The standard of care

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The true meaning of the term **"the standard of care"** is a frequent topic of discussion among **emergency physicians** as they evaluate and perform care on patients. This article, using legal cases and dictums, reviews the legal history and definitions of the standard of care. The goal is to provide the working physician with a practical and useful model of the standard of care to help guide daily practice.
The concept of "the standard of care" is often discussed among physicians, and yet the legal definition of this term is frequently not understood.

A chronological approach to the evolving definition of the standard of care through legal history will help to understand the **current concept and nuances of the term.**

Negligence, in general, is legally defined as "the standard of conduct to which one must conform is that of a reasonable man under like circumstances."In law,
medical malpractice is considered a specific area within the general **domain of negligence**. It requires four conditions (elements) be met for the plaintiff to recover damages. These conditions are: duty; breach of duty; harm; and causation.
The second element, breach of duty, is synonymous with the **"standard of care.**The standard of care was defined by the **legal concept of "custom.**
When "certain dangers have been removed by a customary way of doing things safely, this custom may be proved to show that [the one charged with the dereliction] has fallen below the required standard." Put another way, if others in the business are commonly practicing a certain way that eliminates hazards, then this practice can be used to define the standard of care. A jury still needed to decide, however, whether this "custom" was reasonable and whether the deviation from this "custom" was so unreasonable as to cause harm

Who determines how a dentist should behave?

The principles are all equally important and are not listed in order of priority. They are supplemented by additional guidance documents and which you must also follow.

You have an **individual responsibility** to behave professionally and follow these principles at all times.

The standards set out what you must do. If you do not meet these standards, you may be removed from our register and not be able to work as a dental professional.

The guidance is there to help you to **meet the standards**. You are expected to follow the guidance, to use your professional judgment, demonstrate insight at all times and be able to justify any decision that is not in line with the guidance. **Serious or persistent failure to follow the guidance** could see you removed from our register and not able to work as a dental profession

All the professional regulatory bodies mapping the behaviors of dentist . Like IDA, GDC, ADA.

A local or a global standard of care?

In recent years there has been intense debate regarding the level of medical care provided to **'standard care'** control groups in clinical trials in developing countries, particularly when the research sponsors come from wealthier countries. **The debate revolves around the issue of how to define a standard of medical care in a country in which many people are not receiving the best methods of medical care available in other settings**.

The health system affects locally available medical care in two important ways:

first, the system may be structured to provide different levels of care at different sites with referral mechanisms to direct patients to the appropriate level of care.

Second, inefficiencies in this system may influence what care is available in a particular locale. As a result of these two factors locally available care cannot be equated with **a national 'standard'.**
A reasonable approach is to define the national standard of care as the level of care that ought to be delivered under conditions of appropriate and efficient referral in a national system. **This standard is the minimum level of care that ought to be provided to a control group**. There may be additional moral arguments for higher levels of care in some circumstances. This health system analysis may be helpful to researchers and ethics committees in designing and reviewing research involving standard care control groups in developing country research.

The international community must assist the fulfilment of the human right to health and the duty of justice in cases where they cannot be secured by a country in itself, we developed an action framework that seeks to address both issues related to the protection of the participant and to the generation of medical benefit for the local population. We argued that these two elements are closely related and should not be considered separately.
Therefore, when medical research aiming to restrict health inequity is conducted, everything possible should be done to ensure that participants have been treated in a way that reflects position that ‘what we mean by equity is not that people must always be treated identically, but that for every difference in the way men are treated, a reason should be given that is relevant.

Transparency of care, guidelines, and protocols.

Absolute transparency is the key to driving improvements in standards of care. We need to ensure that every single patient receives great care, every time.

Eight standards for creating scientifically valid and trustworthy clinical practice guidelines.:

establishing transparency
managing conflict of interests
following guideline development group composition
guidelines using high quality systematic reviews
establishing evidence foundations for and rating strength of recommendations
clearly articulating recommendations
using external review
periodic updating

Transparency in action:

Clinical practice guidelines make recommendations based on the balance between the **desirable and undesirable consequences of a particular diagnostic or therapeutic intervention**. A recommendation to perform or implement an intervention implies a greater net benefit compared to **not performing** or **implementing the intervention**; a recommendation against an intervention indicates a greater net harm.

The strength of each recommendation is determined by the level of confidence that the desirable effects outweigh the undesirable effects. Using a systematic approach such as GRADE can minimize bias and inconsistencies in determining net benefit/harm and level of confidence, and aid in the interpretation of the evidence used to support a recommendation.

GRADE is a systematic approach to **rating the certainty of evidence in systematic reviews** and **other evidence syntheses**.

The GRADE approach has several advantages over other recommendation grading systems, some of **which include:**

1) a clear separation between **evidence and strength of the recommendation**;
2) clear criteria for downgrading or upgrading the quality of evidence;
3) explicit evaluation of the relative importance of various outcomes;
4) acknowledgement of patients' values and preferences;
5) a transparent way of moving from the evaluation of evidence to making a recommendation;
6) clear recommendation even when there is very little available evidence; and
7) clear interpretation of "strong" and "weak" recommendations

One of the major barriers to **transparency** is access – access to time from healthcare providers and access to information

Transparency in healthcare systems leads to better patient experiences and improvements in the care delivered. Greater transparency on the performance of providers in terms of outcomes and patient satisfaction would go a long way. How are reviews of healthcare providers by individual patients reported? How do the outcomes differ among different providers who perform the same procedures?

Most patients would like to know the answers to these questions and would prefer to make an informed decision when choosing a provider.
However, there is limited data available comparing physicians for a given specialty
Transparency can also be improved at the hospital level. How is safety of a hospital measured and reported?
What are the overall complication rates of common procedures for a given hospital, and how do their results compare with other healthcare institutions?
Open reporting of a variety of common measures such as outcomes after surgical procedures, infections rates, and lengths of stay for different types of hospitalization can provide patients with transparent ways of evaluating where to get their care.
These measures can also provide institutions with ways of identifying important differences that may ultimately lead to improvements in care if the reasons can be identified and where correctable measures can be instituted

Transparency in DENTISRY promotes better quality and consistency of care at multiple levels in the healthcare system. It can also greatly improve the trust and overall relationships patients have with providers and ultimately promote better outcomes and satisfaction

Shared decision making

Shared decision making is a joint process in which a healthcare professional works together with a person to reach a decision about care.

It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values.

It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing

Benefits

- It allows people to discuss and share information. This makes sure people have a good understanding of the benefits, harms and possible outcomes of different options.
- It empowers people to make decisions about the treatment and care that is right for them at that time. This includes choosing to continue with their current treatment or choosing no treatment at all.
- It allows people the opportunity to choose to what degree they want to engage in decision making. Some people prefer not to take an active role in making decisions with their healthcare professionals

Evidence informed decision making:

Evidence-informed decision-making (EIDM) **entails identifying, appraising, and mobilizing the best available evidence for safe and effective health policy and programmes.**

Evidence-based decision making results in **a process in which an individual patient is informed of the best available evidence and all relevant options**. The outcome of the process is that patient utilities and cost concerns are fully addressed in optimizing the clinical decision.

Evidence-guided decision-making:

Evidence Based Decision-Making is a process for making decisions about a program, practice, or policy that is grounded in the best available research evidence and informed by experiential evidence from the field and relevant contextual evidence.

People in leadership roles often make decisions that affect the entire company, so it's important they have a sound process for making important choices.

Evidence-based decision-making is an approach that prompts professionals to use quantitative and qualitative data to develop informed plans. If you're considering implementing this approach, learning about it can help you decide if it's the right fit for you. In this article, we define evidence-based decision-making, explain how it works, share why it's important and offer some tips that can help you use this method effectively.

What is need the for EBDM?

1-The variation in practice patterns. Variations occur because of a gap between the time that current research knowledge becomes available and its application to care. Consequently, there is a delay in adopting useful procedures and in discontinuing ineffective or harmful ones.

Consequently, trends indicate the longer clinicians are out of school, the greater the gap in their knowledge of up-to-date care. Need for translating it into information that is useful for each decision maker, including the patient. The lack of or weak scientific evidence for answering specific clinical questions. In these cases, an evidence based approach serves another purpose by helping to inform the profession and investigators of needed research.

2-The difficulty that clinicians encountered in assimilating scientific evidence into their practices. Assimilating scientific evidence into practice requires keeping up-to-date through reading extensively, attending courses, and using the Internet and ~lectronic databases, such as MEDLINE (PubMed) and the Cochrane Library, **to search for published scientific articles.**
However, with the proliferation of clinical studies and journal publications, keeping current with relevant research is challenging. Consequently, substantial advances made in the knowledge of clinical health care has not been translated into practice or fully applied to allow patients to receive the total benefit.

3-To improve the quality of health care.

4-To demonstrate the best use of limited resources.

5-Evidence-based decision making is aimed at general practitioners to keep them abreast of the best available evidence on the latest developments in various aspects of clinical practice.

6-It is an invaluable tool for the specialist practitioners needing to maintain an awareness of new approach~s outside their branch of dentistry.

7-In addition it can help to promote self directed learning & teamwork & produce faster & better dentist

The components of evidence-based decision making:

Evidence-based decision making starts with the recognition of a knowledge gap. From the knowledge gap comes a focused question that leads on to a search for relevant information. Once the relevant information is located, the validity of the research needs to be considered in two broad areas.

Firstly, is the science good (internal validity)?
Internal validity focuses on the methodology of research.

Secondly, can the findings be generalized outside of the study (external validity)?
External validity might be affected by the way treatment was performed. For instance, if the time spent on treatment was extensive it might not be practical to provide this therapy outside of a research study. Another example could relate to the use of many specific inclusion criteria in a trial which could make it difficult to generalize the findings to a wider group of patients. The question the reader should ask is whether their types of patients are so different from the study that it is reasonable to expect differences in outcomes. After locating and appraising the research, the results then need to be applied clinically, or at least included in a range of options.

Finally, the results in clinical practice need to be evaluated to reveal whether the adopted technique achieved the expected outcome

Individualization and the standard of care based on a long-term goal for dental treatment

After completion of definitive phase therapy there will be remaining issues that must be addressed and rendered treatment that must be reevaluated. Some of these concerns will need attention for as long as the dentist-patient therapeutic relationship exists. In addition to their importance to patient care, good **maintenance phase** plans provide the patient-specific elements essential to the development of an organized, practicewide system of periodic care that serves as the backbone of a successful and productive dental practice.
Although this aspect of the treatment plan may seem less important at the outset, the maintenance phase represents a critical component of any complex treatment plan. In many cases, the long-term success or failure of the plan depends on it. As this chapter unfolds, it will become clear why the dentist should discuss long-term periodic care with the comprehensive care patient. Furthermore the rationale for initiating this discussion when the original treatment plan is presented will also become apparent.
Prevention of future problems is, of course, the guiding principle of the **maintenance phase**.

The DENTAL practitioner works throughout **all phases of treatment to educate the patient in strategies for maintaining a healthy oral condition and preventing future oral disease**. Certain aspects of a **systemic phase** may include activities that are preventive in nature. The acute phase may include treatment that has the effect of preventing disease progression. The disease control phase, by its nature, is **preventive in orientation**,

Nevertheless, **significant patient education** and the reinforcement of earlier oral hygiene instruction occur primarily during maintenance phase visits.

For that reason, preventive concepts and preventive therapy are emphasized in this chapter. The reader is reminded that it would be shortsighted and inappropriate for the practitioner to make prevention primarily the hygienist's responsibility and to attend to it exclusively in the maintenance phase.

Prevention must be the responsibility of the entire dental team and must be carried out throughout the treatment process.

The maintenance phase must be flexible and individualized, with timing and content specifically tailored to each patient's needs. Although formulated at the treatment planning stage, it will have been modified during the disease control and definitive treatment phases, and will take its final form at the posttreatment assessment, which is discussed in the following section. The dentist implements maintenance phase care through the periodic visit discussed in the final section of this chapter.

The term **periodic visit** or **recare visit** is preferred to recall visit, which suggests that something is defective and needs to be corrected. In contrast, maintenance services should by their very nature be timed and directed to accommodate the individual patient's needs. The American Dental Association (ADA) sanctioned procedure coding system uses the designation **"Periodic Oral Evaluation."** Consistent with that perspective, the terms "periodic examination" and "periodic visit" are used in this text.

THANK YOU

Ethical Decision Making and Conflicting Obligations

As part of a trend that has long been rooted in the complexification of organizations, individuals today handle an increasing number of **commitments at work**, manifested as involvement with and obligations to more and more stakeholders

These multiple commitments originate in organizational matrix structures that expose individuals to various hierarchical authorities in networked organizations where they face several stakeholders, or in the rise of alternative forms of employment, with the freelancers, external contractors, and other independent professionals of today's workplace .

The recognition that people are committed to multiple workplace stakeholders .However, in certain cases, ethical dilemmas emerge as a consequence of multiple, conflicting commitments, and generate severe individual and organizational costs . Against this backdrop, it is important to understand how individuals make ethical decisions in such conflicting situations. Our research question is therefore:

*How do individuals make decisions when **conflicting commitments create ethical dilemmas for them?***

There are a number of models of ethical decision making and action. For example, business ethics educators.

Six factors or elements that underlie moral reasoning and behavior and that are particularly relevant in organizational settings.

The first is moral imagination, the recognition that even routine choices and relationships have an ethical dimension.

The second is moral identification and ordering, which, as the name suggests, refers to the ability to identify important issues, determine priorities, and sort out competing values.

The third factor is moral evaluation, or using analytical skills to evaluate options.

The fourth element is tolerating moral disagreement and ambiguity, which arises when managers disagree about values and courses of action.
The fifth is the ability to integrate managerial competence with moral competence.

This integration involves **anticipating possible ethical dilemmas**, leading others in **ethical decision making**, and making sure any decision becomes part of an organization's systems and procedures. The sixth and final element is a sense of moral obligation, which serves as a motivating force to engage in moral judgment and to implement decisions.
The ethical action is the result of **four psychological subprocesses**: (1) moral sensitivity (**recognition**), (2) moral **judgment**, (3) moral focus (**motivation**), and (4) **moral character**.

Moral Sensitivity (Recognition) Moral sensitivity (recognizing the presence of an ethical issue) is the **first step in ethical decision making** because we can't solve a moral problem unless we first know that one exists.
A great many moral failures stem from ethical insensitivity. **A number of factors prevent us from recognizing ethical issues**.
We may not factor ethical considerations into our typical ways of thinking or mental models.4 We may be reluctant to use moral terminology (values, justice, right, wrong) to describe our decisions because we want to avoid controversy or believe that **keeping silent will make us appear strong and capable**.

We may even **deceive ourselves into thinking that we are acting morally when we are clearly not, a process called ethical fading**. The moral aspects of a **decision fade** into the background if we use **euphemisms to disguise unethical behavior, numb our consciences through repeated misbehavior, blame others,**.

, **and** claim that only we know the "truth.

Fortunately, we can take steps to enhance our ethical sensitivity (and the sensitivity of our fellow leaders and **followers) by doing the following:**
• Active listening and role playing • Imagining other perspectives • Stepping back from a situation to determine whether it has moral implications • Using moral terminology to discuss problems and issues • Avoiding euphemisms • Refusing to excuse misbehavior • Accepting personal responsibility • Practicing humility and openness to other points of view In addition to these steps, we can also **increase ethical sensitivity by making an issue more salient**.

Difficult Professional-Ethical Judgments:

Many professional-ethical judgments **are easy** and **straightforward** and, like most actions in other areas of our lives, they are mostly the result of good habits; rarely do they need to be carefully thought out and self-consciously chosen each time they arise. Of course, **thoughtful people carefully examine their professional habits** from time to time, as well as their other moral habits.

It is precisely reflection of this sort that legitimates the claim that actions done from habit are still rationally chosen actions, even though they are not the product of explicit deliberation in the situation.
The examples used in subject , **however, all focus on what a dental professional**, **thinking carefully** about a particular case, might consider when determining how to act in the case.

For all the centrality of habits in **our moral and professional lives**, though, there are three kinds of circumstances that can arise where determining *what one professionally ought to do* definitely requires explicit and careful deliberation on the alternatives at hand; these are :

(1) when a situation requires a professional to think about the limits of his or her professional obligations and, then, the extent to which he or she is committed to sacrificing other things for the sake of a patient,

(2) when one's professional obligations are themselves in conflict, and

(3) when a person's professional obligations conflict with other commitments or his or her obligations to other people.

The most difficult ethical dilemmas professionals ordinarily face involve one or more of these circumstances.

Yet none of them has been discussed very carefully in the dental ethics literature or **the literature on professional ethics generally**.

Discussing them here will not yield some tidy algorithm that readers can apply **to resolve difficult ethical questions**. This chapter aims, instead, to shed useful light on dentists' most difficult ethical decisions by first reflecting on the general structure of ethical thinking and then on the characteristics of each of these three sets of circumstances.

A Model of Professional-Ethical Decision Making:

When a dentist is faced with making an ethical decision in an unusual or ethically complicated situation, it can help a lot if the dentist has already reflected on the components of a carefully thought-out ethical decision. What will be proposed here, **then, is a *model* of the steps** of **professional-ethical decision-making**. Any model of decision-making is necessarily an oversimplification because it focuses on specific aspects of ethical thinking and treats them as separate "steps" of the decision-making process.

In actual ethical reflection, these "steps" are highly interdependent and **we do not completely finish Step Two**, for example, **before beginning Step Three**. Instead, we move **back and forth between the different steps**, learning from one of them that we haven't adequately answered another and gathering data from one of them that proves informative for another, and so on. It is still worthwhile, though, to carefully separate and describe the several distinct kinds of thinking involved in ethical decision-making. This is because, when an ethical decision is particularly complex, having a kind of "road map" of the steps involved can often be very useful.

Step Zero: Getting the Facts

This model presumes that the person using it has already carefully identified all the relevant facts—that is, about the situation, the people involved, the possible actions that might be chosen, the probability and possible outcomes of these actions, and so forth. It would obviously be a mistake to learn the steps of this model and then use it without always stopping to ask, **"Do I have all the facts I need, and have I understood them all correctly?**"
As with the other steps in this model, however, there is no assumption here that **we always finish Step Zero** completely and only then begin the rest of the process. Often our need to address the issues in a later step in the process requires us to "go back" and get some more facts or to check our facts again. This is because of factors we did not notice at first.
This model will not, however, attempt to describe the methods that careful thinkers use to "get the facts" they need. Therefore, "Getting the Facts" will be considered **"Step Zero"** in this model of Professional-Ethical Decision-Making.

Step One: Identifying the Alternatives

Step One consists of determining what courses of action are available to choose between and then identifying their most important aspects. Sometimes options are obvious from the facts of the situation and do not require one to stop and think carefully about it. But at other times it can be difficult to see what the alternatives are.

Certain circumstances about the situation, or our own habitual ways of perceiving and acting, can cloud our vision of what actions would be possible for us. So it is always useful to make a point of explicitly asking what courses of action are available to us and what would be the likely outcomes of each of these alternatives.

In addition, we will often need to ask about each of our alternatives, what other choices, for ourselves and for others, are they likely to lead to. It is also important to ask, in most situations, how likely it is that the various possible outcomes and future choices that we can envision will actually occur.

Dentists are typically well trained to identify the clinical alternatives for a given patient's presenting condition. Professional-ethical decision-making requires that dentists also carefully identify the alternative ways in which the dentist might act in relating to the patient or other persons involved and in responding to other nonclinical aspects of the situation.

Step Two: Determining What Is Professionally Important

Once the alternative ways in which a dentist might respond to a situation have been carefully identified, the dentist needs to examine them from the point of view of what ought and **ought not be done** ***professionally***.

Each of the identified alternatives must be examined from this point of view. The criteria to be used in this step of the decision-making process are the ethical standards of one's profession .

Step Three: Determining What Else Is Ethically Important

Each alternative must be examined specifically from the point of view of the broader criteria of what ethically ought and ought not be done. This step goes over and above the specific ethical standards of the person's professional life, for one's professional obligations never constitute the entire moral content of a person's life. Moreover, the professional standards themselves have become dentistry's professional standards for *certain reasons*; that is, they have been accepted by the profession and the larger community in dialogue as dentistry's ethical standards so that the dental profession and its members will serve their patients and the larger community well.

Therefore, if in a given situation specific professional-ethical standards conflict with one another, or if they fail to adequately direct which possible action would be professionally and ethically best in the situation, then the *reasons* behind the specific ethical standards should be considered—that is, the thinking that goes into determining what constitutes dentistry's serving its patients and the larger community well.
Situations will also arise when a dentist's other commitments conflict with his or her professional commitments; in these situations, even more fundamental moral categories will need to be considered.

The details of the thought process in such situations will depend on the particular approach that a person takes to ethical reflection in its "largest" or "deepest" sense. Ordinarily, at the most general level, people do their moral reflection chiefly in terms of maximizing certain values for certain people or possibly for everyone affected, conforming to certain fundamental moral rules, respecting certain fundamental rights, or actualizing certain human virtues. So the details of this process will ordinarily have one or the other of these structures, or it may combine several of them together.

Many professional-ethical decisions will not require the kind of ethical thinking described here as Step Three. This is because the decision can be properly made solely on the basis of the ethical standards of the dental profession. The careful professional-ethical thinker will make a point, though, of at least asking whether anything about the situation is ethically important in some other way or for some other reason.

Step Four: Determining What Ought to Be Done (Ranking the Alternatives)

The process of determining what is professionally important and, if needed, what is ethically important for other reasons will sometimes lead, without further effort, to the conclusion that one of the alternative courses of action is what ought to be done. At other times, matters will be more complex because the relevant professional standards, on the one hand, and other ethically important values, rules, rights, virtues, or other kinds of ethical reasons that you judge to be relevant, on the other hand, favor different courses of action. Then one's determination about what ought to be done becomes a careful judgment about which of these competing sets of ethical norms is more suited to be the determining factor in one's decision about the situation.

Trying to determine what ought to be done sometimes leaves a person with a choice between several equally superior alternatives. For example, one's leading alternatives can be functionally equal because of the person's inability or lack of time to get all the information needed to judge more carefully between them. Or the leading alternatives may be equal precisely in that, with regard to competing professional and ethical standards, neither is more suited than the other to be the determining factor in one's decision. In such cases of equally superior alternatives, one may morally choose either of them because they are equal in professional or ethical merit and they are superior to every other alternative considered.

When a person does carefully judge that several alternatives—that are ethically superior to all the others—are either equally suited to the situation or functionally equal because of lack of time or information, then the person must resolve the situation by *choosing* between them; the faculty of judgment will then have done the best it can under the circumstances. It is a presupposition of this model of professional-ethical decision-making that *choosing* to act in a certain way is a specific kind of activity that is distinct from the activity of professionally or **ethically *judging* about possible ways of acting**

Conflicting Professional Obligations Conflicts Between Professional and Other Obligations

When the **duty of the dentist in truth-telling** is conflicted with some other **moral obligations**, the conflict between **the prima facie duties arises.**

The principle-based ethical theories provide a suitable conceptual framework for moral judgement in such conflicts. In cases of conflicts related to truth-telling, a balance should be maintained between principles and rules such as fidelity, respect for autonomy, maintaining trust in dentist-patient relation, and best interest of patients. The decision in truth-telling should be made individually for each patient based on the specific contextual conditions.

This joint statement on 'conflicts of interest' sets out our expectations of health and care professionals in relation to avoiding, declaring and managing conflicts of interest across all healthcare settings. It is intended to support the standards or code for each profession and any additional guidance they may have.

These professional standards, codes and additional guidance should be the over-riding consideration for professionals.

We believe that given the increasing move towards **multi-disciplinary teams**, there is great value in working together for a consistent approach. We will promote this joint statement to our registrants, students, and to the public, to ensure they all know what we expect.

We will support this with case studies to illustrate the principles of the statement, and show how these issues might arise in different settings. We will encourage all registrants to reflect on their own learning and continuing professional development needs regarding conflicts of interest.

Handling conflicts of interest

Conflicts can arise in situations where someone's judgement may be influenced, or perceived to be influenced, by a personal, financial or other interest.

We expect health and social care professionals to:

•Put the interests of people in their care before their own interests, or those of any colleague, business, organisation, close family member or friend.

•Maintain appropriate personal and professional boundaries with the people they provide care to and with others.

•Consider carefully where conflicts of interest may arise – or be perceived to arise – and seek advice if they are unsure how to handle this.

•Be open about any conflict of interest they face, declaring it formally when appropriate and as early as possible, in line with the policies of their employer or the organisation contracting their services.

•Ensure their professional judgement is not compromised by personal, financial or commercial interests, incentives, targets or similar measures.

•Refuse all but the most trivial gifts, favours or hospitality if accepting them could be interpreted as an attempt to gain preferential treatment or would contravene your professional code of practice.

•Where appropriate, ensure that patients have access to visible and easy-to-understand information on any fees and charging policies for which you are responsible.

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Conscientious Disobedience of Professional Obligations

What is conscientious objection?

The problem that has not yet been removed from the list of unresolved issues. As the years go by, despite the jurisprudence that has been produced, there is a lack of positive legislation on the extent, intensity and methods of **conscientious objection** (CO) in the health sector. Lacking legal and medico-legal credentials, I will limit myself to some ethical and deontological considerations on the theory and the internship of odec. I will try to do so

Is, alongside **civil disobedience** or **evasive insubordination**, an attitude of social dissidence by which one rejects, for moral, professional or religious reasons, what is ordered by authority or the law.

Its peaceful character, **never violent**; its moral and religious rather than political basis; and its ultimate intention is to abstain from conduct which, **although socially permitted or administratively enforced**, is judged by the objector to be inadmissible.
It seems to me very important to retain these specific features of conscientious objection in report and in action.

The objector as such does not intend with his action to subvert or change the **prevailing political, legal or social status , as the civil disobedience activist does with his outward manifestations**, or the **insubordinate with his spectacular or aggressive protest actions**.

The objector is only trying to peacefully exempt himself from certain actions, without having to suffer discrimination or reduction of his rights as a consequence.
In medicine, the vast majority of **conscientious objection (CO)** is exercised within the **reproductive healthcare field —oral hygiene** particularly **for abortion and contraception**.

Current laws and practices in various countries around CO in reproductive healthcare show that it is **unworkable and frequently** abused, with harmful impacts on women's healthcare and rights. CO in medicine is supposedly analogous to CO in the military, but in fact the two have little in common.

The dental rules and regulations protects the physician's freedom of **conscience with the same intensity as it protects the patient's freedom of choice**. Since the physician is obliged to state to the patient that his or her conduct is based on reasons of conscience, he or she may not omit to state them in a clear, reasoned and simple manner. **Dentally** , objection cannot be, nor can it be expressed as, a whim. It would be repugnant as tool for hypocritical, changeable, opportunistic behavior. It must be, and be presented as, a **decision based on ethical reasons** and on confessable and defensible professional criteria.

With regard to **human quality**, the objector is obliged to treat with the **utmost respect the patient whom he or she** refuses care for reasons of conscience. The peaceful context repels moral insult, humiliation, self-righteous contempt. The objected status is an occasional event to be regretted, a situation of force majeure, an exception in a relationship that one wishes to preserve, which, on the part of the doctor, cannot end in an irrevocable disagreement, but in an offer to remain at the disposal of his patient if the latter so desires.

The doctor's door must also be open to those who have asked for a service that the doctor could not in good conscience provide.
Obviously ,the duty to provide any other medical care, antecedent or subsequent, to the person who is to undergo or has undergone the objected intervention, but who does not form part, not cooperate, morally with that specific intervention.

THANK YOU