be expressed verbally through figurative language, such as metaphor or allegory, or through nonverbal signals.

These two dimensions of communication are inseparable. Whenever communication is expressed explicitly, implicit meanings are simultaneously conveyed. Communication difficulties may arise when the underlying motive of explicit expression is inconsistent with the implicit intention.

It is commonly believed that the implicit level of communication reflects the true purpose of a message, whereas the explicit level represents only the form of expression. Individuals who engage in manipulative communication may consciously exploit this perception, adopting persuasive strategies that can appear highly convincing.

Nonverbal communication includes:

- body language (form of communication in which the message is transmitted without words);
- gestures (form of communication by means of expressive hand movements);
- facial expressions (using facial movements to convey the message).

External appearance and interpersonal distance also play a role in nonverbal communication.

Effective physician–patient communication yields substantial benefits, most importantly leading to improved therapeutic outcomes.

Characteristics of effective communication include:

- building mutual trust between patient and physician;
- helping patients share relevant information;
- involving patients in decisions about their health;
- fostering realistic patient expectations;
- creating more effective clinical practice;
- reducing the risk of errors;
- resulting in more satisfied patients.

Communication barriers may arise from factors related to the physician or the patient.

Physician-related barriers include:

- inadequate training in communication skills;
- lack of sensitivity and empathy;
- reluctance to recognize patient autonomy;
- unawareness of language and cultural differences;
- time pressure;
- impatience in listening to patient concerns;
- distraction due to external or personal factors.

Patient-related barriers include:

- influence of illness, conditions, or medications;
- anxiety, embarrassment, or denial of illness;
- difficulty recognizing or describing symptoms;
- fear of the dental office;
- intimidation by the physician's status;
- language and cultural differences;
- confusion due to medical terminology;
- fear of asking questions;
- concern about time constraints.

All these factors can impede the patient's ability to express, understand, and apply information and advice.

Effective physician–patient communication is a vital and integral component of successful dental treatment. Accurate symptom reporting and articulation of patient needs result from well-established communication. The physician's ability to elicit comprehensive health-related information depends on communication skills.

Patients may vary in their ability to express health concerns; nonetheless, the physician must rise to every situation, guide and direct communication, and thereby obtain the information necessary to perform dental interventions effectively.

1.1.1. Types of Communication

Communication may be broadly classified into three principal forms:

1. **Interpersonal Communication**
2. **Group Communication**
3. **Communication in Healthcare Institutions**

Interpersonal Communication

Regardless of professional specialization or level of technical expertise, effective communication is indispensable across all sectors, including healthcare. The ability to communicate clearly, accurately, and efficiently is fundamental to achieving meaningful and sustainable outcomes. Even the most innovative ideas lose their value if they are not conveyed appropriately and properly understood by others.

In professional life, communication assumes multiple forms—telephone conversations, written correspondence, emails, meetings, and presentations. These modes of interaction are integral to the daily functioning of any organization. Effective communication is not only central to establishing and maintaining professional relationships, but also constitutes the foundation of both personal and organizational interactions.

In contemporary organizations, communication serves as the primary mechanism through which strategies are implemented and

activities coordinated in pursuit of institutional objectives. It is estimated that managers spend approximately 75% of their working time engaged in communication-related activities. Moreover, communication plays a decisive role in shaping organizational reputation, strengthening stakeholder trust, attracting clients, and retaining and motivating qualified personnel.

From a psychological perspective, interpersonal communication refers to direct or mediated interaction between individuals. It may occur through immediate face-to-face exchange using verbal and symbolic means, or through technological channels when conducted at a distance. Communication may be personalized—taking place directly between individuals—or depersonalized—mediated through institutions, written texts, or digital platforms.

Communication is a complex and multidimensional construct. In its broadest sense, it encompasses all forms of interaction inherent in human activity and, more generally, in the relationship between organisms and their environment. In this context, communication comprises both a specific and a general dimension.

The specific dimension denotes conscious human communication, involving awareness and the intentional exchange of meaning. The general dimension refers to relational processes between organisms and their environments that do not necessarily involve intention or conscious awareness. This broader interpretation has prompted philosophical reflection, including the question of whether a tree falling in a forest “communicates” in the absence of an observer.

Group Communication

Communication in professional settings operates primarily at two levels. The first involves interaction among colleagues within teams and organizational hierarchies, including collaboration within workgroups and communication with supervisors. The second concerns communication with patients or clients, who constitute the central focus of professional activity.

Effective group communication is influenced by multiple factors, including sociocultural context, number of participants, age, social status, professional roles, level of engagement, and mutual expectations. In this regard, effective communication may be defined as the capacity to achieve intended outcomes through the optimal use of time and resources.

Team communication can and should be developed systematically. Unlike spontaneous everyday interaction, communication in professional environments is shaped by organizational structures, formal regulations, and hierarchical relationships. Effective communicators understand that professional communication requires a balance between natural spontaneity and adherence to established norms.

These norms are grounded in individual characteristics such as temperament, cognitive capacity, early learning experiences, family influences, social conditioning, and psychological maturity. Awareness of these determinants contributes significantly to the development of communicative competence within group contexts.

Teams frequently constitute the foundation of participatory management and collaborative decision-making. The principal advantages of teamwork include:

- **Enhanced access to information and knowledge.** By integrating the expertise of multiple individuals, teams expand the informational base available for informed decision-making.

- **Diversity of perspectives.** Team members contribute varied viewpoints, thereby enriching analysis and critical evaluation.

- **Greater acceptance of decisions.** Individuals involved in the decision-making process are more likely to support and implement the final outcome.

- **Improved performance and creativity.** In addressing complex problems, an effective team may surpass even highly competent individuals in terms of innovation and overall performance.

Despite its benefits, teamwork also presents challenges:

- It may consume excessive time and financial resources.
- Teams may develop *groupthink*, where members suppress dissenting opinions to maintain consensus.

- Hidden agendas may influence group dynamics.
- Coordinating schedules, meetings, and tasks can be resource-intensive.

Understanding both the strengths and limitations of team communication is essential for effective organizational functioning.

Communication in Healthcare Institutions

Effective communication is of particular importance in healthcare settings, as it directly affects treatment outcomes, patient safety, and the success of preventive interventions. In dentistry and oral healthcare, communication and oral health literacy constitute key determinants of effective prevention strategies.

Communication between the dental team and the patient is inherently dynamic and interactive. Its effectiveness is influenced by factors such as the patient's age, developmental stage, cognitive capacity, cultural background, and prior experiences with healthcare professionals.

Accordingly, communication strategies must be flexible and tailored to the patient's level of understanding. Language should be clear, concise, and appropriate to the patient's developmental stage. In the case of pediatric patients, parental involvement is essential during both preventive measures and therapeutic procedures.

Members of the dental team should establish structured communication guidelines when providing information on prevention, oral hygiene, and therapeutic procedures. Inadequate communication, particularly when combined with limited health literacy, constitutes a significant barrier to effective oral health promotion.

Enhancing oral health literacy through targeted and systematically designed educational interventions should represent a central objective of preventive programmes. Improving dental health literacy is a systemic responsibility that requires coordinated efforts among healthcare institutions, professionals, and policymakers. Such initiatives contribute to better oral health outcomes and the reduction of long-term treatment costs.

Good communication in healthcare is essential for:

- Forms the foundation of interpersonal relationships.

- Enables clear expression of intentions and information.
- Strengthens trust between healthcare professionals and patients.
- Improves collaboration among healthcare staff.
- Enhances clinical outcomes.
- Increases professional satisfaction and workplace well-being.

1.1.2. Communication Styles

Numerous models describe communicative behavior. One practical and widely applicable framework is based on two dimensions:

- **Level of expressiveness**
- **Level of self-confidence (assertiveness)**

This model identifies four primary communication styles:

1. **Direct Style** (Low expressiveness – High self-confidence)
2. **Assertive Style** (High expressiveness – High self-confidence)
3. **Systematic Style** (Low expressiveness – Low self-confidence)
4. **Considerate Style** (High expressiveness – Low self-confidence)

Direct Communication Style

Individuals exhibiting a direct communication style are typically confident, task-oriented, and focused on efficiency. They tend to provide instructions rather than solicit input and generally display limited emotional expressiveness. Although they perceive their approach as clear and results-driven, others may experience it as abrupt or impersonal. Such individuals are often decisive, action-oriented, and strongly motivated by achievement.

Assertive Communication Style

Assertive communicators emphasize broader perspectives and long-term objectives. They frequently function as innovators and generators of ideas within groups. Their communication is energetic, persuasive, and future-oriented. However, they may demonstrate reduced attention to detail or difficulty maintaining sustained focus on specific operational tasks.

Systematic Communication Style

Systematic communicators prioritize facts, empirical data, and structured analysis. They value precision and logical consistency over abstract or expansive conceptualization. Emotional expression is typically restrained, and they may exhibit a preference for avoiding confrontation. Their primary strengths lie in accuracy, consistency, and reliability.

Considerate Communication Style

Individuals with a considerate communication style are attentive to the emotions and needs of others and place a high value on interpersonal harmony. They prioritize collaboration, empathy, and mutual support. Through active listening and perspective-taking, they foster constructive dialogue. Their principal strength lies in promoting positive interpersonal relationships and enhancing team cohesion.

2. SPECIFIC CHARACTERISTICS OF DENTISTRY

Despite perceptions among some dentists that the profession has lost the esteem it once held, dentistry continues to be highly respected and attracts a substantial number of motivated students worldwide.

Dentistry represents a unique synthesis of science, technology, and creativity, applied in the promotion and maintenance of patients' oral health, irrespective of cultural or religious background.

Why dentistry is unique?

Although dentistry is a branch of medicine, it possesses distinctive characteristics that differentiate it from other medical disciplines. Many dental interventions are not immediately life-threatening; however, the ability to smile, eat, and speak without pain, discomfort, or embarrassment is integral to an individual's overall sense of well-being—a concept increasingly valued in contemporary society.

Individuals seek dental care either to improve or maintain oral health or to obtain relief from pain, depending on their personal perception of oral health. While dentistry is a recognized healthcare profession, it also operates within a commercial framework, as dental practitioners must sustain their livelihoods. Given that the majority of doctors of dental medicine practice in private clinics, they frequently navigate the delicate balance between professional judgment and financial considerations. An excessive focus on profit may compromise patient-centered care and erode public trust in the dental profession. Such conduct contravenes internationally accepted ethical principles, which stipulate that "the dentist must act in a manner that enhances the reputation of the profession." Excessive commercialization may prompt patients to seek multiple opinions regarding proposed interventions. Moreover, dissatisfaction with dental care can lead patients to consult additional dentists and, regardless of the underlying clinical issue, to pursue legal actions, file complaints, or seek compensation. Regrettably, there is a growing trend of patients resorting to such measures.

Can dentistry be both a business and a profession?

Every doctor of dental medicine must prioritize the conscientious and honest performance of professional duties, an obligation that arises from the moment they enter the dental profession. Financial remuneration should remain secondary to professional responsibility. While dentistry is fundamentally a profession, its practice is inherently linked to compensation for services rendered. Given that dentists generate income based on their professional judgment and recommendations, potential conflicts of interest are an inherent risk. Concurrently, patients, as recipients of paid services, are positioned to share their experiences, both positive and negative, with others. In this context, the dentist's reputation and professional success are indirectly influenced by patient feedback and recommendations.

Excessive commercialization may prompt patients to seek multiple opinions regarding proposed interventions. Furthermore, dissatisfaction with dental treatment may lead patients to seek opinions from other dentists and, regardless of the actual problem, to initiate legal proceedings, submit complaints, or claim compensation. Unfortunately, an increasing number of patients are opting for such actions.

The key question arises: how can conflicts of interest be mitigated without causing patients to feel harmed? Professional decision-making in dentistry involves multiple factors, and financial considerations must never supersede professional responsibility.

When determining therapeutic interventions, the dentist must always take into account the patient's capacity to bear the costs of proposed services. If the patient's interests are consistently prioritized and genuinely integrated into the decision-making process, dentistry can operate ethically within a business framework.

Application of the ethical principles in dentistry among others, means to make wat is in the best interest for the patient. This should be a top priority for every dentist.

What does "best interest of the patient" mean?

Acting in the patient's "best interest" requires that professional decisions be guided by the patient's values, preferences, wishes, and informed choices. Achieving this standard

necessitates careful communication, active listening, and thoughtful consideration.

At times, a patient's preferences may diverge from the dentist's professional recommendations. In such instances, it is imperative that patients are thoroughly informed about all potential complications, alternative treatment options, comparative advantages and disadvantages, costs, and anticipated outcomes. By systematically evaluating all possible approaches, associated risks and benefits, and the overall complexity of the decision-making process, balanced and compromise-based conclusions can be reached. Only after such a comprehensive assessment can it be affirmed that the proposed dental treatment genuinely aligns with the patient's best interest.

In contemporary dental practice, where patients actively participate in treatment decisions, conflicts may arise between patient preferences and professional recommendations. The dentist must carefully assess the patient's decision-making competence, consider individual characteristics and values, and involve the patient in treatment planning only if they are deemed capable of making informed choices. Some patients may have unrealistic expectations or fail to comprehend the consequences of their requests. In such cases, additional patient education and explanation are required. For patients with compromised intellectual capacity, the dentist has an ethical obligation to inform legal guardians about treatment choices, costs, possible complications, and expected outcomes.

In clinical practice, dentists may encounter situations in which patients are unable to pay for necessary services due to limited financial resources, lack of insurance, or personal preferences. In such cases, final decisions should be made after considering all constraints, but compromise must never be driven by the dentist's personal desire to reduce costs. Frequently, dentists may opt for less expensive restorative materials, a situation referred to as quality adjustment. In such situations the doctor must cooperate with the patient so that the patient makes the right decision. However, consciously and deliberately providing services below professional standards constitutes unethical conduct.

Trust between dentist and patient develops gradually and constitutes the cornerstone of their professional relationship. This relationship must be characterized by simplicity, honesty, and the absence of deception or professional arrogance. Trust is

founded on transparency, particularly during treatment planning. It is ethically impermissible to charge patients for services covered by insurance (unless the service exceeds standard care and the patient is duly informed), to recommend unnecessary procedures, to refer patients to inappropriate specialists, or to advocate for specific materials for personal financial gain.

To fulfill the expectations of patients and the public, dentists must consistently demonstrate core professional values through their conduct—competence, independence, and compassion. These principles, coupled with respect for fundamental human rights, constitute the essential framework of dental ethics.

3. CODE OF CONDUCT

The term ***code*** (Latin: *codex*) denotes voluntary standards of conduct, customs applied within a particular environment, and unwritten rules, and it serves as a mechanism of professional self-regulation.

Ethical codes of healthcare professionals, issued by the respective Chambers (Medical, Dental, and Pharmaceutical), define their professional rights and obligations. These bodies regulate the activities of professionals (physicians, dentists, pharmacists) by granting licenses for practice and thereby authorizing them to provide medical, including oral healthcare. In cases of unethical or unprofessional conduct during clinical practice by physicians and dentists, these bodies may temporarily or permanently revoke the license. Codes of conduct thus regulate the professional activities of healthcare practitioners (physicians, dentists, pharmacists).

Within the code of conduct issued by Dental Chambers in various states, fundamental ethical principles must be incorporated to ensure an ethical approach to challenges in dentistry. These core ethical principles serve as guidance for dentists in everyday clinical practice when making decisions in ambiguous situations or when determining the application of a specific therapy. Indeed, the resolution of every individual dental case should be approached with an ethical dimension.

Within the general provisions of the Code, the essential duties of the dentist and their associates are established, stipulating that, in addition to providing appropriate dental care, the dentist must act with respect toward the patient, uphold the patient's rights and obligations, comply with applicable laws, and continuously advance their professional and scientific knowledge.

The dentist is obligated to practice the profession conscientiously and responsibly, irrespective of the patient's age, gender, religion, nationality, race, political affiliation, sexual orientation, disability, or socioeconomic status, as well as regardless of any personal relationship with the patient or the patient's family.

The dentist must adhere to deontological norms in relation to patients, fellow dentists, and other healthcare professionals. In

relations with colleagues, the dentist is required to demonstrate respect and to acknowledge their knowledge, expertise, and professional dignity. Disparagement, gossip, and unjustified criticism of colleagues are contrary to ethical principles of conduct, and in cases of more serious or repeated violations, the dentist may be held accountable before the Court of Honor of the Dental Chamber.

Ethics permeates every aspect of dental practice, and if ethical principles are disregarded, there is a substantial risk of adopting unethical or insufficiently ethical decisions in addressing specific clinical issues. Such decisions may seriously compromise the quality of care that the practitioner provides to the patient and, consequently, undermine their professional integrity and functioning.

In recent years, medical ethics and dental ethics have been significantly influenced by the development of human rights. In the multicultural and pluralistic society in which we live, various international human rights instruments provide the foundational framework of medical ethics, generally grounded in the principle of equality among cultures and traditions. In many countries, legislation regulates the resolution of ethical issues in dentistry, particularly concerning the relationship between the doctor of dental medicine and patients, as well as in scientific research. Nevertheless, legal frameworks may be limited in certain jurisdictions, whereas ethics is universal in scope and imposes broader and more demanding standards of professional conduct.

The Code of Conduct for Dentists generally stipulates that every member has a duty to support and enhance the dental profession. Of particular importance is the principle that each member has voluntarily accepted the obligations of the dental profession “in accordance with personal conscience, which should be oriented toward the needs of the population.”

A doctor of dental medicine may, within forensic practice, assume the role of an expert witness. Expert evaluation must be performed in accordance with the dentist’s conscience and professional knowledge, and the expert opinion must be rendered impartially and free from external influence, strictly in compliance with the ethical principles of the dental profession, as a rule in written form.

Providing false testimony with the intent to harm one of the involved parties or to obtain unlawful personal benefit constitutes a serious violation of the Code of Dental Ethics and Deontology, as well as of the Criminal Code.

If a doctor of dental medicine is assigned to supervise another dental practice, they are obliged to inform the colleagues concerned in advance of the intended supervision.

In the Republic of North Macedonia, ethical principles in dentistry are regulated by the Code of Dental Ethics and Deontology issued by the Dental Chamber of Macedonia.

Oral health, as an integral component of the general health of the population, constitutes a fundamental social good, and dentists, as professionals, are entrusted with both the privilege and the responsibility to regulate the quality of delivery of oral healthcare within the scope of their specific professional duties.

4. ETHICAL STANDARDS IN DENTAL PRACTICE

In professions in which everyday professional activities may potentially infringe upon human rights, it is of paramount importance to establish clear standards of conduct to which the professional must adhere. Among such professions is that of the doctor of dental medicine, who, *through personal creativity and individual discretion in decision-making, may be exposed to the temptation to adopt unethical decisions,* including the failure to offer the patient the therapeutic solution that is most appropriate for their condition. The dentist is obliged to act professionally, responsibly, and in compliance with agreements concluded with patients.

Once a doctor of dental medicine agrees to accept a patient, a contractual relationship is established between them. The patient should subsequently sign an informed consent form confirming agreement with the therapeutic procedures to be performed, whereby the dentist assumes professional responsibility for the subsequent course of treatment.

4.1 PROFESSIONAL RESPONSIBILITY AND PROFESSIONAL STANDARDS

Responsible conduct is grounded in a combination of moral principles and pre-established personal, professional, and social obligations. ***Professional responsibility*** entails adherence to the agreement concluded between the dentist and the patient with respect to the planned dental treatment, and simultaneously encompasses economic responsibility in relation to the agreed remuneration for services to be paid by the patient.

In the performance of their profession, within the limits of defined fields of practice and professional competence, doctors are autonomous and independent, and are accountable for their work to their own conscience, to the patient, to the competent bodies of the Medical or Dental Chamber of Macedonia, and to society.

Upon obtaining a professional license, doctors assume legal responsibility for their actions. **Legal liability may be classified as misdemeanor or criminal**, and may arise either through actions undertaken in violation of the law or through failure to act where the law prescribes a mandatory duty to act.

According to most professional codes of conduct, a key competency in the dentist–patient relationship is the formulation and adherence to ***professional standards.*** *The dentist must protect the health of patients regardless of their individual status and must not propose or perform dental treatment that is unnecessary or for which the patient has not been properly informed.*

Within this framework, the dentist may accept or decline to treat a patient, exercising professional discretion, except in urgent cases, such as pain of dental origin, where the dentist is ethically obligated to provide emergency care.

When the dentist and patient agree on a specific dental intervention, both parties are obliged to formalize the agreement, or the patient must provide informed consent for the recommended procedure.

The dentist is required to apply all relevant treatment standards for the specific oral condition, follow established treatment protocols, and use appropriate biocompatible dental materials.

Professional standards also include the patient's assurance that the doctor will maintain professional secrecy. In addition to the doctor, the entire dental staff should be aware of the need to keep patient information confidential. Patient data should be protected in a manner determined by the countries.

In a dental practice, an appointment book or log should be maintained to record dental interventions, and it is highly beneficial to plan the schedule and number of procedures in advance.

Patient personal data, including address, place of work, and telephone contact, must also be available to the dental office.

Patient records should be retained for as long as possible, according to the recommendations of each country.

In the United Kingdom, for example, general dental practice records under the National Health Service regulations are kept for a minimum of two years from each intervention. While sufficient for regulatory oversight, this period may be inadequate for legal

purposes, as patients have the right to initiate legal action within three years of the intervention. Courts may extend this period if necessary. Therefore, it is recommended that records be retained for at least seven years. Records for children should be kept until they reach 25 years of age, since they were minors and legally incapable of making independent decisions before 18.

4.2 INFORMED CONSENT

In modern dental clinical practice, it is necessary before starting an intervention that a statement be signed by the patient agreeing to the course of treatment. In fact, *informed consent or statement of consent,* (as it is also called), is the process of obtaining approval from the patient before any health intervention is carried out.

For a patient to provide consent for a specific dental treatment, they must first receive all necessary information regarding the recommended treatment, alternative options, and potential associated risks. The patient must also have the opportunity to ask questions and be informed about the costs of the proposed dental services.

The recommended dental treatment is based on the prior clinical examination and any conducted paraclinical investigations. Therefore, alongside clinical notes, records should include X-rays, study models, occlusion verifications, photographs, and similar documentation. The consent form, signed by both parties, should include the treatment plan and the calculated cost to be paid by the patient. If the patient has health insurance, documentation confirming their insured status must also be retained.

A doctor of dental medicine must recognize the importance of the patient's signed consent, as it provides protection for both parties. It is recommended that, during the signing of the consent form or agreement, a third party be present in addition to the dentist and the patient.

Consent is also required when a dentist-researcher involves a participant in a scientific study. Informed consent is similarly obtained for organ donation, autopsy, or procedures with risks for which the medical professional is not liable after signing.

According to the needs, informed consent is applied in medical and dental practice, as well as in research ethics.

By signing an informed consent form, the person confirms that they understand the facts, implications, and possible risk factors related to the intervention itself, and for which the medical staff bears no responsibility.

It is evident that not everyone may obtain informed consent from a patient. A physician in clinical practice or a researcher conducting scientific research, with appropriate education, may obtain the patient's or research participant's signature on the consent form. Such consent must be given by adults who are conscious and capable of sound judgment.

In cases of impaired thinking and judgment, the patient cannot independently sign informed consent. This group includes: conditions of severe mental illness such as schizophrenia, as well as anxiety, severe intoxication, Alzheimer's disease, persons in a coma, etc. On their behalf, the informed consent is signed by authorized persons, such as parents, guardians, or children in cases involving elderly individuals who, due to their health condition, are unable to make decisions.

The most important purpose of informed consent is to provide the patient with the opportunity to be an informed participant in decisions related to his or her health and to personally consent to a specific intervention, as well as to the cost of the respective dental service. It is generally accepted that the informed consent signed prior to the performance of the dental intervention should contain the following elements:

- The protocol of the proposed dental intervention;
- Possible alternative treatment options;
- Potential risks, benefits, and uncertainties associated with each treatment option;
- Assessment of the patient's ability to understand the proposed solutions;
- The patient's acceptance of the dental intervention, including the cost of the procedure.

Dentists must prepare the content of the consent form for their patients and ensure that the information is fully understandable. The consent form should be written in clear and simple

language. This does not imply discrimination; rather, it acknowledges that individuals differ in reasoning and perspective, and dentists must know how to communicate the content of informed consent effectively.

All types of health interventions require some form of patient consent. A decision or choice of intervention is invalid if it is not based on understanding the health problem or if participation in research occurs without full information. Consent is not valid if the patient or participant does not act voluntarily.

The patient must be capable of understanding the information, weighing positive and negative aspects, drawing conclusions based on optimal rational judgment, considering circumstances, and making a free decision based on the available information. Therefore, information must be conveyed in a manner appropriate to the patient's capacity to understand it.

Informed consent represents a fundamental ethical principle in conducting dental research involving human participants.

The three essential elements ensuring valid consent are:

1. *Information*

   Research participants must be fully informed about the study's purpose, methods, expected benefits, requirements, and potential risks, if any.

2. *Voluntariness*

   Participation must be entirely voluntary, without any coercion (force) or manipulation

3. *Competence and/or Autonomy*

   Informed consent respects the participant's autonomy and safeguards their well-being, ensuring the highest protection in the event of unexpected harm during the study.

Any process lacking one or more of these elements does not fulfill the principle of informed consent.

5. ETHICAL DILEMMAS IN DENTISTRY

Like many other fields in healthcare, dentistry has undergone numerous changes in recent years. Advances in equipment and material technologies, modifications in health insurance and additional payments for oral healthcare, electronic payment systems, infection control requirements, and the increasing number of disputes with patients have created multiple challenges for dental practitioners in their daily clinical practice. These evolving circumstances have introduced a range of ethical issues that were less prominent in the past.

Fundamental ethical principles direct dentists and other healthcare professionals to act in the best interest of their patients, without prejudice, safeguarding their life and health at all times, and respecting their autonomy by providing comprehensive information regarding all aspects of their health, including oral health.

However, the conditions under which dental practitioners must make ethical decisions are often constrained. When decisions involve manipulating health insurance to secure better treatment for a patient, addressing unhealthy patient habits, or concealing inadequately performed work by a colleague, the dentist faces a challenging situation requiring professional and ethical judgment.

In daily dental practice, the doctor of dental medicine continually encounters new situations, raising questions and dilemmas that require ethical resolution. These issues most often concern patients, colleagues, or other staff members.

Ethical dilemmas can be classified into three main groups:

- *Dilemmas between the dentist and the patient;*
- *Dilemmas related to the pricing of dental services and health insurance; and*
- *Dilemmas between the dentist and employees within the healthcare facility.*

Ethical dilemmas between dentist and patient

Numerous questions arise regarding dental treatment, primarily related to patient autonomy, potential errors, treatment refusal, confidentiality, and the dentist–patient relationship.

When making final decisions on treatment procedures, *the patient actively participates.* It is imperative for the dentist to educate the patient thoroughly about the procedure, ensuring full understanding of potential risks. This approach also mitigates patient dissatisfaction if the final outcome is not as expected.

In clinical practice, the dentist fulfills their duty by providing treatment to the patient in the best possible manner. Nevertheless, despite careful attention, unintended errors may occur, even among the most experienced professionals. In such cases, the dentist should be honest with the patient and promptly inform them of any issues arising during treatment.

When an *error occurs while the dental treatment is in process,* it is crucial to distinguish between systemic errors, where responsibility is shared, and individual errors, where the dentist as the treating professional bears primary responsibility.

Equally important is differentiating between **correctable errors** (which can be remedied and the tooth restored), and **irreversible errors** (which may result in tooth extraction).

Regarding *refusal of dental treatment,* this may occur on the part of either the patient or the dentist. A dentist may refuse treatment only if the patient has a mental disorder that prevents independent decision-making or if the patient is unable to pay for a treatment deemed necessary. To prevent misunderstandings, the dentist must inform the patient in advance about treatment options and costs, indicating all possible therapeutic solutions. Additionally, the dentist should clarify which interventions are covered by the patient's health insurance, if applicable, and which are private services.

If the dentist encounters a patient suspected of using illegal drugs, they should refer the patient for additional testing before any dental intervention.

Refusing treatment to a patient with an infectious disease (e.g., HIV/AIDS) constitutes discrimination and is ethically unacceptable, violating the patient's human rights; legal action may

be taken by the patient or relevant associations.

All health information provided by the patient must be kept confidential, and the dentist must respect patient privacy in accordance with personal data protection laws.

Numerous ethical issues arise in the dentist–patient relationship, yet all are fundamentally grounded in mutual trust. The dentist must not disclose any patient-related information without the patient's consent. The authority to release such information publicly rests solely with the dentist and must never be delegated to other dental staff.

It is essential for the dentist to distinguish personal from professional relationships. When interacting with patients with whom personal connections exist, priority must be given to the patient's oral health care; dental interventions must not be contingent on services the patient may provide to the dentist.

Decision-making in dentistry inherently involves ethical considerations, and the ultimate responsibility for providing oral health care lies with the dentist. The patient must be accurately and thoroughly informed about their oral health and the required treatment to ensure meaningful participation in decisions affecting their health.

Ethical dilemmas related to dental prices and health insurance

In many countries, dental services represent a significant financial burden for patients. Dentists must ensure that their services comply with the ethical codes of the dental profession, which can be challenging in practice, as patients may sometimes be unable to afford necessary care.

Although dentists are not legally obliged to provide services to those who cannot pay (except in emergencies), they should consider individual patient needs and assist whenever possible. Financial discussions regarding treatment costs and payment methods are a routine aspect of dental practice. In all cases, the treatment cost must be communicated to the patient before any intervention, and consent must be obtained. Dentists sometimes provide care to patients despite their financial limitations, but they should not adjust fees based on the patient's current financial status or insurance coverage.

In most cases, the treatment plan depends on the extent to which health insurance can cover the cost of the dental service.

Ethical dilemmas between the dentist and the employees within the healthcare facility

In every dental practice, the manager, as the holder of the activity, is responsible for the staff and strives to employ the most highly trained personnel.

Dentists are also obligated to supervise all procedures performed on patients by auxiliary staff within the practice.

As part of the dental profession, dentists are traditionally expected to treat colleagues with due respect and collaborate to achieve the greatest benefit for patients.

Most conflicts among dentists that arise from behavior outside ethical principles result from:

- profit-sharing disputes (when two dentists share income or one refers a patient to another);
- taking patients from another colleague;
- the duty to report unethical conduct toward patients or colleagues.

The most common ethical issues for dentists relate to attracting patients from other colleagues, patient payments in cases of collaboration among multiple dentists, and mutual professional conduct.

As members of the Dental Chamber, dentists are expected to respect and cooperate with their colleagues, thereby maximizing patient benefit. Dentistry is traditionally considered a self-regulating profession with established high standards of professional conduct among its members.

Chapter 3

LAW, ETHICS AND DENTISTRY

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LAW, ETHICS AND DENTISTRY

1. DENTISTRY AND SOCIETY

Dentists, as professionals, bear responsibility toward their patients, colleagues and collaborators, and the society in which they practice.

The political and economic conditions of any society significantly influence the development of all professions, and this impact is particularly pronounced in dentistry. Often, these conditions lie beyond the control of dentists, as not every government adequately addresses issues related to oral health, leading to dentistry being categorized as a "commercial profession" rather than a health-centered one.

Oral health is an integral part of general health. Many systemic diseases manifest in the oral cavity, allowing dentists to play a crucial role in early detection, local treatment, and referral to appropriate specialists when necessary.

Unlike general healthcare, which is considered a fundamental human right, oral healthcare in many countries receives relatively limited state funding. Consequently, the cost of dental services often presents a greater challenge for patients than other types of healthcare, even in economically affluent countries.

In many low-income nations, dentists have limited resources to assist patients and continuously face the challenge of allocating them appropriately.

Dentistry, both in European and global contexts, belongs to the group of well-compensated professions, generally classified within the higher tiers of the middle class in terms of income. In the Republic of North Macedonia, dentistry remains an attractive profession, as evidenced by the number of students enrolling in dental faculties each year.

The profession's appeal is often linked to earning potential, which in dentistry is largely influenced by the living standards in a country and the regulation of health insurance. This directly affects the benefits available to insured patients, a factor particularly important in developing countries.

In various countries, health insurance provides a defined package of dental services, covering patients who regularly pay their contributions.

Rapid advancements in dentistry and dental technology have created a need for new methods of diagnosing and treating oral diseases and the use of modern dental materials, resulting in new types of dental services. These include services outside the standard health insurance packages, paid privately by patients, often involving advanced materials and costly technical procedures.

In our country, certain dental services are covered by the Health Insurance Fund (FZO), and dentists participating in this insurance scheme are required to enter contracts with FZO and charge patients according to state-recommended rates.

In reality, these agreements are accompanied by the necessary administrative procedures, which are often oversized.

In the Republic of Norh Macedonia, there is a national strategy for the prevention of oral diseases in children aged 0–14, but the care for oral health in the adult population can be considered unsatisfactory.

Given the increased life expectancy and the global rise in the elderly population, an increase in demand for dental services among the older (adult) population is expected. In our country, besides general interventions, health insurance also covers a significant portion of removable acrylic prostheses, which are most commonly associated with individuals over 65 years old (the patient participates with only 10% of the total cost of the prosthesis).

The legal frameworks in the countries, economic limitations, and the specific views of citizens require dentists to work according to strictly prescribed rules and to have defined duties within the scope of their professional practice. Patients and the general public expect dentists to act conscientiously and prepared within the existing conditions, taking into account patient autonomy and the norms prescribed in society, as represented

through institutions.

Doctors of dental medicine should strive to find ways to minimize any possible harm that would be borne by patients and that might arise from fulfilling public health requirements. This may relate to the payment of prostheses and may continuously result in inappropriate financial burden, followed by the continuation of benefits covered by insurance.

Sometimes in everyday clinical practice, dentists may find themselves in specific situations where they are caught between the interests of the patients on one side, and the interests of society on the other. These are often cases where a patient requests from the dentist certain benefits to which they are not entitled under their insurance coverage. The dentist is the one who will determine the need for specific dental services, but they cannot charge a lower price than that regulated by the patient's insurance. Certainly, the dentist must adhere to ethical principles and must not issue unjustified certificates, for which they could be held accountable by the competent state authorities.

For the protection and advancement of professional expertise, ethical duties and rights, for the improvement of the quality of dental care, and for safeguarding the interests of their profession, as well as for monitoring the relationship of healthcare workers towards society and citizens, dentists join professional associations and dental chambers. Dental chambers adopt their own statutes, establish a code of professional ethical duties and rights, form a court of honor, and adopt other acts regulating the operation of their bodies. The statute also determines the manner and procedure for issuing or revoking a license to practice.

Dental chambers have the status of a legal entity, and by issuing licenses to practice, they authorize dentists to carry out healthcare, specifically dental healthcare activities. In cases of behavior that is not in accordance with ethical principles, i.e., unprofessional conduct, or if there is a violation of the quality of healthcare services, these bodies may temporarily or permanently revoke a dentist's license.

In other words, dental chambers establish internal control and supervise the work of professional dentists, thereby protecting their interests and professional activities, which ensures greater acceptance and a stronger position of the profession within society.

The professional obligations of dentists are closely related to a highly sensitive aspect of a person, their health, which obliges members of this profession to continuously improve their skills. Dentists are required to apply all new professional and scientific knowledge and use it to enhance the quality of dental healthcare within their specialty.

They acquire the latest professional and scientific knowledge, among other ways, through seminars and congresses organized by professional associations and chambers, in which they are required to participate actively or passively. Participation earns the dentists a certain number of points or, in some countries, the hours count toward continuing education, which is mandatory to renew their license to practice. In the Republic of Norh Macedonia, licenses are renewed every seven years upon earning 140 points.

The conduct of healthcare professionals in dentistry, as with other healthcare workers, in accordance with ethical principles, is of particular importance in providing healthcare, as it reflects their significant moral responsibility toward patients.

In the Republic of North Macedonia, as a candidate country for EU membership, there is a need to align the practices of dentists with the principles and standards that apply in the countries of the European Union, in accordance with European and national legislation.

2. PATIENTS' RIGHTS

The belief in human equality began as early as the 17th century in North America. Discrimination based on race, age, gender, skin color, language, religion, disability, socio-economic status, political affiliation, and the like, despite widespread condemnation, still exists on some continents.

In 1948, the United Nations adopted the Universal Declaration of Human Rights, which emphasizes the rights of every individual, such as “the right to freedom, the right to life, the right to movement, freedom of thought, the right to education, the right to an adequate standard of living sufficient to maintain one's health and the health of one's family, including food, clothing, housing, healthcare, social protection...”

Today, in modern societies, there is an increasing emphasis on the principle that all people deserve dignified respect, with special attention given to respecting and treating individuals equally when they are in a vulnerable position, such as patients, or when they require some form of healthcare service.

A patient is an individual, whether sick or healthy, who seeks or undergoes a medical or dental intervention with the aim of preserving or improving their health.

In Lisbon in 1981, at the 34th Assembly of the World Medical Association, patients' rights were confirmed and a declaration known as the Lisbon Declaration was adopted (amended in 1995 and revised in 2005), which emphasizes: *“Taking into account possible practical, ethical, and legal difficulties, **the doctor must always act in accordance with their conscience and always in the best interest of the patient.”***

This Declaration includes some of the fundamental rights that the medical profession should ensure for patients, such as:

- The patient has the right to freely choose their doctor;
- The patient has the right to be treated by a doctor who freely makes clinical and ethical decisions without external influence;
- The patient has the right to accept or refuse treatment

after receiving appropriate information;

- The patient has the right to expect that their doctor will respect the principle of confidentiality of all health-related and personal information.

The rapid development of dental science and technology, and the application of modern dental materials and techniques in clinical practice, on the one hand, and the abandonment of the traditional paternalistic doctor–patient relationship, on the other hand, have highlighted the need for continuous adaptation to the numerous rules, regulations, and laws related to dental practice.

The laws applied and regulated in dental practice do not generally create ethical conflicts. This is because most of them are related to discrimination and informed consent, and accordingly, they have inseparable ethical connections.

If ethics and the law are in conflict, it is advisable to seek guidance from other institutions or individuals who are competent in that area. In such a potential situation, where possible solutions lie on a fine line between ethics and the law, consultations with more experienced colleagues in healthcare, mentors in the educational sector, or the competent Dental Chamber are essential for finding the correct solution.

Human rights in healthcare constitute a legal field that in the Republic of Norh Macedonia is appropriately regulated both by national legislation and by ratified international treaties, conventions, declarations, and other international documents related to the protection of patients' rights.

Since the country's independence, the right to health and the duty to care for one's own health and that of others have been incorporated into the Constitution of the Republic of North Macedonia and into positive legal provisions, and since then have been developed with rights and obligations for both patients and healthcare professionals, as well as for healthcare institutions.

In the Republic of North Macedonia, patients' rights are regulated by the Law on the Protection of Patients' Rights, which ensures that the protection of these rights provides quality and continuous healthcare in accordance with current medical and healthcare achievements, within the healthcare system and health insurance framework, appropriate to the individual needs of the patient, free from any mental or physical abuse, with full respect

for the dignity of the individual, and always in their best interest.

The principles set out in this law are consistent with international declarations and regulations governing patients' rights. They primarily concern patients' rights to be informed, to give consent for interventions, to access medical documentation, to confidentiality, to lodge complaints, and similar rights. In Brussels in 2002, the European Charter of Patients' Rights was adopted, according to which:

"Every individual has the right to access all information that will allow them to actively participate in decision-making regarding their own health; this information is a prerequisite for any procedure or treatment, including participation in scientific research.

Healthcare institutions and professionals must provide the patient with all information related to their treatment, including possible risks, inconveniences, side effects, and available options. This information must be provided in a timely manner (at least 24 hours in advance), allowing the patient to actively participate in the choice of therapy, depending on their health condition.

Healthcare institutions and professionals must use language that is understandable to the patient and communicate in a manner comprehensible to individuals without professional training.

In cases where a legal representative is required to provide informed consent, the patient, whether a minor or an adult unable to understand or give their own consent, must still be involved in decision-making regarding their health, as much as the situation allows. Consent from the patient must be obtained on this basis. The patient has the right to refuse treatment or medical intervention and to change their mind during the course of treatment by declining its continuation. The patient also has the right to refuse information concerning their health condition."

In recent decades, as a result of the changing global perspective on the relationship between patients and healthcare professionals or institutions, and the shift from the traditional paternalistic approach to patient autonomy in making decisions about their health, there has arisen a need for greater health education for patients, as well as increased awareness of the rights and obligations of both patients and healthcare providers.

In accordance with **the** Law on the Protection of Patients' Rights (Article 25), the patient has the right to confidentiality of

personal and medical data, which must be maintained even after the patient's death, in accordance with personal data protection regulations. All healthcare professionals, including students and trainees, are obliged to maintain professional confidentiality.

By exception, patient data may be disclosed if:

- the patient provides written consent;
- it is necessary for a medical intervention of the patient in another institution;
- it is required for processing prescribed by law by a healthcare institution providing health services to the patient;
- it is used for historical, scientific, research, or educational purposes, provided that the patient's identity is not revealed;
- it is in accordance with another law for the purpose of protecting the lives, safety, or health of other individuals.

The privilege that doctors have to access confidential information regarding a patient's health does not allow them to disclose information that could be subject to a court proceeding. This right belongs more to the patients than to the doctors. Only if the patient waives the right to confidentiality can the doctor testify in court.

Special attention is given to the confidential nature of information about patients who are HIV-positive or who have AIDS. States have adopted various legislations regarding the disclosure of confidential information concerning HIV and AIDS.

Additional regulations establish the right to protection from any form of harassment, humiliation, or abuse, and patients must not be discriminated against on the basis of their mental health status.

Violation of professional confidentiality constitutes a breach of employment obligations. The management, maintenance, collection, and handling of medical records are governed by provisions from regulations in the fields of health recordkeeping, patient rights protection, and personal data protection.

In case of a violation of their legally prescribed rights, the patient has the right to file a complaint and may sue the service provider or the healthcare institution.

The protection of patient rights should ensure quality and continuous healthcare, appropriate to the individual needs of the patient, free from any psychological or physical abuse, with full respect for the dignity of the person and in the best interest of the patient, in accordance with regulations in the field of healthcare and health insurance.

Modern lifestyles and greater public awareness of their rights are the main reasons for the increased prevalence and significance of ethical issues and dilemmas faced today by dentists compared to the past. For these reasons, dentists, as healthcare professionals, must fully adhere to the standards of conduct prescribed by Dental Chambers in their respective countries.

3. ETHICS OF SCIENTIFIC RESEARCH

The daily diverse supply of new dental materials by companies reflects the rapid development of technology and the improvement in the composition of materials, which, once placed in the patient's mouth, should remain functional for several years.

The production of dental materials has seen significant growth in recent years, and their introduction to the market naturally requires prior research to demonstrate their biocompatibility. Before receiving approval from governmental authorities for clinical use, their safety must be established. After clinical application, further research is necessary to evaluate their quality and assess their clinical impact on specific diseases.

On the other hand, many questions remain unanswered regarding the causes of certain oral diseases. Answers to these questions, as well as methods for preventing their occurrence, can only be obtained through more extensive dental research.

Clinical dental research falls under the broader category of 'biomedical research' and can be conducted in laboratory settings (in vitro), experimentally on animals, or through studies involving human participants. When it comes to testing materials, techniques, or medications, clinical research is of utmost importance and typically follows the positive results obtained from prior preclinical studies.

Clinical research is conducted on a small group of healthy volunteers who are compensated for their participation; on patients who have a specific oral disease to study the effects of a drug intended as appropriate therapy; or on a larger group of subjects who receive the drug and are compared with another drug or a placebo. Once favorable results are obtained and a drug begins to be used in dental clinical practice, it is necessary to continue monitoring its effects for a certain period due to possible adverse events that did not appear in the earlier phases.

The research of new drugs involving a placebo (double-blind studies) raises new ethical questions and dilemmas. A placebo represents a drug or procedure that has no specific effect on the patient's health but is administered to produce a psychological effect. In a study conducted in Alabama from 1932 to 1972, the U.S. Public Health Service carried out the Tuskegee Syphilis Study,

which aimed to investigate the effects of untreated syphilis in 400 African American men. These subjects were unaware of the nature of their disease or that it could be treated with penicillin. The study was designed to determine whether penicillin treatment would be more effective than symptomatic care. This 40-year study was extremely controversial due to its violation of ethical standards, and the consequences for the participants were severe. From 1947 onwards, penicillin was included as a standard therapeutic treatment for syphilis.

When it comes to research in dentistry, one cannot fail to mention the problem that may arise, which is closely linked to the flagrant violation of ethical principles. Specifically, dental research is a well-paid activity, and dentists are sometimes offered opportunities to participate in such studies. In these cases, conflicts of interest may occur, where the dentist may promote a certain drug or use a specific material out of personal interest, rather than because the latest scientific research—or evidence-based dentistry—supports it. In this way, the dentist is put in conflict with the duties he or she has as a dental professional. In such situations, the dentist may fail to inform patients about all possible therapeutic options and their associated risks, all in the direction of achieving the “most appropriate and best” solution for the dental treatment.

The fundamental principles of ethics in scientific research are today well known and established by the Declaration of Helsinki as an international document on the ethical aspects of biomedical research involving humans. Key points from the Declaration of Helsinki that relate to research in dentistry are:

- Research must adhere to ethical and scientific principles that justify medical investigation. It must be based on laboratory experiments, animal experiments, or scientific evidence;
- Clinical research may be conducted by a doctor, dentist, or scientifically qualified person under the supervision of appropriately qualified personnel;
- Clinical research involving humans cannot be legitimate if the importance of the research object is not proportional to the risk to the subject;

- Every clinical research project must be preceded by a careful assessment of the potential risks in relation to the benefits for the patient.

Coerced biomedical testing on humans ranks among the most serious violations of ethical principles. Procedures for testing new scientific methods involving humans are strictly controlled and are permitted only if they are medically and biologically justified, and if the necessary technological and personnel resources are available, in accordance with prior approval from a competent scientific and professional body, as well as the consent of the participant or their guardian/representative.

The question arises: "Must every study involving a human subject be approved by an appropriate ethics committee?"

Before beginning a study involving a participant, it is necessary to complete a questionnaire to determine whether a request must be submitted to the relevant ethics committee for studies involving that individual.

Once the need for ethics committee approval is established, in addition to obtaining informed consent or a declaration of consent for participation from the participant, the researcher must submit a completed ethical assessment form and the study protocol to the committee.

The study protocol involving a participant must clearly outline the experimental procedure, the objectives and methodology of the research, the study participants, potential risks and benefits, conflicts of interest, and other relevant aspects.

Biomedical and dental research involving humans must be conducted by professionally qualified and competent individuals. Special attention must be given to the possibility of predictable risks for those included in the study.

Even if a participant has initially consented to participate in the study, they have the right to withdraw at any time. In this segment of working with patients, their autonomy must be respected after they have been fully informed about all phases of the research and the ways in which they will participate.

4. ETHICAL RESPONSIBILITIES OF STUDENTS AND PROFESSORS

Since June 1999, with the signing of the Bologna Declaration, the higher education system has been reformed compared to the previous model, in which the professor was at the center of the educational process. The so-called European system of higher education has been implemented, which emphasizes greater interaction between professors and students. This includes increased student engagement in courses through the preparation of seminar papers, presentations on specific topics, and similar activities.

In the curricula of dental faculties, alongside theoretical teaching, practical training plays a crucial role, as it is essential for acquiring the practical skills necessary for the dental profession. Professors, assistants, and other teaching staff, in addition to imparting theoretical knowledge, have an exceptional role in the practical component, revealing the “craft” of dentistry. Every student at a dental faculty, to a greater or lesser extent, experiences this and expresses gratitude to their professors both during their studies and after graduation.

Moreover, the Geneva Declaration, as a modern version of the Hippocratic Oath that doctors take upon joining the dental profession, states among other things: *“I WILL SHOW RESPECT and gratitude to my teachers.”*

On the other hand, professors must also show respect toward their students and, through their personal example, demonstrate how to behave toward patients, dental assistants, and colleagues. Experience shows that it is not sufficient to present theoretically how one “should” behave; what is remembered and internalized by students is the professors’ behavior, their professional integrity, and essentially, this is what students are most likely to follow throughout their careers.

In the educational process, and in the effort to provide students with as much practical exposure as possible, professors and other teaching staff must never provide dental treatment to a patient for educational purposes if the patient does not need it.

The ethical responsibility of dental students is equal to that of

dentists and doctors, and it increasingly grows during the final years of study when students are in direct contact with patients. Namely, modern educational methods allow for greater personal evaluation of students and better preparation for addressing patients' problems.

At the core of dental practice, students' actions should focus on helping patients rather than being driven by commercial motives. They must possess communication skills, good interpersonal relationships, and a reasonable balance between altruism and self-respect.

Dental students are expected to demonstrate high standards of ethical behavior and to accept all risks associated with the dental profession, including the risk of infectious diseases.

They must be protected from infections, wash their hands before and after examinations, wear gloves and masks, and in some cases, gowns and protective eyewear.

In some highly developed countries with well-regulated legal frameworks, particular attention is given to preventive measures, including broader education of students on protection against HIV, hepatitis B, and hepatitis C infections, and, if necessary, referral for vaccination.

Students are expected to assist one another, provide advice, contribute to joint projects, and carry out tasks if involved in research. If participating in research studies, students must comply with all ethical norms, just as dentists and doctors do.

Each university has its own code of conduct for academic staff, which at medical and dental faculties includes the ethical codes of the medical profession. These codes also address issues related to sexual misconduct toward students, including sexual or emotional exploitation or any other inappropriate behavior.

Professors and their collaborators must not coerce students to provide any material or immaterial benefits.

Dental and medical students must demonstrate empathy toward patients, seek to help them out of altruistic motives, and do so voluntarily and without prejudice regarding patients' ethnic background, race, or socio-economic status.

When students have contact with patients, they are required to introduce themselves and obtain the patient's consent for

conducting examinations, taking medical history, and similar procedures. They must be aware that they are not yet qualified to independently practice dentistry and, while performing interventions, they must work under the supervision of a professor or one of the professor's collaborators. If a patient refuses to cooperate with a student, the professor, their collaborators, and the student are obliged to respect this decision without any repercussions for the patient.

Students must not engage in any disputes with patients and must respect their moral views. By establishing contact with patients, students improve their communication skills with individuals of different religious and political beliefs, as well as diverse cultural and social backgrounds. During examinations and interventions, students must ensure the patient's privacy, and all information obtained from the patient must be kept strictly confidential.

Wearing a white coat is often accompanied by a special sense of pride and self-respect among students; however, it can sometimes lead to a sense of authority, which should be avoided.

From the very beginning of their studies at dental faculties, students are required to attend both theoretical and practical classes, pass multiple quizzes, and complete oral and practical exams, which increases their anxiety. Stressful situations intensify in the final years of study, when students work intensively and are in direct contact with patients, which brings additional responsibility.

For these reasons, students are expected to possess high moral values, demonstrate empathy, and show an unconditional willingness to help people.

In some highly developed countries, before enrollment in the faculty, psychological testing is conducted for each student, which may be supplemented by interviews with academic staff and an external member.

Chapter 4

ANNEXES

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ANNEXES

1. HIPPOCRATE OATH

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold the one who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work. Into whatever houses I may enter, I will come for the benefit of the sick, remaining clear of all voluntary injustice and of other mischief and of sexual deeds upon bodies of females and males, be they free or slaves.

Things I may see or hear in the course of the treatment or even outside of treatment regarding the life of human beings, things which one should never divulge outside, I will keep to myself, holding such things shameful to be spoken.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being hon- ored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Source: Kass L. R. 1985. Toward a More Natural Science. Mumbai: Free Press in Stigall W. The Hippocratic Oath. Linacre Q. 2022 Aug;89(3):275-286.

2. GENEVA DECLARATION

The Physician's Pledge

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006 and the WMA General Assembly, Chicago, United States, October 2017.

AS A MEMBER OF THE MEDICAL PROFESSION:

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 that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of health care;

I WILL ATTEND TO my own health, well-being, and abilities in order 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 honour.

Source: World Medical Association. WMA Declaration of Geneva. Ferney-Voltaire, France: World Medical Association; revised October 2017. Available from: https://www.wma.net/policies-post/wma-declaration-of-geneva

3. WMA DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN PARTICIPANTS

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964
and amended by the:
29th WMA General Assembly, Tokyo, Japan, October 1975
35th WMA General Assembly, Venice, Italy, October 1983
41st WMA General Assembly, Hong Kong, September 1989
48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996
52nd WMA General Assembly, Edinburgh, Scotland, October 2000
53rd WMA General Assembly, Washington DC, USA, October 2002 (Note of Clarification added)
55th WMA General Assembly, Tokyo, Japan, October 2004 (Note of Clarification added)
59th WMA General Assembly, Seoul, Republic of Korea, October 2008
64th WMA General Assembly, Fortaleza, Brazil, October 2013
and by the 75th WMA General Assembly, Helsinki, Finland, October 2024

PREAMBLE

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human participants, including research using identifiable human material or data.

The Declaration is intended to be read as a whole, and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs.

2. While the Declaration is adopted by physicians, the WMA holds that these principles should be upheld by all individuals, teams, and organizations involved in medical research, as these principles are fundamental to respect for and protection of all research participants, including both patients and healthy volunteers.

GENERAL PRINCIPLES

3. The WMA Declaration of Geneva binds the physician with the words, “The health and well-being of my patient will be my first consideration,” and the WMA International Code of Medical Ethics declares “The physician must commit to the primacy of patient health and well-being and must offer care in the patient’s best interest.”

4. It is the duty of the physician to promote and safeguard the health, well-being and rights of patients, including those who are involved in medical research. The physician’s knowledge and conscience are dedicated to the fulfilment of this duty.

5. Medical progress is based on research that ultimately must include participants.

Even well-proven interventions should be evaluated continually through research for their safety, effectiveness, efficiency, accessibility, and quality.

6. Medical research involving human participants is subject to ethical standards that promote and ensure respect for all participants and protect their health and rights.

Since medical research takes place in the context of various structural inequities, researchers should carefully consider how the benefits, risks, and burdens are distributed.

Meaningful engagement with potential and enrolled participants and their communities should occur before, during, and following medical research. Researchers should enable potential and enrolled participants and their communities to share their priorities and values; to participate in research design, implementation, and other relevant activities; and to engage in understanding and disseminating results.

7. The primary purpose of medical research involving human participants is to generate knowledge to understand the causes, development and effects of diseases; improve preventive, diagnostic and therapeutic interventions; and ultimately to advance individual and public health.

These purposes can never take precedence over the rights and interests of individual research participants.

8. While new knowledge and interventions may be urgently needed during public health emergencies, it remains essential to uphold the ethical principles in this Declaration during such emergencies.

9. It is the duty of physicians who are involved in medical research to protect the life, health, dignity, integrity, autonomy, privacy, and confidentiality of personal information of research participants. The responsibility for the protection of research participants must always rest with physicians or other researchers and never with the research participants, even though they have given consent.

10. Physicians and other researchers must consider the ethical, legal and regulatory norms and standards for research involving human participants in the country or countries in which the research originated and where it is to be performed, as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research participants set forth in this Declaration.

11. Medical research should be designed and conducted in a manner that avoids or minimizes harm to the environment and strives for environmental sustainability.

12. Medical research involving human participants must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Such research requires the supervision of a competent and appropriately qualified physician or other researcher.

Scientific integrity is essential in the conduct of medical research involving human participants. Involved individuals, teams, and organizations must never engage in research misconduct.

13. Groups that are underrepresented in medical research should be provided appropriate access to participation in research.

14. Physicians who combine medical research with medical care should involve their patients in research only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research will not adversely affect the health of the patients who serve as research participants.

15. Appropriate compensation and treatment for participants who are harmed as a result of participating in research must be ensured.

Risks, Burdens, and Benefits

16. In medical practice and in medical research, most interventions involve risks and burdens.

Medical research involving human participants may only be conducted if the importance of the objective outweighs the risks and burdens to the research participants.

17. All medical research involving human participants must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation.

Measures to minimize the risks and burdens must be implemented. The risks and burdens must be continuously monitored, assessed, and documented by the researcher.

18. Physicians and other researchers may not engage in research involving human participants unless they are confident that the risks and burdens have been adequately assessed and can be satisfactorily managed.

When the risks and burdens are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians and other researchers must assess whether to continue, modify or immediately stop the research.

Individual, Group, and Community Vulnerability

19. Some individuals, groups, and communities are in a situation of more vulnerability as research participants due to factors that may be fixed or contextual and dynamic, and thus are at greater risk of being wronged or incurring harm. When such individuals, groups, and communities have distinctive health needs, their exclusion from medical research can potentially perpetuate or exacerbate their disparities. Therefore, the harms of exclusion must be considered and weighed against the harms of inclusion. In order to be fairly and responsibly included in research, they should receive specifically considered support and protections.

20. Medical research with individuals, groups, or communities in situations of particular vulnerability is only justified if it is responsive to their health needs and priorities and the individual, group, or community stands to benefit from the resulting knowledge, practices, or interventions. Researchers should only include those in situations of particular vulnerability when the research cannot be carried out in a less vulnerable group or community, or when

excluding them would perpetuate or exacerbate their disparities.

Scientific Requirements and Research Protocols

21. Medical research involving human participants must have a scientifically sound and rigorous design and execution that are likely to produce reliable, valid, and valuable knowledge and avoid research waste. The research must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation.

The welfare of animals used for research must be respected.

22. The design and performance of all medical research involving human participants must be clearly described and justified in a research protocol.

The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding aims, methods, anticipated benefits and potential risks and burdens, qualifications of the researcher, sources of funding, any potential conflicts of interest, provisions to protect privacy and confidentiality, incentives for participants, provisions for treating and/or compensating participants who are harmed as a consequence of participation, and any other relevant aspects of the research.

In clinical trials, the protocol must also describe any post-trial provisions.

Research Ethics Committees

23. The protocol must be submitted for consideration, comment, guidance, and approval to the concerned research ethics committee before the research begins. This committee must be transparent in its functioning and must have the independence and authority to resist undue influence from the researcher, the sponsor, or others. The committee must have sufficient resources to fulfill its duties, and its members and staff must collectively have adequate education, training, qualifications, and diversity to effectively evaluate each type of research it reviews.

The committee must have sufficient familiarity with local circumstances and context, and include at least one member of the general public. It must take into consideration the ethical, legal, and regulatory norms and standards of the country or countries in which the research is to be performed as well as applicable international norms and standards, but

these must not be allowed to reduce or eliminate any of the protections for research participants set forth in this Declaration.

When collaborative research is performed internationally, the research protocol must be approved by research ethics committees in both the sponsoring and host countries.

The committee must have the right to monitor, recommend changes to, withdraw approval for, and suspend ongoing research. Where monitoring is required, the researcher must provide information to the committee and/or competent data and safety monitoring entity, especially about any serious adverse events. No amendment to the protocol may be made without consideration and approval by the committee. After the end of the research, the researchers must submit a final report to the committee containing a summary of the findings and conclusions.

Privacy and Confidentiality

24. Every precaution must be taken to protect the privacy of research participants and the confidentiality of their personal information.

Free and Informed Consent

25. Free and informed consent is an essential component of respect for individual autonomy. Participation by individuals capable of giving informed consent in medical research must be voluntary. Although it may be appropriate to consult family members or community representatives, individuals capable of giving informed consent may not be enrolled in research unless they freely agree.

26. In medical research involving human participants capable of giving informed consent, each potential participant must be adequately informed in plain language of the aims, methods, anticipated benefits and potential risks and burdens, qualifications of the researcher, sources of funding, any potential conflicts of interest, provisions to protect privacy and confidentiality, incentives for participants, provisions for treating and/or compensating participants who are harmed as a consequence of participation, and any other relevant aspects of the research.

The potential participant must be informed of the right to refuse to participate in the research or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information and communication needs of individual potential participants as well as to the methods used to deliver the information.

After ensuring that the potential participant has understood the information, the physician or another qualified individual must then seek

the potential participant's freely given informed consent, formally documented on paper or electronically. If the consent cannot be expressed on paper or electronically, the non-written consent must be formally witnessed and documented.

All medical research participants should be given the option of being informed about the general outcome and results of the research.

27. When seeking informed consent for participation in research the physician or other researcher must be particularly cautious if the potential participant is in a dependent relationship with them or may consent under duress. In such situations, the informed consent must be sought by an appropriately qualified individual who is independent of this relationship.

28. In medical research involving human participants incapable of giving free and informed consent, the physician or other qualified individual must seek informed consent from the legally authorized representative, considering preferences and values expressed by the potential participant.

Those persons incapable of giving free and informed consent are in situations of particular vulnerability and are entitled to the corresponding safeguards. In addition to receiving the protections for the particularly vulnerable, those incapable of giving consent must only be included if the research is likely to either personally benefit them or if it entails only minimal risk and minimal burden.

29. When a potential research participant who is incapable of giving free and informed consent is able to give assent to decisions about participation in research, the physician or other qualified individual must seek that assent in addition to the consent of the legally authorized representative, considering any preferences and values expressed by the potential participant. The potential participant's dissent should be respected.

30. Research involving participants who are physically or mentally incapable of giving consent (for example, unconscious patients) may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research group. In such circumstances the physician or other qualified individual must seek informed consent from the legally authorized representative. If no such representative is available and if the research cannot be delayed, the research may proceed without informed consent provided that the specific reasons for involving participants with a condition that renders them unable to give informed consent have been stated in the research

protocol and the research has been approved by a research ethics committee.

Free and informed consent to remain in the research must be obtained as soon as possible from a legally authorized representative or, if they regain capacity to give consent, from the participant.

31. The physician or other researcher must fully inform potential participants which aspects of their care are related to the research. The refusal of a patient to participate in research or the patient's decision to withdraw from research must never adversely affect the patient-physician relationship or provision of the standard of care.

32. Physicians or other qualified individuals must obtain free and informed consent from research participants for the collection, processing, storage, and foreseeable secondary use of biological material and identifiable or re-identifiable data. Any collection and storage of data or biological material from research participants for multiple and indefinite uses should be consistent with requirements set forth in the WMA Declaration of Taipei, including the rights of individuals and the principles of governance. A research ethics committee must approve the establishment and monitor ongoing use of such databases and biobanks.

Where consent is impossible or impracticable to obtain, secondary research on stored data or biological material may be done only after consideration and approval of a research ethics committee.

Use of Placebo

33. The benefits, risks, burdens, and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in the following circumstances:

- If no proven intervention exists, the use of placebo, or no intervention, is acceptable; or
- If for compelling and scientifically sound methodological reasons the use of any intervention other than the best proven one(s), the use of placebo, or no intervention is necessary to determine the efficacy or safety of an intervention; and the participants who receive any intervention other than the best proven one(s), placebo, or no intervention will not be subject to additional risks of serious or irreversible harm as a result of not receiving the best proven intervention.

Extreme care must be taken to avoid abuse of this option.

Post-Trial Provisions

34. In advance of a clinical trial, post-trial provisions must be arranged by sponsors and researchers to be provided by themselves, healthcare systems, or governments for all participants who still need an intervention identified as beneficial and reasonably safe in the trial. Exceptions to this requirement must be approved by a research ethics committee. Specific information about post-trial provisions must be disclosed to participants as part of informed consent.

Research Registration, Publication, and Dissemination of Results

35. Medical research involving human participants must be registered in a publicly accessible database before recruitment of the first participant.

36. Researchers, authors, sponsors, editors, and publishers all have ethical obligations with regard to the publication and dissemination of the results of research. Researchers have a duty to make publicly available the results of their research on human participants and are accountable for the timeliness, completeness, and accuracy of their reports. All parties should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results must be published or otherwise made publicly available. Sources of funding, institutional affiliations, and conflicts of interest must be declared in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

Unproven Interventions in Clinical Practice

37. When an unproven intervention is utilized in an attempt to restore health or alleviate suffering for an individual patient because approved options are inadequate or ineffective and enrollment in a clinical trial is not possible, it should subsequently be made the object of research designed to evaluate safety and efficacy. Physicians participating in such interventions must first seek expert advice, weigh possible risks, burdens, and benefits, and obtain informed consent. They must also record and share data when appropriate and avoid compromising clinical trials. These interventions must never be undertaken to circumvent the protections for research participants set forth in this Declaration.

Source: ***World Medical Association.*** *WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Participants. Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964; and amended by the 75th WMA General Assembly, Helsinki, Finland, October 2024. Ferney-Voltaire, France: World Medical Association. Available from: https://www.wma.net/policies-post/wma-declaration-of-helsinki/*

4. CODE OF ETHICS FOR DENTISTS IN THE EUROPEAN UNION

(Adopted by the CED General Meeting on 26 May 2017, amending earlier versions of the CED Code of Ethics from 1965, 1982, 1998, 2002 and 2007)

1 PREAMBLE

This document outlines a set of minimum general principles which reflect the standard of professional conduct and ethics which underpin high quality dental care and services throughout Europe.

These general principles have been developed and agreed upon by the Council of European Dentists - which represents National Dental Associations from the EU Member States and the European Economic Area Countries - against a background of cross-border mobility of both patients and health professionals. It is intended to underpin the specific professional and ethical frameworks which dentists must follow in the country in which they work, which reflect the different cultures, traditions and needs of each nation.

1.1 Purpose and guiding principles of the dental profession

The purpose and guiding principles of the dental profession reflect those of all liberal professions and are:

- to contribute to society's wellbeing by promoting the oral health of the community
- to ensure professional independence, impartiality, professional confidentiality, integrity, honesty, competence and professionalism
- to promote oral health as part of general health and contribute to ensuring equitable access to dental care

- to contribute to society with special and unique knowledge, professional skills, aptitudes and social values
- to respect the dignity, autonomy and choices of the patient
- to act always in the best interests of patients
- to apply current standards of practice and update professional knowledge and skills throughout their professional life
- to safeguard the best interest of patients from negative impact arising from commercial interest of third parties

2. COMMITMENT TO THE PATIENT

2.1 The dentist must put patients' interests first.

2.2 The dentist must safeguard the health of patients, and must not discriminate against any individual patient or group of patients.

2.3 The dentist must prescribe treatment that is appropriate to the individual patient's oral health and in accordance with the patient's needs.

2.4 The dentist, must advise the patient on treatment options on the basis of independent professional judgement. He/she must not depend on third parties' commercial interests.

2.5 The dentist must uphold the principle of free choice of practitioner by the patient.

2.6 Good communication is fundamental to the dentist-patient relationship. The dentist must enable the patient, or the legal representative of the patient, to give informed consent for the treatment that is to be carried out, and must provide information about the proposed treatment, other treatment options, relevant risks, as well as costs, so as to enable the patient to make an informed choice.

2.7 The dentist must inform the patient of any complications or of failed treatment and discuss the options for resolving them.

2.8 The dentist must facilitate continuity of care where treatment of a patient ceases.

2.9 The dentist must endeavour to ensure the continuity of care in the event of conflicts with moral or religious beliefs arising from the request for care, or where the practitioner-patient relationship breaks down and it is neither possible nor appropriate to continue care.

2.10 The dentist must undertake only those treatments that he/she is competent to perform, and must refer a patient if a recommended treatment is beyond their competence.

2.11 The dentist must at all times strive to justify the confidence of the patient and the public.

2.12 The dentist must do everything possible to enable the patient to have realistic expectations of the outcome of treatment.

2.13 The dentist must respect the right of the patient to complain, respond promptly, actively and openly and try to resolve the issue in the patient's best interests.

2.14 The dentist must comply and co-operate with the national procedures for protecting the public in relation to complaints and conduct.

2.15 The dentist must take out appropriate professional indemnity insurance cover.

2.16 The dentist must subscribe to the key principles of healthcare confidentiality, that is:

• that individuals have a fundamental right to privacy and confidentiality of their health information;

• that individuals have the right to control access to, disclosure and rectification of their own health information by giving, withholding or withdrawing consent.

2.17 Patient consent should be given by a clear affirmative act establishing a freely given, specific, informed and unambiguous indication of the individual's agreement to the processing of their personal data such as by a written statement, including by electronic means or verbal statement.

2.18 The dentist must ensure that accurate and relevant medico-dental records are kept and that dental staff are aware of their obligation to maintain confidentiality of patient data. Data must be obtained and processed in a lawful, fair and transparent way for specific, explicit and legitimate purposes and according to data protection principles as laid down in the General Data Protection Regulation and national laws.

2.19 The dentist must keep all data relating to patients secure for the period of time specified by European and/or national laws. Where data is stored electronically, special security precautions must be taken to prevent access from outside the premises during electronic transfer procedures or remote maintenance of the system.

2.20 When sharing patient information with colleagues for the purpose of advice or second opinion, dentists must obtain the patient's consent.

2.21 When using patient data in scientific publications and presentations, the patient's anonymity must be respected and their consent obtain

2.22 The dentist must transmit patient data to third parties only when it is justified by the consent of the patient or where it is required by legal provisions. Records must be kept of all data

passed on to third parties.

2.23 Provisions must be made to ensure the safety of patient data for the eventuality of the death of a dental practitioner or the closure of a dental clinic.

2.24 The dentist must raise any concerns he/she may have about the possible abuse or neglect of children or vulnerable adults, and refer such concerns to an appropriate authority in line with national procedures.

3. COMMITMENT TO THE PUBLIC

3.1 The dentist should be conscious of the social nature of his/her profession and must direct society's attention to public health issues and to the promotion of quality of care.

3.2 The dentist has a personal responsibility to contribute to the wellbeing of society by virtue of having special knowledge and skills.

3.3 The dentist must comply with national law and ethical custom governing the practice of the profession, the use of titles and establishment of dental practice.

3.4 The dentist must operate in compliance with EU and national legislation and the applicable professional code on the promotion and advertising of services, including the use of modern and social media. Advertisements must respect patient rights, be clearly identified, and must be clear, honest, truthful and non-misleading.

3.5 The dentist must ensure that patients are informed of the names and roles of those involved in their care.

4. PRACTICE OF THE PROFESSION

4.1 The dentist must practise according to sound scientific principles and professional experience and expertise.

4.2 The clinical decision must not be driven by economic interests.

4.3 When working in a managed environment, the dentist must be free to provide care in the best interest of patients, and to comply with the ethical principles of the profession and sound clinical practise.

4.4 The dentist must assure the quality of patient care by updating his or her professional knowledge and skills throughout his or her professional life.

4.5 In providing a second opinion on a patient's treatment, the dentist must do so with regard to available evidence and patient records.

4.6 The dentist must lead and support all members of the dental team, ensuring that they have the knowledge and skills necessary to undertake their tasks effectively and efficiently and that they work strictly within the national law governing their scope of practice.

4.7 The dentist must employ and work only with individuals who are practising legally.

4.8 The dentist must comply with ethical principles of the profession in his/her relationship with the industry.

4.9 In countries where advertising is permitted by law, it must not create unnecessary treatment needs, promise unrealistic results, or be misleading, unfair or disrespectful towards the profession and colleagues.

4.10 In all advertising, the dentist must comply with the principles established in this code and in the Conduct for Electronic Commerce attached.

5. ELECTRONIC COMMERCE

The principles of the CED Code of Conduct for Electronic Commerce, including across borders, are attached and are an integral part of this Code of Ethics.

Source: Council of European Dentists (CED). Code of Ethics for Dentists in the European Union. CED-DOC-2017-016-FIN-E. Brussels: CED; 2017. Available from: https://www.cedentists.eu/wp-content/uploads/2023/02/CED-DOC-2017-016-FIN-E.pdf

5. CODE OF DENTAL ETHICS AND DEONTOLOGY OF THE DENTAL CHAMBER OF THE REPUBLIC OF MACEDONIA

– Commission for Ethical and Legal Affairs –

I. INTRODUCTORY PROVISIONS

Article 1

The term “DEONTOLOGY,” in the broader sense of the word, denotes the science of duties. The addition “medical,” i.e., “dental deontology,” narrows and locates this concept as the teaching of medical ethics, that is, the ethical conduct of physicians in all actions related to patients and medical staff.

The Code of Dental Ethics and Deontology represents a system of ethical norms on which the mutual obligations between the dental profession and society are founded, serving the protection and improvement of human health, strict professional conduct, patient engagement, and the protection of the patient’s personal integrity as well as the integrity of every dental worker.

Ethical and legal norms are close in their essence, but they are not identical. Legal solutions always strive to be ethically grounded, yet they can never sanction all ethical norms; for that very reason, ethical norms are often stricter than legal ones.

The fundamental norms and principles of the Code of Dental Ethics and Deontology derive from the Hippocratic commandment and the Solemn Declaration signed by every person who has obtained a diploma as a Doctor of Dentistry.

Upon entering the dental profession, the Doctor of Dentistry (Dental Medicine) solemnly undertakes that:

- they will devote their life to humanity;
- they will practice their profession conscientiously and responsibly;
- the highest imperative in professional activity will be the preservation and restoration of the patient's health;
- they will keep the secrets entrusted to them in the practice of the profession;
- with all their strength they will preserve the honor and noble traditions of the dental profession;
- in performing dental duties they will make no distinctions by age, sex, nationality, race, political affiliation, sexual orientation, disability, or socio-economic status;
- they will respect human life from conception onward, and even under threat will not apply their knowledge contrary to the laws of humanity;
- they will show due respect to their teachers;
- toward colleagues, doctors of dentistry, physicians from other medical fields, and other medical staff, they will act with respect and due regard for their personal integrity and their work.

II. GENERAL PROVISIONS

Article 2

A Doctor of Dentistry may actively and legally practice dentistry only if they have obtained the relevant diploma, passed the professional exam, and obtained a license to practice issued by the Dental Chamber of Macedonia.

Article 3

The Doctor of Dentistry (Doctor of Dental Medicine) has the right to be a member of the Macedonian Dental Society and relevant professional societies and associations, while membership in the Dental Chamber is mandatory.

With termination of membership in the Dental Chamber, the license to practice is also lost.

Article 4

A Doctor of Dentistry who is a member of the Dental Chamber is obliged to fulfill obligations toward the Chamber, to respect and implement the decisions of the Chamber's bodies, and at the same time to require the Chamber to protect their rights and interests.

Article 5

In the practice of the profession, a Doctor of Dentistry, in accordance with the level of their expertise, is autonomous and independent. They are accountable for their work before their conscience, before the patient and the patient's family, before the bodies of the Dental Chamber of Macedonia, and before the Law.

Article 6

A Doctor of Dentistry must respect laws, by-laws, and instructions from competent state bodies, except where these are contrary to the interests of the patient's health.

Article 7

A Doctor of Dentistry is obliged to provide appropriate dental care and, in doing so, must respect the patient's human dignity.

Together with colleagues and other medical collaborators, the Doctor of Dentistry must respect the patient's rights and nurture their trust.

The Doctor of Dentistry must respect ethical and deontological norms in the profession and in relationships dentist–dentist, dentist–patient, and dentist–other healthcare workers.

Article 8

A Doctor of Dentistry is obliged to continuously improve professional knowledge and follow processes of continuing professional education.

They are obliged to care for and advocate the professional competence, morality, and ethics of collaborators.

In accordance with their training and competence, they are obliged to provide urgent medical assistance and to ensure con-

tinued care of an endangered person.

Article 9

Overemphasizing one's own personality and one's own work is not consistent with the dental profession and the Code of Dental Ethics and Deontology.

Article 10

In daily dental practice, the Doctor of Dentistry shall apply treatment methods and means confirmed by doctrinal positions of competent scientific and professional institutions and associations.

Article 11

In applying new diagnostic, preventive, or therapeutic methods, as well as when conducting research, the dentist is obliged to respect national and international rules and regulations.

Among the most serious violations of ethical principles is coerced biomedical experimentation on humans.

Strictly controlled procedures for testing new treatment methods are permitted only when medically and biologically justified and when adequate technical and staffing capacity exists, following prior expert review by a highly qualified scientific body and the consent of the patient, or their guardian/legal representative.

III. SOCIAL POSITION OF THE DENTIST

Article 12

The dentist has an important role in the community, addressing sensitive issues related to human health and life. This creates special duties, special obligations, and personal responsibility.

All of this should represent personal and professional satisfaction.

Article 13

The dentist has the right and duty, through professional and other organizations, to advocate for appropriate valuation of their work and social status, and to be protected from professional risks.

Article 14

The dentist has no right to initiate procedures for which they do not have appropriate knowledge and experience.

The only exception is necessary (emergency) interventions for injuries and diseases that acutely and directly endanger the life of the patient or injured person.

Article 15

The dentist must not use titles they have not legally acquired or that have not been officially awarded by competent scientific/professional institutions, organizations, or state bodies.

Use of false titles that do not match actual qualifications is prohibited, especially if they have an advertising character.

Article 16

The dentist must not use their public healthcare role to extort any benefit (material or non-material) from the patient, except the publicly permitted and announced material compensation for their services, assessed through service valuation.

Article 17

The dentist refuses any cooperation with persons who illegally and unprofessionally perform dentistry and is obliged to inform competent state bodies and the bodies of the Dental Chamber about such cases.

Article 18

In professional practice, the dentist must not obtain material or other benefit by promoting pharmaceutical, cosmetic, or other products.

IV. THE PROFESSIONAL CHARACTER OF THE DENTIST

Article 19

In professional and private life, the dentist nurtures and demonstrates personal qualities appropriate to the role and dignity of the dental profession in society.

The dentist is aware that any inappropriate, reckless, dishonest,

or degrading gesture compromises all colleagues and the dental profession as a whole.

Article 20

When publishing professional and scientific works, the dentist is obliged to respect general laws on the press and public appearances, and especially to protect the personal integrity of the patient and collaborators.

Article 21

Ethical–moral principles in the publishing segment of the dental profession are incompatible with plagiarism, fabrication of results and data from tests and research, falsification of results, and selective reporting of data to highlight results for obtaining funds for scientific/professional projects, scholarships, or other types of profit from interested business groups.

Article 22

Debates concerning professional and scientific disputes may be conducted exclusively through scientific and professional journals and meetings, and never through public general media or by irresponsible statements before the lay public.

Article 23

The dentist should be aware of any potential professional impairment due to health, physical, emotional, or other reasons.

The dentist must not perform dental interventions under the influence of alcohol or other substances that endanger their ability to fulfill professional obligations.

A dentist who misuses such substances should be helped through collegial guidance to seek professional assistance.

A dentist who witnesses that a colleague is working professionally under the influence of alcohol or hallucinogens or similar substances is obliged to report this to the competent bodies of the Dental Chamber.

Article 24

A dentist who, due to illness or other reasons, is unable to fully perform professional duties, especially where this may endanger patients or collaborators, shall seek appropriate professional help

and advice, continuously adhere to it, and adapt and, where necessary, limit professional activity.

V. THE DENTIST AND THE PATIENT

Article 25

The dentist consistently respects the patient's right to free choice of doctor.

Toward patients who have chosen them, the dentist performs the profession conscientiously and responsibly, regardless of age, sex, religion, nationality, race, political affiliation, sexual orientation, disability, socio-economic position, and regardless of the dentist's personal attitude toward the patient and the patient's family.

Article 26

The dentist continuously follows achievements of dental science and the principles of professional conduct and freely and independently decides on the manner and methods of treatment.

In deciding on treatment, they are guided by their knowledge and conscience and do not yield to inappropriate desires of the patient or the patient's family.

Article 27

The patient always expects the doctor to be well-disposed, understanding of their health problems, and maximally patient.

The effectiveness of treatment depends greatly on the patient's trust in the doctor.

The dentist's actions should be directed exclusively toward relieving the patient's difficulties and restoring health, and should not be motivated by greed, personal ambition, or extortion of material or other benefit at the expense of the patient's misfortune.

Article 28

Before beginning treatment or undertaking an immediate intervention, the dentist is obliged to inform the patient in detail about: the type of disease, the cause of the disease, possible progression (if no intervention is performed), the manner and method of treatment/intervention, the course of the intervention, the

outcome of treatment/intervention, and possible post-intervention complications.

Article 29

Informing a patient about their disease and treatment outcome is an especially difficult task in incurable disease. In such cases, it should be individually assessed whether the truth should be communicated to the patient or to the patient's family.

In any case, the patient must not be denied necessary medical care, moral support, and the hope that the disease will be overcome.

Article 30

For certain interventions, the dentist is obliged to obtain written consent from patients before proceeding.

For surgical interventions in minors, written consent from a parent, guardian, or legal representative is required.

Only in cases where the patient is in life-threatening danger and urgent intervention is needed may the doctor act without consent of the patient, family, or guardian.

Article 31

The dentist must not refuse to intervene when urgent dental care is needed.

After such intervention, the dentist is obliged to refer the patient to their primary dentist with written information about the intervention performed.

Article 32

The dentist should be self-critical regarding the level of expertise and the level of interventions they can perform.

When they assess that their professional capabilities are exhausted and the condition is unresolved, they refer the patient to an appropriate specialist.

Together with the referral, they provide all documentation of treatment up to that point.

Article 33

The specialist receiving the referred patient does not publicly comment, or comment in front of the patient, on prior treatment steps.

They take all measures for appropriate treatment and, after recovery, return the patient to the primary doctor for further care.

If the specialist identifies irregularities in previous treatment, they must communicate this to the colleague who previously treated the patient in a friendly and collegial atmosphere.

Such findings should not be commented on or communicated to the patient, except in a judicial–medical procedure where expert testimony is requested by the court.

Article 34

The dentist shows understanding for the concerns of the patient's family and relatives and cooperates with them in line with ethical principles and in the patient's interest.

At the same time, the dentist should not establish relationships with family/relatives that could be interpreted as interference in the patient's family relations.

Article 35

A dentist treating a patient who lives in a family or larger organized group warns members of the community that they must respect the conditions and regime of home stay and that they too bear responsibility for treatment success.

Article 36

If during treatment the dentist determines inappropriate behavior by the patient, or by parents/guardians of a minor, the dentist carefully and authoritatively warns them.

If such behavior continues and there is no urgent need for intervention, the dentist may discontinue treatment.

The dentist informs the patient of this decision and records the reasons for discontinuation in the dental documentation.

Article 37

When there is no need for urgent dental intervention, the dentist may withdraw from further treatment of the patient in cases of:

- close kinship or emotional relationship;
- a request by the patient, his/her family or guardian to apply treatment methods contrary to the principles of dental deontology that is, the Criminal Code;
- if the dentist assesses their professional abilities are insufficient for the specific case;
- a legal dispute between the dentist and the patient or the patient's family.

The withdrawal is made in written form. In public health institutions, the request is submitted to the head of the public health institution; in private health institutions, to the Commission for Ethical and Legal Affairs at the Dental Chamber.

Article 38

The dentist should help the patient in exercising health and social rights, but must not agree to participate in abuses, fraud, false certificates, or issuing falsified documents in general.

Article 39

The dentist will not explain the established diagnosis and recommended therapeutic interventions in an untrue way that could deceive the patient, nor in a way that could mislead the patient.

Statements presented in an untrue way or in a way that may mislead or deceive the patient include:

- those containing inaccurate presentation of the patient's factual condition;
- intentional omission of facts necessary for making a proper decision on further treatment;
- clear or probable intent to create unjustified expectations about results the dentist can achieve;
- imposing an opinion and suggestion that the stated services are qualitatively superior to those provided by other dentists without possessing scientifically or professionally

recognized qualifications from a competent institution;

- suggesting or recommending unnecessary dental services where material motive is placed in the foreground.

VI. THE DENTIST AND EMERGENCY MEDICAL CARE

Article 40

The dentist must not refuse emergency dental care at any time and from any patient when requested. If faced with a situation in which the patient's life is acutely endangered and requires urgent intervention, regardless of not having the most appropriate specialist training and even if they are not directly asked to intervene, the dentist is obliged to do everything within their power to save the patient's life.

During epidemics, natural disasters, and other mass catastrophes, the dentist voluntarily makes themselves available to the competent state authority managing the consequences of the disaster.

In doing so, they primarily provide care for the most critically ill and injured.

Article 41

Potential danger to the health and life of the dentist must not be a reason for failing to provide emergency medical care if there is an immediate threat to the patient's life.

In cases of force majeure that directly threatens the dentist's health and life, not providing emergency medical care is justified.

VII. THE DENTIST IN EXTRAORDINARY CONDITIONS

Article 42

Working in an extraordinary institution places special obligations on the Doctor of Dentistry.

The dentist should be familiar with contemporary doctrinal principles for work in extraordinary conditions, in which healthcare personnel have a special position and responsibility.

In accordance with the principles of humanity and solidarity, the dentist, regardless of where they work, should be prepared to make themselves available to work in situations of extraordinary danger, aware of the moral and human dimension of the situation.

Article 43

In the event of war and other armed conflicts, the dentist is obliged to respond immediately to the call of the competent state authority and begin practicing their profession where assigned.

In performing their professional duties, the dentist is obliged to respect the Geneva Conventions and the additional protocols.

VIII. THE DENTIST AND HEALTH EDUCATION

Article 44

In everyday practice and development, healthcare achieves solid and lasting results through health education of the individual and the population.

The World Health Organization obliges all doctors from all fields of medicine and dentistry, as well as other healthcare workers, to continuously work, both at the workplace and in public life, on health education and raising health culture, thereby helping people achieve a better quality of life.

Article 45

The dentist encourages the population to be directed toward training in first aid and health assistance in extraordinary circumstances.

The dentist has obligations to support the activities of the Red Cross of the Republic of Macedonia in the area of population healthcare.

IX. RELATIONS AMONG DENTISTS

Article 46

Dentists are obliged to cooperate with each other.

The fundamental values of mutual cooperation are based on camaraderie, sincerity and openness, tolerance, transfer and exchange of knowledge and experience, and mutual respect as persons and for the effort invested.

The dentist should treat their colleague and other collaborators in the way they would like to be treated.

Article 47

The dentist values and respects the knowledge, work, and dignity of fellow doctors and every collaborator, regardless of workplace, because only such relations provide conditions for creativity and constructive criticism.

Article 48

Relations between senior and junior doctors should be based on mutual respect and sincere cooperation.

Senior doctors are obliged to selflessly pass on their professional and life experience to younger doctors.

The professional and life experience of senior doctors can be of invaluable value to younger doctors, who are obliged to appreciate and respect it.

Article 49

Dentists are obliged to be supportive and respectful toward each other, as well as toward other medical personnel, and to demonstrate this by being ready to help a severely ill or injured colleague or other collaborator, as well as students of dentistry.

Dentists are obliged, upon the call of the bodies of the Dental Chamber, to react practically in the sense of assisting a colleague who needs help.

Article 50

Dentists are obliged to show solidarity with a colleague in cases of severe breakdowns of their work equipment and premises caused

by human violence, fires, floods, and other natural disasters.

Article 51

The rule of collegiality, sincerity, and fairness requires dentists to defend a colleague who is attacked unfairly i.e., without concrete evidence, by a patient or the patient's family, the media, or a state authority.

Article 52

Differences of opinion between dentists must never lead to public manifestations contrary to the fundamental values of mutual cooperation.

Work-related and other mutual disputes should be resolved quickly, peacefully, and tolerantly, without involving other collaborators in the dispute, and, if possible, through mutual agreement.

Bringing a dispute into the public sphere through inappropriate behavior harms business ethics, damages the reputation of dentists, the dental profession, the dental institution, and patients' trust.

When disagreements cannot be overcome by the doctors involved, the Dental Chamber, through its Commission for Ethical and Legal Affairs, undertakes urgent and mandatory actions for calming the situation, using all measures established by the Chamber's Statute.

In resolving disputes among dentists, the following wisdom will be respected: "Even the worst agreement is better than the best lawsuit."

Article 53

Gossiping, belittling, and unfounded, lay-public criticism of a colleague doctor, collaborators, or superiors at different levels is unworthy of a dentist.

Article 54

If an objectively established error is identified in diagnostic and therapeutic procedures in prior treatment, the dentist is obliged to record their opinion and remarks in writing and submit them to the professional and management bodies of the public health organization (if the prior treating doctor works there), or to the bodies of the Dental Chamber (if the doctor works in a private dental institution).

Expressing an opinion about inappropriate treatment verbally in front of the patient, auxiliary staff, or the lay public is not permitted and is professionally untenable.

A negative opinion about the manner of treatment in a professional setting may be expressed only in the presence of the doctor concerned, and it must be objective, evidence-based, without personal discrediting or insults.

Article 55

If a patient complains about the manner of treatment or conduct by another doctor and their collaborators, the complaint should be received and recorded only for possible further procedures.

In direct conversation with the patient or the patient's family, no statements or evaluations should be given about unexamined issues.

Evaluating treatment approaches is a professional and ethical matter and should be left to competent professional bodies, organizations, and institutions.

Article 56

The dentist must not, without reason, refuse to help another colleague if asked.

They are obliged to provide assistance in their own institution if the patient can come, or in the institution of the colleague who requests help.

The doctor called to help completes the intervention without any comments in front of the patient.

Any remarks should be conveyed in a friendly manner to the colleague who called them, and they should congratulate the colleague for the virtue and responsibility shown toward the patient.

Article 57

The dentist has the right and duty, together with colleagues, to fight for their social and socio-economic status, in accordance with their important and responsible role in society.

The dentist has the right to request from their professional organizations an adequate valuation of their work, through quantitative determination of prices for services and interventions.

The quantified values of individual services offered by the dentist are defined as service prices, with a minimum and maximum price that may be charged to the patient.

Failure to respect the quantified service values adopted by the Dental Chamber represents a serious violation of the fundamental values of mutual relations and cooperation among dentists and a degradation of the work of other doctors.

X. THE DENTIST AND THE CONSULTATION BOARD (CONSILIUM)

Article 58

If the dentist assesses that specialist help is needed, they consult another doctor individually or a medical consultation board. Consultation may be initiated by the treating doctor, or at the request of the patient or the patient's family.

The consulting doctor may be proposed by the patient or the patient's family, but the final decision, with full responsibility, is made by the treating doctor.

Article 59

A consultation board is also formed at the initiative of the doctor or at the request of the patient or the patient's family.

The number of doctors in the board is not strictly determined, but it must include at least two doctors from the relevant specialty and the treating doctor.

The consultative examination is conducted in the presence of all board members.

As a rule, the board does not deliberate or decide in the presence of the patient or a family member.

Article 60

After examining the patient and reviewing the dental documentation of prior treatment, the consultation board adopts its opinion and position regarding the treatment up to that point and further treatment of the patient.

The board's opinion is documented in writing and remains in the healthcare institution where the patient is treated. If any board

member disagrees with the opinion of the others, the dissenting opinion is also recorded and kept in the dental documentation.

The board's opinion is communicated to the patient by the treating doctor.

Article 61

Participation in a consultation board leaves no room for insincerity, bias, prestige, competitive intentions, or envy.

The dentist must not refuse participation in a consultation board, except in cases where the dentist has the right to withdraw from treating the patient.

The call to participate should be regarded as an expression of trust in the dentist's knowledge and competence.

XI. PROFESSIONAL CONFIDENTIALITY

Article 62

The dentist is legally obliged to keep professional confidentiality.

Professional confidentiality includes everything the doctor or another healthcare worker learns in the course of work about the patient and the patient's personal or family matters.

The doctor is obliged to keep professional confidentiality even from members of their own family if this is in the patient's interest.

Maintaining professional confidentiality remains a duty even after the patient's death.

Article 63

In professional and scientific-research publications, during teaching, symposia, and seminars, data on research results and conclusions must be communicated in a way that ensures patient anonymity. Public presentation of a patient for scientific or teaching purposes may be done only with the patient's consent.

XII. THE DENTIST AND THE PUBLIC

Article 64

Professional statements by the dentist in popular media may be intended exclusively for popularizing dental practice and science and for spreading general health education and health culture. Statements and publications by doctors regarding treatment results with certain drugs, materials, devices, or equipment should always be presented within professional circles, in healthcare and scientific publications.

Article 65

In practicing the profession and publishing results of certain treatment methods, the dentist must not collect or falsify results in order to favor specific drugs, materials, or devices so as to obtain material benefit from sponsors.

Article 66

In advertising dental healthcare institutions in public media, it is not permitted to use attributes such as: best, most effective, fastest, safest, cheapest, because this constitutes self-proclamation of supreme authority without evidence.

In public media advertising, it is permitted to state:

- the name of the dental institution;
- location and address;
- premises and equipment;
- treatment methods applied;
- the staff available.

Article 67

Publishing prices of dental services in public media is not permitted, because the risk of misinformation and misleading the patient is high.

Without an examination and a treatment plan, it is not possible to determine the price of a specific service.

Article 68

The dentist is obliged to disclose a conflict of interest, if it exists, when a certain material is publicly presented or promoted for educational or scientific purposes, i.e., when any financial or other interest from the manufacturer or commercial representative is made public.

When recommending a product or procedure, the dentist must truthfully present the value of the product and provide reasoned evidence of the success achieved through its use.

XIII. THE DENTIST AS AN EXPERT WITNESS

Article 69

In forensic-medical practice, the dentist very often finds themselves in the role of an expert witness. Expert evaluation must be performed in accordance with one's conscience and knowledge; the expert opinion and findings must be precise and complete, with absolute respect for the ethical principles of the dental profession.

Article 70

Regardless of any personal or other relationship to the involved parties, the expert witness must be impartial and professionally honest.

Findings and opinions must be professionally sound and convincingly grounded exclusively on arguments. As a rule, the expert's findings and opinion are provided in written form.

Article 71

False expert testimony intended to harm one party or to obtain a benefit from one party represents a serious conflict with the Code of Dental Ethics and Deontology as well as with the Criminal Code.

XIV. PURPOSE OF THE CODE

Article 72

The purpose of the Code of Dental Ethics and Deontology of the Dental Chamber in Macedonia is to affirm ethical values and establish ethical standards that all members of the Dental Chamber of Macedonia and every representative of the dental profession must adhere to.

Members of the Dental Chamber voluntarily and responsibly accept the provisions of this Code and thereby make an individual and active contribution to the trust society places in dentistry.

XV. FINAL PROVISIONS

Article 73

The provisions of the Code of Dental Ethics and Deontology of the Dental Chamber are binding for all Doctors of Dentistry who are members of the Chamber. Failure to comply with this Code is a direct basis for undertaking appropriate measures by the bodies and organs of the Chamber.

Article 74

Proceedings initiated for violation of the provisions of the Code of Dental Ethics and Deontology of the Dental Chamber of Macedonia are conducted before the Court of Honor within the Chamber.

Article 75

Authentic interpretation of the provisions of the Code of Dental Ethics and Deontology, and whether an action by a dentist is contrary to the Code, is provided by the Commission for Ethical and Legal Affairs.

Source: Kamcev M. Code of Dental Ethics and Deontology [Internet]. Skopje: Dental Chamber of Macedonia. Available from: https://skm.mk/document/etichki-kodeks/

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