

Patient autonomy as a necessary but limited ethical principle in shaping the dentist-patient relationship (*)

Jos VM Welie¹

¹Department of Interdisciplinary Studies - Creighton University
California Plaza Omaha, NE - USA

Corresponding author:
jwelie@creighton.edu

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ABSTRACT

Today, the ethical and legal organization of the therapeutic relationship is determined in large extent by the principle of respect for patient autonomy or self-determination. From it, the patient derives important legally enforceable rights, most notably the right to consent to (or refuse) any proposed dental treatment. And yet, historically and indeed by its very nature, this principle is actually foreign to the health care context. Patients do not seek to defend themselves against their dentists in the same way that citizens need protection against a potentially tyrannical government. We will argue that the principle of patient autonomy sets important legal boundaries to the therapeutic relationship. But it does little to cement the relationship itself. Rather, it is the ethical principles of beneficence and non-maleficence that structure the dentist-patient relationship

THE PRIMACY OF THE BIOETHICAL PRINCIPLE OF PATIENT AUTONOMY

The prevailing method of analyzing ethical dilemmas in clinical practice is to apply various principles of health care ethics. Several authoritative lists of such principles exist, ranging from the short three-principle list proposed by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in its groundbreaking *Belmont Report* from 1978,¹ to the *Universal Declaration on Bioethics and Human Rights* adopted by UNESCO in 2005² which, depending on how one counts, contains at least 20 principles. The most widely known enumeration is surely the one proposed by the American bioethicists Childress and Beauchamp in their classic handbook *Principles of Biomedical Ethics*, first published in 1979³ and currently in its eight edition⁴: Autonomy, non-maleficence, beneficence, and justice.

As the order of the Beauchamp & Childress list suggests, the principle of autonomy – or as it is known in full, the principle of respect for patient autonomy – is generally considered to be the most important principle. A cursory review of the scientific literature likewise reveals that of these four, the principle of autonomy is discussed far more often than any of the other three principles (see Table 1).

One also finds this principle back in many professional codes of ethics, including codes of dental ethics. When in 1996 the American Dental Association (ADA) decided to completely restructure its Code around five principles, the first listed was the principle of autonomy.

Table 1. PubMed Search Results

The Primacy of Autonomy: PubMed					
Ethics AND AND		Autonomy	Justice	Nonmaleficence	Beneficence
	206,230	20,072 (9.7%)	13,775 (6.7%)	4,067 (2.0%)	4,006 (1.9%)
Dentistry	3770	279 (7.4%)	177 (5.0%)	97 (2.6%)	94 (2.5%)
Pharmacy	2039	93 (4.6%)	52 (2.6%)	37 (1.8%)	35 (1.7%)
Nursing	22,337	2,571 (11.5%)	1,173 (5.3%)	558 (2.5%)	554 (2.5%)
Ethics AND AND		Autonomy*	Justice**	Nonmaleficence	Beneficence
	206,230	18,879 (9.2%)	13,633 (6.6%)	4,067 (2.0%)	4,006 (1.9%)
Dentistry	3770	246 (6.5%)	176 (4.7%)	97 (2.6%)	94 (2.5%)
Pharmacy	2039	83 (4.1%)	51 (2.5%)	37 (1.8%)	35 (1.7%)
Nursing	22,337	2,107 (9.4%)	1,168 (5.2%)	558 (2.5%)	554 (2.5%)

* ANDNOT “professional autonomy” ** ANDNOT “justice system”

The 2018 version of the ADA’s *Principles of Ethics and Code of Conduct* defines autonomy as “self-governance” and then elaborates that “the dentist has a duty to respect the patient’s rights to self-determination and confidentiality.”⁵

It is debatable whether the duty to maintain confidentiality can be subsumed under the principle of patient autonomy.* Suffice it to say here that respect for the patient’s autonomy – a Greek word variously translated as self-law, self-governance, and self-determination – requires the dentist “to treat the patient according to the patient’s desires, within the bounds of accepted treatment.... Under this principle, the dentist’s primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient’s needs, desires and abilities...”. Practically, this means that “the dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions”.⁶

Similar language can be found in other codes of dental ethics. For example, the Canadian Dental Association *Principles of Ethics* from 2015 includes the principle of “respect for autonomy” which it defines as “respect the patient’s right to choose.” The document elaborates that “patients have the right to be fully informed and make choices for, and actively participate in, their care and pursue their personal values, beliefs and goals in

achieving their optimal oral health.”⁷ The German Dental Board in its 2017 *Code of Professional Conduct* includes in §2 on professional duties the statement that “the dentist is in particular obligated to respect the patient’s right to self-determination.”⁸ And the Indian Dental Association’s *Ethics Code* includes in the section on “Duties of Dental Practitioners to Their Patients” a paragraph entitled “Patient Autonomy”: “The patient has the right to choose, on the basis of adequate information, from alternative treatment plans that meet professional standards of care.”⁹

Some codes of dental ethics do not specifically mention autonomy, but go directly to the single most important operationalization of this ethical principle, that is, the duty to obtain patient consent prior to treatment. For example, the Royal Dutch Dental Association in its *Code of Conduct* from 2000 notes that “the dentist needs the permission of the patient for the intended examination and the proposed treatment.”¹⁰

A remarkable absentee in this list of codes of dental ethics is the FDI-World Dental Federation. The FDI’s *International Principles of Ethics for the Dental Profession*, adopted in Seoul, Korea in 1997, makes no mention of patient autonomy nor of the patient’s right to consent to or refuse a proposed intervention.¹¹ The closest reference to the principle of respect for patient autonomy surfaces in the FDI’s the *Basic Rights*

and Responsibilities of Dental Patients, adopted in Dubai, UAE in 2007.¹² There we find that dentists must exhibit “necessary concern for [patients’] reasonable preferences”; furthermore, dentists must provide patients with “encouragement to participate in decision-making processes affecting their oral health care.” But as the quotes make clear, these obligations are not formulated in very strong terms (“concern” instead of “respect” for patient preferences, and “encouragement to participate” instead of a “right to consent”).

The FDI, while an exception among the other dental associations discussed above, is not completely aberrant in its failure to assign the principle of respect for patient autonomy a prominent place among the norms guiding dental practice. There are two good reasons for not doing so. The first is historical, the second concerns the scope of patient autonomy.

SOME NOTES ON THE HISTORY OF THE PRINCIPLE OF PATIENT AUTONOMY

Historically, we need to be mindful that the principle of patient autonomy is a very modern invention, roughly one century old. In that sense, it stands in marked contrast to the principles of beneficence and non-maleficence. We can find the latter two already in the *Hippocratic Oath*.¹³ In fact, each of them is referenced twice: “I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. ... Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm.” But one looks in vain for a reference to the concept of patient self-determination, right to choose, or consent. The same is true for later, pre-20th-century oaths and codes. And why would there be such a reference? For on closer inspection, it seems rather odd to place so much emphasis on patient self-determination. For isn’t it exactly the disease-induced inability of a person to lead life as (s)he sees fit that brings that person to visit a health care professional? And isn’t it exactly the professional’s expertly designed treatment plan that will benefit the patient while minimizing harmful side-effects, and that the patient hence desires so as to restore his/her own ability to live life as (s)he sees fit? So why

this emphasis on patient self-determination, choice and consent?

If one could ask the author of the Hippocratic Oath why he had failed to include patient autonomy, he would have likely responded that this principle does not need to be included as long as the physician takes the principles of beneficence and non-maleficence seriously. It is only if we distrust the intentions and/or abilities of service providers to competently care for us that we need something like a principle of respect for autonomy. But the relationship between health care provider and patient is one of trust, a fiduciary relationship.

Or is it? Is the therapeutic relationship still essentially a relationship of trust? The Canadian Dental Association in the aforementioned *Principles of Ethics* guide insists that “trust is the cornerstone of the dentist-patient relationship and the contract between the dental profession and society.” It next lists four specific virtues under the header of trust: Honesty, competence, fairness, and accountability. Interestingly, it does not include “respect for autonomy” in this section (but lists it instead under the header “Health”).

The hypothetical response of the author of the ancient Hippocratic Oath and the CDA’s placement of the principle of patient autonomy in its 21st century code reflect an important historical change in our understanding of the relationship between health care provider and patient. This change mimics even more dramatic changes that took place in our understanding of the morally right relationship between people in general and those who claim to be their guardians, that is, the government. By the time the United States of America emerged as a new country, the old medieval order in which monarchs were obligated to safeguard the well-being of those they governed, and the people were expected to exhibit trusting allegiance, had been thoroughly uprooted. Instead of trust, consent of the governed became the foundational political principle. The “natural” state of human beings was thought to be one of freedom from such predetermined allegiances and all other communal ties and binds, except if freely engaged in. Or in the words US Declaration of Independence: “Governments are instituted among Men, deriving their just powers from the consent of the governed.”¹⁴

This idea then migrated to other areas of social life in which power differences shape the relationship between people, including the doctor-patient relationship. And so we find, roughly a century after the American Revolution, American courts applying this political principle to the health care context. In 1891, US Supreme Court Justice Gray argued that a person, even one suing for bodily damages, cannot be forced by a court to undergo a medical examination: "No right is held more sacred or is more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestionable authority of law. ...The right to one's person may be said to be a right of complete immunity; to be let alone" (Union Pacific Railway Co. v. Botsford, 141 U.S. 250 (1891)). Indeed, a surgeon who performs an operation without his patient's consent commits an assault, thus Appeals Court Justice Brandeis (Schloendorff v. Society of New York Hospital, 105 N.E. 92 (N.Y. 1914)).

Maybe even more remarkable than the courts applying to the health care context this new right to be left alone, is the very similar line of reasoning put forward by Pope Pius XII in 1957.¹⁵ While struggling with the question whether and when a physician may apply a life-sustaining medical intervention to an unconscious patient, the Pope considers that "the doctor has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission." The Pope does not elaborate on the reasons for this acknowledgment of what we now label as the principle of respect for patient autonomy. But from a Judeo-Christian perspective, we can understand that principle to be grounded in the conviction that human beings must freely accept their own calling and must freely "will" to undertake the actions needed to fulfill that calling. Somebody else cannot fulfill my God-given calling for me.

The latter line of reasoning is analogous to the Kantian understanding of autonomy. The German philosopher Immanuel Kant (1724-1804) is often referenced in contemporary discussions about patient autonomy. In fact, most of these references are highly questionable because Kant's understanding of autonomy has (virtually) no

relationship to the contemporary idea of individual self-determination and subjective choice. For Kant, we are autonomous when and because we discern and then freely submit ourselves to rational, universally binding moral rules, as opposed to being guided by other forces such as coercion, appetites, fears, or self-interest (which would render us heteronomous).

A NEGATIVE OR LIBERTY RIGHT

We are now in a better position to define the moral core of patient autonomy: Even if a person is in need of, wants and voluntarily seeks out medical care, the patient's dignity, the inviolability of his/her body, and the individual's right and responsibility to freely do what is good, preclude even the most benevolent health care provider from treating the patient without the latter first authorizing the provider to do so. Consent is a necessary requirement for medical treatment. In other words, somehow consent must be obtained before treatment of any kind can be initiated.

Preferably that consent is an explicit and informed consent given by the patient him/herself. The second best consent is probably an implied consent, that is, a consent implied by a previous explicit act by the patient (e.g., coming to a dentist's office implies consent to the dentist taking a history and doing a basic physical exam). If the patient is not competent to consent, a consent given in advance by the patient while still competent (i.e., in a so-called living will) would be preferable. A substituted consent given by a third person authorized by the patient or a court also qualifies, as does a parental consent for treatment of minors. Finally, there is the option of a presumed consent in case of genuine emergencies. But somehow, consent must be obtained before a medical intervention can be initiated. The good that can come from such interventions, even the good of sustaining human life, does not justify forcing such interventions onto the patient. Ultimately, the patient has a right to be left alone.

In technical terms, this means that patient autonomy generates a liberty or negative right. It is the right to be *free from* medical interventions, that entails a duty on others *not* to do something towards the patient (i.e., *not* to treat). It is important to note that autonomy does not generate a positive right, that is, a claim right or

entitlement. Respecting autonomy does not entail a duty on others *to do* something for the patient. Hence, the patient cannot, in reference to the principle of respect of patient autonomy, demand certain medical interventions; the patient can only refuse them. This is because the health care provider likewise has a right to respect of his/her autonomy.

The professional's right to autonomy is admittedly a more limited right than the patient's. For example, it is widely acknowledged that in emergencies, health care providers may not refuse treatment to patients that is urgently needed and that can be competently provided by them. But the provider's own right to professional autonomy does include the right, even the duty, not to embark on treatments that cannot be justified medically, even if the patient wants them.

This also explains why the primary operationalization of the bioethical principle of respect for patient autonomy is the patient's right to consent. "Con-sent" literally means "with-agreement", that is, agreement with one of the treatment plans suggested by the health care provider. So when it is said that respect for patient autonomy obligates the dentist to fulfill the patient's choice, that obligation is limited to so-called medically indicated treatments agreed-to by the patient.

Hence, we find the American College of Dentists (ACD) in its *Core Values & Aspirational Code of Ethics* under the header "autonomy" remind dentists that "patients have the right to determine what should be done with their own bodies. Because patients are moral entities, they are capable of autonomous decision-making. Respect for patient autonomy affirms this dynamic in the doctor-patient relationship and forms the foundation for informed consent... The patient's right to self-determination is not, however, absolute. The dentist must also weigh benefits and harms and inform the patient of contemporary standards of oral health care."¹⁶ What the ACD calls "contemporary standards of oral health care", the ADA calls "accepted treatment". Hence, the principle of autonomy "expresses the concept that professionals have a duty to treat the patient according to the patient's desires, within the bounds of accepted treatment..."¹⁷

This insistence on meeting objective, scientifically determined standards of care, even if the patient is explicitly and persistently

demanding something beyond those standards, underscores that patients, though fully free and rational, can still make choices that will actually harm them. Respect for patient autonomy requires health care providers to not force beneficial treatments onto the patient. Even if death is the outcome, coercion is still considered a greater violation of the dignity of the human person and undermines the possibility of moral action. But if a patient demands some intervention from the dentist that is objectively harmful to the patient, the health care provider is not obligated to facilitate the patient's self-harming choices.

THE SCOPE OF THE PRINCIPLE OF PATIENT AUTONOMY

The latter line of reasoning assumes that health care providers can in fact determine what is objectively beneficial and what is harmful to patients, such that they can recommend a (range of) treatment options from which patients can choose the one that best meets their particular needs. This is an age-old assumption. And since ancient physicians had few objectively beneficial options to offer their patients, the author of the Hippocratic Oath in our hypothetical dialogue sketched above would not have seen a need to include a specific reference to patient autonomy. But it is exactly this assumption that has come under fire in recent decades, particularly since the latter quarter of the 20th century.

The modern popularity of the principle of respect for autonomy reflects not only and maybe not primarily concerns about authorization, but today's struggle to meet the demands of beneficence and non-maleficence. For even though biomedical science has skyrocketed in the past half-a-century, and with it the ability of the health care professionals to provide effective treatments, there is ever more doubt that health care professionals can know what is in the best interest of an individual patient. One of the dominant assumptions in modern bioethics is that the health care professional cannot know the preferences, interests and values of an individual patient, unless the patient makes those known. So the only way to fulfill the principles of beneficence and non-maleficence is to do what the patient requests. It seems, then, that the principles of beneficence and non-maleficence have become subcategories of the principle of autonomy.

We can see this shift most dramatically in debates about the legalization of physician assisted suicide and euthanasia: Even death, traditionally considered the greatest harm that health care providers should strive to prevent and fight against, can become a benefit that should be brought about by physicians when and because the patient wants it. Similar considerations propel the field of reproductive medicine, facilitate the sale of blood, sperm, eggs and other tissues, and justify direct-to-consumer advertising of prescription drugs. It is employed by commercial companies to persuade people to undergo genome scans. And in dentistry, it facilitates the merger of interventions aimed at improving health and those aimed at improving beauty.

For sure, it has long been acknowledged that biomedical science can only determine what is beneficial or harmful for categories of patients who share a particular characteristic. Dental science – by definition – only yields generic knowledge that is statistically probable. Dental science cannot, in and of itself, tell the dentist what will benefit *this unique* patient. So to really do good, the dentist must – as pointed out by the FDI – encourage the patient to participate in the treatment planning. This participation occurs when the dentist takes the patient’s history; when the dentist ascertains the patient’s concerns, wishes and expectations; when the dentist uses empathy to learn more about the patient as a person, particularly if the patient is non-communicative; and when the dentist carefully observes the patient to determine the impact of various interventions. All of this has traditionally been understood not as a matter of respecting patient autonomy but as acting beneficently.

If, on the other hand, the definition of the patient’s good is purely subjective and hence beneficence is a matter of respecting patient autonomy, it becomes very difficult to draw lines between a root canal, the placement of esthetic veneers, and a person’s attempt to change his appearance into that of a lizard. The dentist then becomes a technician, who can determine which of the client’s wishes can be effectively realized using dental techniques, but who cannot judge whether the outcome is beneficial or harmful to the patient.

We have seen that the ADA, while listing patient autonomy as the first of five principles, has subsumed neither beneficence nor non-maleficence under autonomy; they remain

independent principles in the ADA’s *Code of Ethics*. But on closer inspection it appears difficult to distinguish between autonomy and beneficence. The only difference seems to be that autonomy is defined as “abiding by patients’ choices while also meeting the standard of care,” while in beneficence, the order is reversed: “meeting the standard of care while also abiding by patients’ choices” (Table 2).

A subsumption of beneficence and non-maleficence under patient autonomy negates the clinician’s ability to reach a clinical judgment about the care of an individual patient and as such goes against a 2500 year-old tradition of understanding the nature of medicine as both a science and an art. But it not only underestimates the health care professional’s ability to care for individual patients; it also overestimates the ability of the individual patient to determine what is in his/her best interests. It assumes that patients can easily determine what will medically benefit or harm them as long as they are adequately informed. Moreover, it assumes that patients want to be in charge of their own health care. The Dutch Patient Federation has even adopted as its main motto “the patient behind the wheel” (De patient aan het stuur), while also using the metaphor of patients directing their own care in the same way a movie director directs the making of a film.¹⁸

Table 2. ADA code of ethics

American Dental Association – Code of Ethics

Section 1 - PATIENT AUTONOMY

This principle expresses the concept that professionals have a duty to treat the patient according to the patient’s desires, within the bounds of accepted treatment, ...

Section 3 - BENEFICENCE

...The most important aspect of this obligation is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration being given to the needs, desires and values of the patient.

Now there is no question that many, maybe most patients, want to be partners in their care planning; they want truly beneficial care, that is, care that meets their specific and unique needs

and interests. But to many patients, exercising their autonomy is not a cherished right but a heavy burden, and hence they frequently will ask "What would you do doc?" This burden becomes even more daunting when family members are expected to make difficult health care decisions on behalf of incompetent family members, such as minor children or parents with Alzheimer's dementia. Conversely, when a maxillofacial surgical team tells the parents of a child with Down syndrome, "We have decided not to attempt surgery to 'normalize' your kid's appearance," they thereby take onto their own shoulders part of the decision-making burden, even if the parents themselves had previously expressed hesitation to give-in to social pressures and submit their child to this purely esthetic operation.

Patients should not expect the health care provider to respect their autonomy, while also wanting the health care provider to shoulder the full responsibility for the decisions made. This is why the UNESCO in its *Universal Declaration on Bioethics and Human Rights* combines the two into one: "Article 5 - Autonomy and individual responsibility: The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected ..." But health care providers should not, under the guise of respect for patient autonomy, turn autonomy from a patient's right into a patient's duty. In is therefore troublesome that in American care facilities, patients must sign consent forms even before they are being seen by a health care provider; that consent forms are increasingly designed as risk management documents to protect the care provider against complaints or malpractice suits; and that the verb "to consent" is now changing from an active verb ("Mr. P. consents to the treatment") into a passive verb ("Mr. P. has been consented").

RECAPITULATION

Our cursory review of the history of the bioethical principle of respect for patient autonomy has revealed its origins to be primarily political and reflecting concerns about power differences unduly restricting the freedom of the more vulnerable individuals in human relationships. In the words of the American Supreme Court justice Brandeis, "The makers of our Constitution ... conferred

the right to be let alone" (Olmstead v. United States, 277 U.S. 438 (1928)). Of course, patients do not visit dentists because they want to be left alone. And from that perspective, it makes little sense to list autonomy as a normative principle guiding health care, let alone as the principal such principle. There are, however, other important reasons to respect patient autonomy, specifically the intrinsic dignity of the human person, the inviolability of the patient's body and mind, and the importance of individual freedom for any moral course of action.

The health care provider has a duty to act beneficently and first and foremost not to harm the patient. But that duty only takes effect once the patient has authorized the health care provider to treat. The health care provider does not have a duty (nor a right) to treat independently of the patient's own duty to be a good care taker of his/her life and health. By consenting to treatment, the patient both authorizes the dentist to treat him/her, and assumes joint responsibility for that treatment and its outcomes. Consent, understood as authorization, thus becomes a necessary condition of any dental intervention. However, the principle of respect for patient autonomy should not be "exploded" to comprise a variety of normative aspects that are not properly a matter of autonomy. Most notably, respect of patient autonomy should not become an excuse for dentistry to evade the difficult scientific and clinical challenge of determining the best interests of individual patients. Dental science is always only statistically true. To determine a treatment plan that will benefit a unique patient here and now necessitates active involvement of and participation by the patient. But such participation should not be understood as an exercise of patient autonomy. Instead, it is the operationalization of the ancient bioethical principles of beneficence and non-maleficence. It is in the ongoing dialogue between health care provider and patient, that the patient's best interests can be determined and translated into a scientifically supported and effective treatment plan. Patient autonomy only takes center-stage towards the very end of this constructive process when the patient authorizes the dentist to implement the mutually agreed-upon treatment plan.

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NOTES

* The UNESCO Declaration does not subsume the duty to maintain confidentiality under the principle of autonomy but dedicates a separate principle to it. There are many other reasons to

question the ADA's subsumption. Historically, it is questionable since the duty to maintain confidentiality can be found in documents as ancient as the Hippocratic Oath, whereas the duty to respect patient autonomy is a 20th century addition to such normative documents. More importantly, the right to autonomy is a negative right or liberty right, as explained later. It requires others, specifically health care providers, *not* to do something, that is *not* to treat or otherwise intervene in the patient's life, body, and mind. In contrast, the duty to maintain confidentiality requires dentists to undertake a variety of steps to assure that no information about the patient can be accessed by others, such as designing the office so that nobody can eaves-drop on conversations between dentist and patient, and locking up medical records or encrypting electronic such documents.

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