Dental Practice Management: Six Modules Covering Seven CODA Competencies (STUDENT VERSION)

Richard Manski, Principal Investigator and Executive Editor
Brian Lange, Chief Editor
Joel Kabot, Technical Editor

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The authors and editors would like to thank the American Dental Education Association (ADEA) for its administrative support. The authors and editors would like to recognize and thank the DentaQuest Partnership for Oral Health Advancement for its generous financial support.

The Dental Practice Management Modules in this document were created as part of a special project conducted independently of ADEA. Any opinions expressed are those of the authors and do not necessarily represent ADEA.

HISTORY OF THE PRACTICE MANAGEMENT PROJECT

Over several years, faculty from many dental schools charged with teaching practice management had asked the section on Practice Management for help in finding resource material. At the 2016 March meeting of the American Dental Education Association, the section on Practice Management voted to coordinate the development of a practice management resource curriculum. It was determined that the curriculum would focus on CODA standards. DentaQuest was approached with the idea and agreed to provide funding for the project. A process was developed to identify potential authors. Potential authors were asked to submit curriculum proposals. Proposals were reviewed by a committee from the Practice Management Section and authors selected. After authors submitted their material, it was placed in the format you will find below.

When this project was approved the following served as the section officers:

Dr. Richard Manski, Chair
Dr. Andrew Schwartz, Chair-Elect
Dr David Thein, Secretary
Dr. Brian Lange, Councilor

Over the last three years, Dr. Dieter Schonwetter, Dr. James Harrison, and Dr. James Cottle served as section officers. All significantly contributed to this project.

PREFACE

Dental educators have many challenges to meet the requirements of a competency-based curriculum. Competencies must be designed to ensure that our students can properly demonstrate the skills, knowledge, and values associated within a given Commission on Dental Accreditation (CODA) standard. The scope of dental education has created significant demands on faculty resources and course schedules.

Therefore, we have utilized the resources within dental schools to create common solutions to the design and format of competencies. Our program involve six competencies within the CODA standard under Practice Management, Health Care Systems, Ethics, Professionalism, and Behavioral Science. Educators in the fields of Dental Practice Management, Behavioral Science, Public Health, and other related disciplines have been asked to design competency modules for all schools to utilize. These modules reside in the public domain and are available to all dental, dental hygiene, and other related students registered at a CODA-accredited school.

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*Competencies are taken from the July 1, 2019 version of CODA's *Accreditation Standards For Dental Education Programs*.

EFFECTIVE VERBAL AND NONVERBAL THERAPEUTIC COMMUNICATION

Dieter J. Schonwetter, PhD, MA
University of Manitoba College of Dentistry
Kathy Yerex, BS
University of Manitoba School of Dental Hygiene

CODA competencies covered:

2-16 Graduates must be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving, and maintaining oral health.

2-20 Graduates must be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

Intent: In attaining competence, students should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences, that involve working with other healthcare professional students and practitioners. Students should have educational experiences in which they coordinate patient care within the health care system relevant to dentistry.

NOTE TO SUPERVISING FACULTY

The Practice Management Section's intent is that the teaching of each module be interactive. Students will be able to access the student modules only. You can use any of the material that you have access to in the expanded module, the appendix, to lead discussions, and present material. Each appendix represents the author's module before being edited for student use. The appendices are designed to be your resource material.

The evaluation section is for your eyes only. We request that you do not share any of evaluation material. We ask that you use the same procedures you use in protecting your test material.

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EFFECTIVE VERBAL AND NONVERBAL THERAPEUTIC COMMUNICATION MANUAL

Dieter J. Schonwetter, PhD, MA
University of Manitoba College of Dentistry
Kathy Yerex, BS
University of Manitoba School of Dental Hygiene

Overview

Effective therapeutic clinical communication (ETCC) is critical for positive oral and general health outcomes[1-4] and essential because the nature of the oral healthcare provider-patient relationship is changing from one of unquestioning trust to increasing negotiation.[5] This shift includes increased patient expectations: for oral healthcare providers to listen, to pay attention to patient concerns, to treat patients as individuals, and to involve patients in their own health care.[5-9] A recent survey showed that dentists do not communicate adequately with their patients and reported the reputation of oral healthcare provider as "resting on precarious levels of trust and skepticism."[7] Dental education must adapt to adequately address oral healthcare provider communication skills.[10] In response, a new empirically derived oral healthcare model of ECC has been developed[11-13] to enable education and assessment of the quality of provider communication on five domains of effective clinical communication. These domains include: Caring and Respectful, Sharing Information, Tending to Patient Comfort, Interacting with Other Team Members, and Experience with Other Dental Team Members.[11-13] Just as important as verbal communication, is nonverbal communication. What we do not say can have a greater impact than what we do say: Over 90 percent of interpersonal communication happens nonverbally and can leave a longer lasting impression than our verbal communication.[14] Kinesics (body movement), facial gestures and expressions, proxemics (degree and effect of spatial differences between individuals), smell, touch, eye contact, showing empathy and tone are all components of our nonverbal communication skills.[14] Developing effective nonverbal therapeutic communication skills is critical for all oral health professionals to build trusting patient-provider relationships, improve patient satisfaction and to improve oral health outcomes.[14,15] The proposed ETCC learning module will provide students with an overview of effective clinical verbal and nonverbal communication and a number of hands-on experiences in communicating effectively with patients.

The module content includes a definition of ETCC model; evidence-based research literature supporting the impact of ETCC on patient compliance, satisfaction, and oral health behavior change; the importance of questioning; and a section on ETCC with a sensitivity to multiculturalism and the work environment all within the context of the ethics of the dental and dental hygiene professions. The sources of the module content are based on first author's extensive research (last 12 years), current literature on ETCC, and best practices and golden standards in dentistry. The module includes up to nine hours of instruction, two hours of student activities and six hours of clinical application.

1. Introduction to Verbal Effective Therapeutic Communication

Communication is an interactive process that sends some meaning, information, message, emotions, and/or beliefs from one person to another or to a group. Communication can occur through spoken or oral communication, written communication, body language and gestures, or nonverbal communication.

For communication to occur and achieve its goal requires various components. First, the sender of the message must be able to create and express the message. Second, the receiver of the message must be able to process the message and then effectively reply to the message.[16]

Effective therapeutic communication (ETC) is interpersonal communication between the patient and health care provider (HCP) with the intent of consciously influencing the patient in beneficial directions and actions to promote and advance the physical and emotional well-being of a patient[13,17,18] while maintaining a level of professional distance and objectivity.[19] "Therapeutic" relates to the science and art of healing or dealing with treatment or beneficial act.[20,21]

Benefits resulting from effective communication skills by health care practitioners include:[12,13]

- higher patient satisfaction;[22,23]
- improved care outcomes;[11,34-36]
- decreased patient anxiety;[29,30,36-38]
- higher patient-rated clinical proficiency;[30]
- improved patient adherence to recommendations;
- reduced risk of malpractice claims; and
- increased return patient rates.[36,37,39-41]

Factors

Many factors impact and adversely affect communication. These include:

Age and Developmental Level. Young children will respond differently than adults. The same might be the case for older adults who might be in assisted living for whom communication might be challenging. The HCP will assess the patient's communication needs in respect to his or her specific age and developmental status and modify care accordingly to these age-related needs.[17]

Consciousness Level. Some patients are fully able to communicate, while others may be only able to send a message or receive a message effectively; others are unable to do either. The HCP needs to assess the patient's communication needs in terms of his or her level of consciousness and plan care accordingly.[17]

For example, an HCP might communicate care and her presence to a nonresponsive patient through touch, or use pictures to communicate messages to a nonverbal patient.[17]

Emotional and Stress Levels. Patients adversely affected with stress and other emotional states such as anxiety, fear, distress, and confusion will have challenges communicating. Thus, the HCP needs to alleviate these barriers to effective communication.[17]

Relationship Dynamic between Patient and HCP. A patient who perceives the HCP as one with power and authority will respond differently than a patient who perceives the HCP as someone who is mutually exchanging a message and makes the patient feel that he or she is in a position of power and able to make decisions. The HCP must establish trust with the patient to encourage a patient-centered care practice.[17]

Language. Patients who communicate in a language other than English may require interpreters. Patients with profound hearing loss may require American Sign Language interpreters and blind patients may require Braille reading materials.[17]

Culture. Culture is a set of established beliefs, values, and preferences that are unique to a certain group of people and have been handed down from generation to generation. Culture influences patients' use of terms and terminology as well as their perceptions of nonverbal messages. Some cultures view eye contact, touch, and proximity as culturally acceptable and therapeutic, while other cultures may consider them offensive. The HCP needs to be sensitive to these differences.[17]

HCPs practice must incorporate cultural needs (i.e., beliefs, values, and preferences) to provide care that is individualized and appropriate to the patient's needs.

This includes:[42]
• Identifying a patient's culture and its impact on perceptions, beliefs, values, experiences with health, wellness, illness, suffering, and even death.
• Accepting, welcoming, and being respectful of human diversity.
• Facilitating more holistic assessments and plans of care based on the patient's culture.
• Embracing the importance of the whole person vs. a set of symptoms or illness.
• Integrating his or her full and in-depth cultural knowledge into the treatment of patients.
• Developing and integrating open-mindedness into care, which can lead to innovative, nontraditional, and/or alternative interventions.

Individual Values, Beliefs, Perspectives, and Perceptions. Some patients will perceive what they hear or see based on their own values, perspectives, perceptions, and beliefs, rather than an objective view or perspective. This may include gestures and other forms of body language. HCPs need to assess patient values, beliefs, perspectives, and perceptions, as they impact communication. For example, an HCP should interpret a patient's nonverbal grimacing as either a sign of pain or a sign of disgust.[17]

ETC Techniques

ETC involves a variety of technical skills in combination with social/interpersonal competence. Technical skills are more easily observed and include eye contact, types of questions asked, time of silence, etc. Social/interpersonal competence is usually subtle, including the ability to

demonstrate active listening, a patient-centered approach, unconditional positive regard, empathy, rapport, interpersonal trust, the platinum rule, as well as the ability to communicate information effectively with a patient.

Active Listening. This involves the HCP hearing, processing, and purposefully comprehending the patient's words; the context of the patient's situation; and the patient's nonverbal communication.[17] By using nonverbal (see the nonverbal unit for more details) and verbal cues such as nodding and saying "I see," HCPs can encourage patients to continue talking. Active listening involves showing interest in what patients have to say, acknowledging that you are listening and understanding, and engaging with them throughout the conversation. HCPs can offer general leads such as "What happened next?" to guide the conversation or propel it forward.[19]

Patient-Centered Communication. A therapeutic provider-patient alliance involves:[43]
• Valuing people as individuals;
• Holistic understanding of the individual;
• Negotiation, compromise, and active participation for shared responsibility;
• Autonomy to make decisions;
• Affirming and useful communication; and
• Incorporation of the patient's perspective, values, and beliefs.[17]

Unconditional Positive Regard. An unconditional positive regard also builds the patient-clinician relationship through:[44]
• Believing that the patient is inherently good;
• Accepting patient for who he or she is;
• Viewing the patient with dignity;
• Offering care with no preconditions;
• Requiring no reciprocation or demands; and
• Not judging.

Empathy. Empathy demonstrated by the HCP goes a long way in building the relationship with the patient.[45,46] Webster's Dictionary (2019) defines empathy as:

"The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner."

Rapport. Webster's Dictionary (2019) defines rapport as:

"a friendly, harmonious relationship[.] [E]specially: a relationship characterized by agreement, mutual understanding, or empathy that makes communication possible or easy."

There are three types of rapport:

Emotional Mirroring.
• Empathizing with someone's emotional state by being "on their side."

• Listening for key words and problems that arise when speaking with the person.
• Aims to better understand what patients are saying and showing empathy toward them.

Posture Mirroring.
• Matching the tone of a person's body language (but not doing so through direct imitation, or mockery.
• Mirrors the general message of their posture and energy.

Tone and Tempo Mirroring.
• Matching the tone, tempo, inflection, and volume of a person's voice.

Developing rapport can be accomplished in two ways: **reciprocity** and **commonality**. Webster's Dictionary defines as "reciprocate" as to "to give and take mutually." Giving or doing favors without asking for something in return triggers feelings of obligation.

The Cambridge dictionary defines "commonality" as the "fact of sharing interests, experiences, or other characteristics with someone or something." What is important here is that it is done in order to build a sense of camaraderie and trust.

Interpersonal Trust vs. Social Trust. Mechanic and Schlesinger state that "Interpersonal trust refers to the trust built through repeated interactions through which expectations about a person's trustworthy behavior can be tested over time."[47] According to Pearson and Raeke, "Social trust, however, is trust in collective institutions, influenced broadly by the media and by general social confidence in particular institutions."[48]

Research on trust showed that "The patient trust subscale correlated most highly with patient assessment of the physician's communication (0.75), level of interpersonal treatment (0.73), and knowledge of the patient (.68)."[49]

Golden Rule vs. Platinum Rule. The Golden Rule is "Do unto others as you would want done to you." Written in many religious texts as the highest form of reaching out and touching others. However, since all people and all situations are different, in many cases what you'd want done to you is different from what another would want done to him or her.

Alternatively, there is the Platinum Rule, which is "Do unto others as they would want done to *them*."[50] By following this, you are more likely to do what the other person wants done and therefore assure yourself of a better outcome. You are better able to elicit beliefs and feelings regarding the information and options given and the joint decisions that follow.

Manitoba Dental and Dental Hygiene Communication Skills Framework

There are various communications skills frameworks that can be used by the HCP. Most come from other disciplines, such as the Calgary-Cambridge Guide for the Medical Interview,[51] the University of Michigan Interviewing Skills Guide, or Smith's Five-Step Patient-Centered Interviewing Guide.[52]

The Manitoba Dental and Dental Hygiene Communication Skills Framework was initially developed by Wener in 2012 and based on the Calgary-Cambridge Guide.[51] More recently, it was revised to include Smith's Five-Step Guide,[52] and has been tailored to fit the dental and dental hygiene practitioner.

Prior to Meeting the Patient

Preparation

1. Learn the patient's name with help from online pronunciation resources, if necessary (http://www.pronouncenames.com or http://pronounce.voanews.com).
2. Scan the patient's health record for information.
3. Look at patient's history to determine how to establish rapport.

Meeting the Patient

Building Rapport and Patient Respect

Building rapport and providing the patient with a sense of respect is foundational to the patient-clinician relationship and it includes the following actions:

• Greeting the patient while washing your hands, showing the patient that you care about the patient's safety and hygiene.
• Introducing yourself, your role , and your philosophy of care (if meeting for the first time). An effective introduction does much to lessen patient anxiety.[53]
• Finding out how the patient prefers to be called (Mrs., Ms., first name, last name).
• Shaking the patient's hand. (However, be aware of cultural norms. Some Jewish and Muslim patients may not welcome exchanging handshakes with someone of the other gender.)
• Smiling and exhibiting a friendly disposition, which is both welcoming, polite, and respectful.
• Being cognizant of your general demeanor, including your dress.
• Being attentive and calm.
• Making eye contact. (However, be aware of culturally inappropriate eye contact among some indigenous people.)
• Demonstrating respect.
• Referring to the rapport-building commonality above. Create interest in the relationship by finding out what commonalities that you might share in terms of hobbies, vacations, pets, etc.
• Explaining what will happen during the visit. E.g., how long will the visit be? What will be done? Why does it need to be done?
• Helping patient feel comfortable physically/emotionally.
• Looking for physical clues to see if patient might be too hot or too cold; tired; relaxed or stressed.
• Determining if there are any accommodation issues (i.e., sitting in the dental chair).

Interview: Gathering Information

Obtaining an accurate patient history is vital both to diagnosis and oral health management.

For the Clinician:

• Gather info to help formulate treatment and care plan.
• Identify critical information.
• Obtain a patient's accurate medical history and information about the patient's dental condition, as well as patient expectations.

Doing this will save time in the long run. According to Blinkhorn and Kay, 80 percent of the information we need in order to make a diagnosis comes from the chat that precedes the examination.[54]

For the patient:
• Ideas about his/her problem or what will help in dealing with their feelings/fears/worries, the effect on function and their expectations.

This will build rapport and trust, which in turn decreases patient anxiety, increases patient compliance, and reduces missed appointments.

For the Patient and Clinician:
• In patient-centered care, the clinician and patient "build" together rather than a clinician merely "taking" a medical history.[55] Through this, they
– Discover the patients' dental needs and develop a more targeted and realistic oral care plan.
– Establish rapport using relationship-building skills.
– Integrate clinician's and patient's agendas, finding common ground for plan.

However, according to a 2019 study in the Journal of General Internal Medicine, clinicians only requested the patient's story in 40 of 112 (36 percent) encounters. Stories were requested more often in primary care (30 of 61 encounters, or 49 percent) than in specialty care (10 of 51 encounters, or 20 percent). Shared decision-making tools did not affect the likelihood of requesting the patient's needs (34 percent vs. 37 percent in encounters with and without these tools). In 27 of the 40 (67 percent) encounters in which clinicians requested patient concerns, the clinician interrupted the patient after a median of 11 seconds. Uninterrupted patients took a median of 6 seconds to state their concern.[56]

The greatest single problem in clinical interviewing is the failure to let the patient tell his or her story.

Interview Phases

Orientation Phase[1]
• HCP introduces himself or herself to the patient and explains purpose of interview.
• HCP explains why the data is being collected.
• HCP needs to understand the patient's needs.
• Trust and confidentiality must be conveyed.
• Professionalism is extremely important.

Working Phase[1]
• Ask questions to obtain data for the purpose of developing an oral care plan.

• Use such strategies as silence, listening, paraphrasing, clarifying, etc., to facilitate communication.

Termination Phase[1]
• Patient needs to know the interview is coming to an end.
• Can say that there are just a few more questions to ask.
• Summarizes the information and asks the patient if this information is accurate.

Procedures in Gathering Information: Interviewing

Open-Ended Questions. These give patients freedom in responding, and does not limit their response. They encourage patients to tell their full story about their health problem,[1] and provides them with a sense of control. It elicits more information than a closed-ended question.

Listen Attentively to Opening Statement Without Interruption. Identify problems/issues. Ask relevant questions, one at a time, to explore the topic before continuing. The HCP establishes concern about the patient and may encourage the patient to add more information by simply saying: “Is there anything else?”[1]

Accepting. Sometimes it’s necessary to acknowledge what patients say and affirm that they’ve been heard. Acceptance isn’t necessarily the same thing as agreement; it can be enough to simply make eye contact and say “Yes, that makes sense.” Patients who feel their HCPs are listening to them and taking them seriously are more likely to be receptive to care.[19]

Examples:
• What can I do for you today?
• What are your goals for your dental health?
• Tell me about your past dental experiences.
• What concerns do you have about your dental health?
• Tell me more about the problem you’ve been having with your gums?
• What does it feel like when you brush in that area?

Probes, Facilitations, and Focusing. These entail asking more specific and/or guided questions to follow up on a patient’s response to open-ended questions. Focusing is another aspect of probes. Sometimes during a conversation, patients mention something particularly important; when this happens, HCPs can focus on their statement, prompting patients to discuss it further. Patients don’t always have an objective perspective on what is relevant to their case. As impartial observers, HCPs can more easily pick the topics to focus on.[19]

By using probes, facilitations, and focusing, HCPs encourage patients to tell more, and often more specific, information. It also lets patients know the HCPs are listening.

Examples:
DENTIST: Have you or anyone in the family had issues with coronary heart disease?
PATIENT: Yes.
DENTIST: (Probe) Please explain what the issues were.

PATIENT: [Discloses she is a smoker.]
DENTIST: (Probe) How long have you been a smoker?

DENTIST: (Focusing) Mr. Smith, your family is very interesting and successful. Thank you for sharing this information with me. Now, let's discuss your care plan as you leave our clinic.

Placing the Event in Time or Sequence. Asking questions about when certain events occurred in relation to other events can help patients and the HCP get a clearer sense of the whole picture. It forces patients to think about the sequence of events and may prompt them to remember something they otherwise wouldn't.[19]

Encouraging Comparisons. Often, patients can draw upon experience to deal with current problems. By encouraging them to make comparisons, HCPs can help patients discover solutions to their problems.[19]

Menu or Checklist Questions. Provide a list of a wide range of possible answers when asking a question. This is great when a patient is having a hard time describing a medical condition.

Examples:
- Is it sensitive to heat, cold, or both?
- Does it hurt all the time, or just when you have something hot/cold, or when you bite down?
- Is it a dull ache or a sharp pain?
- On a scale of one to 10, how painful is it?

Clarifying and Paraphrasing. Clarifying is assessing whether the patient understood the information.[1] Similar to active listening, asking patients for clarification when they say something confusing or ambiguous is important. Saying something like "I'm not sure I understand. Can you explain it to me?" helps HCPs ensure that they understand what's actually being said and can help patients process their ideas more thoroughly.[19] Paraphrasing is restating the patient's message in the HCP's own words.

Clarifying patient statements that are unclear sends a message that the HCP is listening.[1] During the interview, sometimes it is important to allow for times of deliberate silence, which can give both HCP and patients an opportunity to think through and process what comes next in the conversation. It may give patients the time and space they need to broach a new topic. HCP should always let patients break the silence.[19]

Making observations about the appearance, demeanor, or behavior of patients can help draw attention to areas that might pose a problem for them. Observing that their gums are bleeding after a hygiene cleaning may prompt patients to explain why they haven't been flossing; making an observation that they may have issues with lack of saliva may lead to the discovery of a new symptom.[19]

Examples:
- You appear upset. Would you like to talk about it?

• So you mean ...
• I hear you saying that ...
• If I understand you correctly ...
• Correct me if I'm wrong, but ...
• Am I right in assuming ...
• Let me see if I've got this straight ...

PATIENT: I am too tired to even think.
DENTIST: Do you mean that you are too tired now to continue with this education?

Summarizing. This means providing a response to the patient that sums up the primary and main points that were discussed as well as the conclusion of the discussion that was mutually decided upon. It demonstrates that you have tried to understand what the patient has just said.

It is very important for HCPs to summarize what patients have said after the fact. This demonstrates to patients that the HCP was listening and allows the HCP to document conversations. Ending a summary with a phrase like "Does that sound correct?" gives patients explicit permission to make corrections if they're necessary. Furthermore, it also helps build rapport and empathy.

Examples:
DENTIST: It seems that the bleeding occurs right after you floss and that this has been going on for about six weeks. This makes you uncomfortable and so you have brushed less frequently to avoid the discomfort. Did I understand that correctly?

DENTIST: During our discussion today, we have discussed brushing your teeth and flossing and how these impact on the successful management of a healthy mouth.

Closed-Ended Questions. These are questions with one- or two-word answers such as "yes" or "no."[1] These are used when the HCP wants to know a specific answer to a question and guides the patient to focus on important details. They are also useful when the patient is not able to, for one reason or another, formulate more complete feedback and communication to the HCP.

Examples:
• Are you currently taking any medications?
• Are you brushing every day?
• Have you ever been told you have gum disease?
• How old is your child?
• Are you pregnant?

Transitions for Changing Theme. These are words that signal to the patient that there is a change in the interview process.

Example: "Now, there are some important things I need to find out about your past dental history ... "

Clinical Care: Examination and Treatment

Confirm list and screen for more problems. The HCP (student) will be trained in other courses in dentistry and dental hygiene on how to complete this task. Throughout the examination and treatment, the HCP continues to provide empathy towards the patient.

Sharing Information/Explanation and Treatment-Planning: Patient-Centered Feedback

This is when the HCP provides information that the patient needs to know in a manner that gives the patient a sense of control of the treatment plan options.[1] It includes:

1. Helping the patient feel in control and providing him or her with the power to decide, negotiate the agenda, and include their needs.

Examples:
(Poor Example) You've got to take that denture out every night!
(Excellent Example) You're really coming along with adjusting to your new denture – that's great! I'm concerned about the tissue on the roof of your mouth ... it's really red and angry looking [show, and allow for a response/question]. To really keep your gum tissues healthy, it's best if your denture comes out at least once a day. When would be a good time for you? ... How are you storing your dentures when you do take them out? ...

2. Framing comments around patient's beliefs, knowledge, concerns, and expectations.[1] Providing explanations that patients can understand and remember. For example, use analogies and similes; personalize handouts, or draw pictures.

Example:
DENTIST: Why do you think your gums are bleeding?
PATIENT: From brushing too hard.
DENTIST: Well, if you're using a really hard toothbrush, it may be possible that it makes your gums bleed. I think what is happening in your situation is ...

3. Narrating during the exam.

4. Avoiding hurtful terms or phrases, hot-button words, or acronyms, such as "pain," "hurt," "needle," "cancer," or saying "No, we can't do that" or "You have to."

5. Providing info sooner rather than later. Providing info later will reduce the impact it might have on a patient in terms of making some sort of behavioral change. For example, encourage a patient to begin flossing immediately rather than waiting to tell him or her at the next appointment in six months.

6. Being descriptive (focused on behavior), not judgmental (focused on the person).

Examples:

(Poor Example): Your teeth are loaded with plaque; I guess no one has ever taught you how to brush before!
(Excellent Example): (While using hand mirror) Your gums are bleeding in this area. Have a look at the plaque here at the gum line.

7. Being specific, not general.

Examples:
(Poor Example): You're not cleaning your teeth well and have some pockets.
(Excellent Example): I want to point out a few specific areas where you are developing some gum problems. These are the areas that we found when we were measuring your gums ... there is actually a pocket. ... A pocket means ...

8. Avoiding medical jargon; use everyday, understandable language.

9. Categorizing. An example would be, "There are three important things. First, we. ... Second ... "

10. Being aware of timing when providing challenging feedback or bad news. If a patient is a smoker and has an ulcer on her tongue, don't say "My first guess would be cancer."

11. Not overloading the patient with information. Break down information into manageable chunks.

Example: "For next week, do you think you could work on flossing just this area where you have some bleeding?"

12. Giving Recognition. Recognition acknowledges a patient's behavior and highlights it without giving an overt compliment. A compliment can sometimes be taken as condescending, especially when it concerns a routine task like brushing teeth. However, saying something like "I noticed your gums are not bleeding today" draws attention to the action and encourages it without requiring a compliment.[19]

13. Making suggestions instead of giving directives. Explore and suggest all possible management options and state your own preference in terms of options.[1]

Negotiation of Care

This involves the maintenance of health following the dental appointment. Discuss with the patient regarding the next steps for both patient and HCP. This includes the next appointment. For patient safety, explain possible unexpected outcomes, especially following a surgical procedure.

Techniques for When the Patient Is Less Receptive:

Confronting. This helps the patient realize his or her inconsistencies in feelings, attitudes, or beliefs.[1] HCPs should only apply this technique after they have established trust. It can be vital to the care of patients to disagree with them, present them with reality, or challenge their assumptions. Confrontation, when used correctly, can help patients break destructive routines or understand the state of their situation.[19]

Voicing Doubt. This can be a gentler way of calling attention to incorrect or delusional ideas or perceptions of patients. By expressing doubt, HCPs can force patients to examine their assumptions.[19] Doing so gives the patient full ownership of his or her personal health maintenance.

Examples:
• *Confronting (a patient who may have been physically abused and is blaming it on having fallen):* Mrs. Jones, based on the X-rays, the fracture on your jaw bone seems to have been from something more forceful than a fall. Is there something you wish to share with me?
• *Voicing doubt:* I hear that you are concerned that the diet that you are on is potentially inflaming your gums. I am not quite sure that is the only issue. Might there be any other issues that might be causing this issue? (Hint at lack of flossing).

Wrap-up and Forward Plan

Ensure appropriate closure with patient by providing a summary of the session. Ask for corrections or additions, and make a final check if the patient is comfortable with the plan or has questions. Doing so brings a sense of closure to the conversation.

Verbal Communication Summary

Effective therapeutic communication requires special attention from the clinician toward the patient, which promotes patient-centered care. It involves core relationship-building skills including developing rapport, empathy, unconditional positive regard, and practicing the Platinum Rule.

The patient interview is well-suited for the patient telling his or her story. Through the various stages, from prior to meeting the patient, to the interview, and the wrap-up, the patient is prompted and encouraging to tell his or her story through various types of questioning. In doing so, the HCP gains valuable information about the symptoms, the context of the symptoms, and establishes a relationship with the patient that is critical going forward. The patient feels more empowered to be a part of his or her own health care.

3. Nonverbal Effective Therapeutic Communication

Although some disagreement exists among communications scholars concerning what is commonly meant by “nonverbal communication,” it is generally accepted that those human communication events or situations which go beyond the use of spoken or written words are considered instances of nonverbal communication. These events may take any number of forms, such as body motion, gestures, eye movements, vocal qualities, speech hesitations, use and

perception of personal space, and touch.[57] Studies estimate that between 65 percent and 90 percent of the emotional impact of a message comes from nonverbal sources.

Studies have shown improved diagnostic ability and patient satisfaction when providers attend to patients' nonverbal signals.[58-60] Studies have also demonstrated that greater clinician warmth, less "nurse negativity," and greater clinician listening were associated with greater patient satisfaction. Practical implications of communication-based interventions that target these areas may lead to greater patient satisfaction.[61]

Skill Development

Reading Your Patients. Studies provide evidence that nonverbal empathic behaviors increase patient perceptions of clinician empathy, warmth, and competence. Recent meta-analysis shows empathy training can be successful and may contribute to improved cross-cultural care. It can be an important tool to improve patients' emotional and physical health, leading to a patient-clinician relationship that has a positive effect on medical outcomes.[62]

Physical Appearance

Studies show that nonverbal empathic behaviors increase patient perceptions of clinician empathy, warmth, and competence, regardless of whether the clinician is wearing a white coat.[62]

Physical Appearance and Child Patients. According to one study, a majority of children preferred dental professionals to wear traditional formal attire (white coat and name tag). The popular view that children are fearful of white coats was not found in this survey. Children also preferred the use of plain masks and white gloves but disliked protective eyewear or head caps. They liked dentists with closed-toed shoes and no jewelry but preferred the use of a wristwatch.

These results can help dentists decide what is appropriate when dealing with children in order to minimize anxiety and improve delivery of health care.[63] Small alterations in a dentist's appearance may reduce dental anxiety among children[64] and improve any first communication with them.[65]

Whether or not a clinician is formally dressed has no effect on perceptions of treatment credibility in patients with acute low back pain.[66]

Regardless of child anxiety levels, PPE followed by paediatric coasts were preferred over other choices of dentists' attire. Children tended to choose a dentist who was of a younger age, and of the same gender and ethnicity as themselves. Parents tended to choose younger, female dentists of the same ethnicity as themselves.[67]

Younger children have a greater preference of colorful attire of dentists and camouflage syringe over the conventional one when compared to older children.[68]

Anxious children have preference of colorful attires of dentists and prefer dentists with protective wear.[69]

Parents favor traditional dress as it gives the air of professionalism. Children prefer dental students in casual attire. Both parents and children rank formal white in favor of a pediatric coat.[70]

Physical Appearance and Adult Patients. In one study, patients of all ages considered appearance to be an important factor when choosing an orthodontist. Participants largely preferred younger professionals who dressed in white coats, because this type of attire was considered clean and hygienic.[71]

Kinesics

Webster's Dictionary defines kinesics as "a systematic study of the relationship between nonlinguistic body motions (such as blushes, shrugs, or eye movement) and communication." Clinicians must consider how nonverbal methods can allow the clinician to build trust, promote healing, and improve health outcomes.[15]

Facial Expressions. Facial expressions are important part of creating rapport with patients.[15,72]

Emotions. There are seven cardinal emotions: happiness, sadness, anger, fear, surprise, disgust, and contempt. In these, specific muscles are used that are consistent globally.[73]

Studies have detected a progressive age-related decline in the ability to identify emotional facial expressions. Very old adults display more difficulties in identifying emotional facial expressions, especially low-intensity expressions and those associated with difficult emotions like disgust or fear. Practitioners should be mindful of how aging affects communication with older patients.[74]

Using a Genuine Smile vs. Social Smile. Patients will perceive a smiling HCP as being friendlier.[75] But there is a difference between a social smile — just the lips and muscles closest to the lips change in shape — and genuine smile. In a genuine smile, an individual smiles with his or her eyes, so to speak. It is impossible to fake because the involuntary and spontaneous contraction of muscles that move the skin around our cheeks, eyes, and nose create a smile that's distinct from a fake or polite smile.[76] A genuine smile has a positive association with patient rapport and patient disclosure.[15]

Body Tension. This can often be seen in the facial region, especially above the eyes, as well as in the hands, if they are tightened, or in the feet if they are exposed (the toes will tighten).

Gestures. Gaze avoidance[77] can indicate uncertainty or disagreement with a speaker's remarks, while a sustained cut-off may reveal shyness or dislike. A sudden body-shift[77] may telegraph an unspoken feeling, mood, or opinion, and thus offer a probing point. Crossed arms[77] are a defensive barrier sign, and that guard-like stance is suggestive of arrogance, dislike, or disagreement.

Tilting the head[77] to the side can show friendliness and fosters rapport; it can also indicate coyness. It can be a submissive pose (e.g., showing deference to one's boss). A blank face,[77] by contrast, expresses "Do Not Disturb." In shopping malls, elevators, and subways we adopt

neutral faces to distance ourselves from strangers. It can also be a subtle sign used to keep others a polite distance away.

The dentist trained in nonverbal communication conveyed information more correctly to the hearing-impaired patients over the dentists who had no knowledge of this type of communication. Dentists should be made aware of nonverbal communication, and signs and gestures related to dentistry should be taught to the hearing impaired as well as dental [students].[78]

Body Position. This relates to movement and posture (please also refer to "SOLER" acronym, described below).

Proxemics (Personal Space)

This involves a patient's space and how intrusion into this space affects the patient should be taught and discussed.[80] HCPs should learn how to convey effective and appropriate nonverbal messages to patients and to one another.[81]

Intimate, Personal, Social, Public, and Cultural Norms.

Zones of space. A critical understanding is knowing the vulnerable position in which patient place themselves by lying in the chair next to the HCP. Note that the only other place this might most likely happen is in an intimate position for the patient. Hence, being aware of this very intimate position is critical for any HCP as the HCP conducts therapy on the patient. Part of this is knowing "the zones of space":[80]
• Intimate distance for embracing, touching or whispering
– Close phase: less than 6 inches (15 cm)
– Far phase: 6 to 18 inches (15 to 46 cm)
• Personal distance for interactions among good friends or family members
– Close phase: 1.5 to 2.5 feet (46 to 76 cm)
– Far phase: 2.5 to 4 feet (76 to 120 cm)
• Social distance for interactions among acquaintances
– Close phase: 4 to 7 feet (1.2 to 2.1 m)
– Far phase: 7 to 12 feet (2.1 to 3.7 m)
• Public distance used for public speaking
– Close phase: 12 to 25 feet (3.7 to 7.6 m)
– Far phase: 25 feet (7.6 m) or more.

Spatial Relationships. When directly opposite or facing a person, that is more confrontational; side-by-side is more of a partnership.

Barriers. When confronted with barriers, either go around them, move them out of the way, or comment on them if fixed, or do none of above if the barrier useful to patient or clinician.

Paralanguage

Webster's defines paralanguage as "vocal features that accompany speech and contribute to communication but are not generally considered to be part of the language system, as vocal quality, loudness, and tempo: sometimes also including facial expressions and gestures."

Rate is the speed of which the communication occurs. **Rhythm** is the pattern of the speech occurring; can be staccato or very melodious. The **volume** at which verbal communication occurs can make a big difference. Each level of volume indicates something different to the patient.

Autonomic Changes

Autonomic changes include flushing, blanching, tearing, sweating, changes in breathing, changes in pupil size, and swallowing.

Psychotherapeutic nonverbal suggestion (i.e., hypnosis) has an effect on the autonomic system. An increase in psycho-emotional tension is observed in response to nonverbal suggestion. The clinical implication is that patients do respond autonomically (such as an increased heart rate) to our nonverbal suggestions.[83]

An intervention of loving-kindness meditation (compassion), whether tactile or non-tactile, has an association with significant changes in subjects' autonomic nervous system, with an overall increase in wellbeing. The clinical implications is that extending appropriate nonverbal communication is not only good care, but also good medicine for the patient.[84]

Pupil size and emotional perception are intertwined and develop over time as we age regardless of gender. Large pupils are associated with a happy face, small pupils are associated with an angry face. Clinical implications: patients will make perceptions of our emotion based on pupil size.[85]

Haptics

Webster's Dictionary defines "haptics" as "the branch of psychology that investigates sensory data and sensation derived from the sense of touch and localized on the skin."

Touch. Touch is a powerful way to connect with patients. Touch communicates care. Touch crosses boundaries and requires safe spaces (i.e., space between health provider and patient, space between patients, or physical environment space). Touch exercises power.[86]

Touch has physical, psychological, and spiritual impacts. Gentle, soothing touch important to calm a patient with dementia. Touch displays care.[87]

Presence (being physically there and being with a patient emotionally), **touch** (task-oriented, procedural, or non-procedural, caring) and **listening** are three concepts that help the health professional communicate with a patient to help him or her through a challenging experience.[88]

A **reassuring** touch is comforting.

Example: "I know that when I feel like my patients are getting a little antsy, I'll touch them on the shoulder just to let them know that I'm there and that they shouldn't get nervous."

A **procedural** touch is controlling.
Examples: Retracting cheeks, lips, tongue; getting the "job" done. Guard against being task-focused vs. patient-centered. Don't work on patients as if they were mannequins.

An **appropriate** touch is respectful. Assess patient comfort with touch; be cognizant of power, gender, and cultural considerations. Address any inadvertent touching.
Watch how other clinicians use touch.

A dentist's reassuring touch affects children's emotional and behavioral reactions, helping them relax and give up control in the chair and be more cooperative.[89]

With all patients, establish a relationship before touch. Give patient the autonomy when it comes to touch. Give touch instructions before touching (i.e., tell-show-do). When touch needs to be intimate in a patient-clinician encounter, decision-making needs to be shared, relative to how and by whom the touch will be provided. The HCP needs to touch in a manner that communicates professionalism at all times.[90]

Oculesics or Eye Contact

It has been said that "eyes are the window to the soul."[91] When making eye contact, regulate interaction and provide turn-taking signals. Monitor communication by receiving nonverbal communication from others. Signal cognitive activity: that is, we look away when processing information. Express engagement:[15] we show people we are listening with our eyes.

Maintaining eye contact can enhance trust and build rapport,[75] an important component of patient-centered communication. Increased eye contact increases patient interaction.[93] Gaze and body orientation contribute to the perception of an HCP as being more empathetic toward the patient with whom they are communicating with.[94] Maintaining eye contact facilitates patient-centeredness and has positive implications for patient understanding and adherence.[95]

Cultural Differences/Norms (Please Also See "Proxemics and Culture" in the Verbal Communication Section)

Being culturally competent means understanding the values and beliefs of the patient while providing care that is sensitive to the patient's culture. Being culturally component will improve and enhance the patient's satisfaction with care.[96]

Strategies to address intercultural challenges include cultural validation through alliance-building, proactively seeking clarification, and acquiring cultural knowledge.[97] For verbal and nonverbal barriers to effective communication with limited English proficiency (LEP) patients, including issues with using interpreters, there are strategies to overcome the barriers at systemic and individual levels.[98]

Regardless of child anxiety levels, children tend to choose a young dentist of the same gender and ethnicity as themselves. Parents tended to choose younger, female dentists of the same ethnicity as themselves.[67]

The SOLER Model

The SOLER Model[99] is an important strategy in meeting with patients and has been successfully used by counselors and psychologists for many years. It stands for:

• Face client **SQUARELY** = available
• Adopt an **OPEN** posture = non-defensive
• **LEAN** toward the client at times = attentiveness[75]
• Maintain **EYE CONTACT** without staring = interest, warmth, caring. Using the same eye level for discussions indicates equality and respect. Using little eye contact indicates apprehensiveness. When someone is fearful, the pupils are dilated; when in pain, patients wince or blink rapidly.
• Remain relatively **RELAXED** = confidence

A revised version of SOLER that includes touch and intuition and encourages educators to consider therapeutic space when teaching nonverbal communication skills is "**SURETY**." It stands for:[100]
• **SIT** at an angle
• **UNCROSS** legs and arms
• **RELAX**
• Make **EYE CONTACT**
• Utilize respectful **TOUCH**
• Rely on **YOUR INTUITION**

Gender

Gender differences exist in both verbal and nonverbal communication. Research shows perceptions of dentists and patients are influenced by gender, and that traditional gender stereotypes are applied to perceptions of dentists and also shape perceptions of patients.[101] Regardless of child anxiety levels, children tend to choose a dentist who was of the same gender as themselves. Parents tend to choose younger, female dentists of the same ethnicity as themselves.[67,102]

There is a highly significant difference in preference of patients towards gender of their dental HCP; male patients favor males, and female patients favor females.[70]

Nonverbal Communication Summary

Nonverbal communication is much more powerful than verbal communication and takes on various forms as listed above. Each are important in building the respect and rapport of patients and critical in the therapeutic process of effective communication.

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PRACTICE MANAGEMENT AND THE ROLE OF COMMUNICATIONS IN PATIENT-CENTERED CARE SYSTEMS

Kathryn Atchison, DDS, MPH
University of California, Los Angeles School of Dentistry and Fielding School of Public Health
Carol Kunzel, PhD
Columbia University College of Dental Medicine

CODA competency covered:

2-17 Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

Intent: Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:
• basic principles of culturally competent health care;
• basic principles of health literacy and effective communication for all patient populations
• recognition of health care disparities and the development of solutions;
• the importance of meeting the health care needs of dentally underserved populations, and;
• the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi- dimensionally diverse society.

NOTE TO SUPERVISING FACULTY

The Practice Management Section's intent is that the teaching of each module be interactive. Students will be able to access the student modules only. You can use any of the material that you have access to in the expanded module, the appendix, to lead discussions, and present material. Each appendix represents the author's module before being edited for student use. The appendices are designed to be your resource material.

The evaluation section is for your eyes only. We request that you do not share any of evaluation material. We ask that you use the same procedures you use in protecting your test material.

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PRACTICE MANAGEMENT AND THE ROLE OF COMMUNICATIONS IN PATIENT-CENTERED CARE SYSTEMS

Manual

Kathryn Atchison, DDS, MPH
University of California, Los Angeles School of Dentistry and Fielding School of Public Health
Carol Kunzel, PhD
Columbia University College of Dental Medicine

Overview

This module focuses on three tenets of modern-day dental practice in a multicultural community:

- The importance of communication: with patients, other health care providers, the community, and our employees to assure safe, effective dental care.
- The concept of health literacy and applying the universal precautions of health literacy in dental practice.
- A basic understanding of the patient-centered medical-dental home and the importance of provider communication to provide patient-centered care.

This module integrates behavioral science concepts with health literacy, cultural competency, and the importance of effective provider-patient and provider-provider communication in primary care. The module provides practical activities on the topics of communication, cultural competence, and health literacy.

The overall objective is that students learn how to apply universal precautions of health literacy and cultural competency principles in the provision of effective communication needed in the dental practice.

SECTION 1: INTRODUCTION TO HEALTH LITERACY

Required reading:

1. "Introduction" to the "Health Literacy Universal Precautions Toolkit, 2nd Edition" (Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services) (excerpted below)

To successfully manage their health, people must be able "to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[1] Known as health literacy, this ability involves using reading, writing, verbal, and numerical skills in the context of health.[1] Being health literate, however, also depends on the complexity of the health information given to patients and the tasks they are asked to perform. A national survey showed that 88% of U.S. adults do not have the health literacy skills needed to manage all the demands of the current health care system and 36% have limited health literacy.[2]

Research shows that clinicians have trouble identifying patients with limited health literacy.[3-6] Although some groups have higher rates of health literacy limitations, such as some racial/ethnic minority and older populations, limited health literacy is seen in all sociodemographic groups.[2] Moreover, managing one's health can be more challenging in times of stress. When patients or caregivers are anxious or overwhelmed with too much information, their ability to absorb, recall, and use health information can decline,[7] compromising their ability to manage their health.

What Are Health Literacy Universal Precautions?

Because limited health literacy is common and is hard to recognize, experts recommend using health literacy universal precautions. Practices should assume that all patients and caregivers may have difficulty comprehending health information and should communicate in ways that anyone can understand. Health literacy universal precautions are aimed at—

- *Simplifying communication with and confirming comprehension for all patients, so that the risk of miscommunication is minimized.[8]*
- *Making the office environment and health care system easier to navigate.*
- *Supporting patients' efforts to improve their health.*

Everyone gains from health literacy universal precautions. Research shows that interventions designed for people with limited health literacy also benefit those with stronger health literacy skills.[9-10] Communicating clearly helps people feel more involved in their health care and increases the chances of following through on their treatment plans.[9] All patients appreciate receiving information that is clear and easy to act on.

Why a Health Literacy Universal Precautions Toolkit?

The purpose of this Toolkit is to provide evidence-based guidance to support primary care practices in addressing health literacy. The Toolkit can help practices reduce the complexity of

health care, increase patient understanding of health information, and enhance support for patients of all literacy levels.

The Toolkit comprises 21 tools addressing 4 domains that are important for promoting health literacy in your practice:

• *Spoken Communication.*
• *Written Communication.*
• *Self-Management and Empowerment.*
• *Supportive Systems.*

The Toolkit appendix contains over 25 resources, such as sample forms, PowerPoint presentations, and worksheets that practices may use or revise to suit their needs. ...

What is the Evidence for a Focus on Health Literacy?

Individuals with limited health literacy experience a variety of negative outcomes. They have more restricted knowledge of their health problems, make more errors taking medicine, use more inpatient and emergency department care, receive fewer preventive services, and have worse health status and higher health care costs.[11-14]

Fortunately, primary care practices can enhance outcomes for their patients by addressing health literacy in their office environments and clinical procedures. Addressing health literacy is associated with improved health outcomes.[15] *Below are a few illustrative research studies showing how good health literacy practices can improve specific health behaviors and outcomes for patients.* [Links are available in appendix.]

Colon Cancer Screening: Link to Exit Disclaimer This study shows how teaching clinicians to communicate more effectively can increase participation in colon cancer screening.[16]

Depression Management: This study shows that, when low-literate patients with depression were referred to literacy programs, their symptoms significantly improved compared to control participants, who just received depression treatment.[17]

Diabetes and Heart Failure Management: Link to Exit Disclaimer These studies show that, when patients receive self-management education using effective communication techniques, diabetes and heart failure control are improved.[9, 18-20]

How Can Addressing Health Literacy Support Your Practice Goals?

Addressing health literacy in your practice can serve both your patients' needs and your practice's other goals. Many of the action steps recommended in this Toolkit are consistent with and may help qualify your practice for certification as a patient-centered medical home (PCMH). Linking the implementation of the health literacy tools to your practice's other quality improvement activities and/or PCMH-related efforts can help increase staff buy-in as well as the efficiency and "pay-off" of your work. ...

Addressing health literacy is important to achieve patient safety goals. Both the AMA and The Joint Commission have provided guidance on improving health literacy to improve patient safety.[22, 23]

Implementation of specific tools in this Toolkit also may support practices and clinicians in their efforts related to Maintenance of Certification and Meaningful Use. To make the most of their quality improvement work, we encourage practices to consider how their health literacy-related efforts can also address these other goals.

Who Should Use this Toolkit?

This Toolkit is designed to be used in any primary care setting, although some tools are applicable to other settings as well. The Toolkit can help practices with little or no experience addressing health literacy as well as those that are already engaged in health literacy-related quality improvement work. With an extensive set of tools to choose from, even practices with substantial health literacy experience can benefit from this Toolkit.

Can Your Practice Improve Its Health Literacy Environment?

Yes! This Toolkit has been tested in primary care practices and community clinics. Participating facilities showed that they could make changes to improve the way they communicate with and support their patients.

Just like these practices, your practice can benefit from this resource. The Toolkit can guide you in addressing health literacy limitations among your patients and help you to achieve your practice's other goals.

Getting Started

To get started, we recommend that you begin by implementing Tools 1 through 3. These Tools will help you establish the foundation you need to successfully implement health literacy-related quality improvement efforts in your practice.

Tool 1: *Form a Team provides guidance on developing a team to lead your health literacy efforts.*
Tool 2: *Create a Health Literacy Improvement Plan will guide you in assessing your practice and identifying areas to target in your quality improvement efforts.*
Tool 3: *Raise Awareness provides guidance on resources for educating your staff about health literacy. …*

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2) "Communicate Clearly: Tool #4" of the "Health Literacy Universal Precautions Toolkit, 2nd Edition" (Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services) (excerpted below)

Using clear oral communication strategies can help your patients to better understand health information. Communicating clearly also helps patients to feel more involved in their health care and increases their likelihood of following through on their treatment plans. …

Actions

Use strategies for communicating clearly.

• ***Greet patients warmly****: Receive everyone with a welcoming smile, and maintain a friendly attitude throughout the visit.*
• ***Make eye contact****: Make appropriate eye contact throughout the interaction. Refer to Tool 10: Consider Culture, Customs and Beliefs for further guidance on eye contact and culture.*
• ***Listen carefully****: Try not to interrupt patients when they are talking. Pay attention, and be responsive to the issues they raise and questions they ask.*
• ***Use plain, non-medical language****: Don't use medical words. Use common words that you would use to explain medical information to your friends or family, such as stomach or belly instead of abdomen.*
• ***Use the patient's words****: Take note of what words the patient uses to describe his or her illness and use them in your conversation.*
• ***Slow down****: Speak clearly and at a moderate pace.*
• ***Limit and repeat content****: Prioritize what needs to be discussed, and limit information to 3-5 key points and repeat them.*
• ***Be specific and concrete****: Don't use vague and subjective terms that can be interpreted in different ways.*
• ***Show graphics****: Draw pictures, use illustrations, or demonstrate with 3-D models. All pictures and models should be simple, designed to demonstrate only the important concepts, without detailed anatomy.*
• ***Demonstrate how it's done****. Whether doing exercises or taking medicine, a demonstration of how to do something may be clearer than a verbal explanation.*

• ***Invite patient participation**: Encourage patients to ask questions and be involved in the conversation during visits and to be proactive in their health care.*
• ***Encourage questions**: Refer to Tool 14: Encourage Questions for guidance on how to encourage your patients to ask questions.*
• ***Apply teach-back**: Confirm patients understand what they need to know and do by asking them to teach back important information, such as directions. Refer to Tool 5: Use the Teach-Back Method for more guidance on how to use the teach-back method.*

Help staff remember these strategies.

• ***Review these strategies** with staff during staff meetings, and hang the Key Communication Strategies poster in non-patient areas (e.g., kitchen or conference room) as a reminder. …*

Here are some important points to consider and recognize:

1. Health Literacy and Health Literacy Universal Precautions

Low health literacy is difficult to identify within dental patients, so using Universal Health Literacy Precautions is the best practice. Patients with low oral health literacy often have the most need for oral health care and are the least able to access it.

2. Health Literacy and Oral Health Outcomes

Patients with low health literacy may have difficulty understanding communications regarding health promotion and treatment plans and procedures. Patients' ability to read flyers, announcements, understand consent forms, and their ability to present for an appointment can affect the care delivery process. Consider the implications of such associations for community-based programs as well as outreach efforts.

3. Health Literacy and Health Beliefs and Culture

There is a complex relationship between health literacy, health beliefs, and cultural competency. Recognize how a wide variety of cultural, ethnic and religious health beliefs may impact the health literacy and behavior of a patient. This, in turn can affect access to care and personal health outcomes, as well as the patient's ability to access care.

4. Health Literate Organizations or Systems

Private and public health organizations can become more health literate by using the Health Literacy Universal Precautions Toolkit. Consider how the recommendations for communication with patients pertain to spoken, written and verbal communications.

5. Health Literate Patient-Provider Communication

A successful health care provider must develop good health literacy communication skills. These include the sort of literacy 'tasks' (prescription management, oral health behaviors, selection of

treatment options like sealants) patients need to perform in order to make appropriate health decisions and actions. Practice several health literate communication skills so that you can learn how to use strategies to communicate more effectively, such as developing template forms or other patient educational materials, or using symbols and shapes.

6. Implementation of Health Literate Best Practices

Practice good patient-provider communications that can improve the ways in which verbal and non-verbal communication take place between patients and staff or other health care providers. Select or create appropriate, easy to read written educational materials for the office; strategies to improve the patients' ability to better understand your recommendations; and ways in which you and your staff can identify whether or not patients understand your recommendation(s).

SECTION 2: CULTURAL COMPETENCY

Required reading:

1) "Consider Culture, Customs, and Beliefs: Tool #10" of the "Health Literacy Universal Precautions Toolkit, 2nd Edition" (Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services) (excerpted below)

Religion, culture, beliefs, and ethnic customs can influence how patients understand health concepts, how they take care of their health, and how they make decisions related to their health. Without proper training, clinicians may deliver medical advice without understanding how health beliefs and cultural practices influence the way that advice is received. Asking about patients' religions, cultures, and ethnic customs can help clinicians engage patients so that, together, they can devise treatment plans that are consistent with the patients' values.

Tips

Here are some examples of how religion, culture, and ethnic customs can influence how your patients interact with you.

• ***Health beliefs****: In some cultures, people believe that talking about a possible poor health outcome will cause that outcome to occur.*
• ***Health customs****: In some cultures, family members play a large role in health care decisionmaking.*
• ***Ethnic customs****: Differing roles of women and men in society may determine who makes decisions about accepting and following through with medical treatments.*
• ***Religious beliefs****: Religious faith and spiritual beliefs may affect health care-seeking behavior and people's willingness to accept specific treatments or behavior changes.*
• ***Dietary customs****: Disease-related dietary advice will be difficult to follow if it does not conform to the foods or cooking methods used by the patient.*
Interpersonal customs: Eye contact or physical touch will be expected in some cultures and inappropriate or offensive in others.

Learn from patients.

*• **Respectfully ask patients** about their health beliefs and customs, and note their responses in their medical records. Address patients' cultural values specifically in the context of their health care. For example:*
--"Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"
--"Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"
--"Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"
--"What do you call your illness and what do you think caused it?"
--"Do any traditional healers advise you about your health?"
•Avoid stereotyping based on religious or cultural background. Understand that each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care.

Learn from other sources.

*• **High-quality online resources** provide education about cultural competence, both as a general topic and as related to specific groups. …* [Links in appendix.]
*• **Community organizations** such as religious institutions and cultural organizations can often provide information and support to help make your practice more "culture-friendly."*
--Invite a member of a relevant cultural group to attend a staff meeting and share observations about how cultural beliefs may impact health care.
--Invite an expert to conduct an in-service training to educate staff about cultural competence.
*• **Integrate cultural competence into orientation and other trainings**. Take advantage of opportunities to integrate cultural competence into all of your training activities.*
*• **Use interpreters as cultural brokers**. Interpreters can eliminate language barriers as well as help you and your patients avoid misunderstandings due to cultural differences. Go to Tool 9: Address Language Differences for more information about interpreters.*

Help staff learn from each other.

To raise awareness about cultural competence among your staff, you could:

•Hire staff that reflects the demographics of your patient population. These staff members can help contribute to a comfortable environment for patients and can share insights with other staff regarding the customs of their religious or ethnic groups.
• Encourage staff to complete online cultural competence trainings and share what they learned with each other during a staff meeting. …

2) "Use the Teach-Back Method: Tool #5" of the "Health Literacy Universal Precautions Toolkit, 2nd Edition" (Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services) (excerpted below)

Regardless of a patient's health literacy level, it is important that staff ensure that patients understand the information they have been given. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand. The related show-me method allows staff to confirm that patients are able to follow specific instructions (e.g., how to use an inhaler).

- *The teach-back and show-me methods are valuable tools for everyone to use with each patient and for all clinic staff to use. These methods can help you:*
- *Improve patient understanding and adherence.*
- *Decrease call backs and cancelled appointments.*
- *Improve patient satisfaction and outcomes.*

Fact

Studies have shown that 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect.

Action

Learn the teach-back method.

Teach-back is a tool for a health care provider, whether dentist or staff, to find out if the patient understands what you are telling him or her. Teach-back is also used in training clinical and nonclinical office staff on new procedures or policies. In both cases, the recipient of the instruction needs to know both the reason to follow your instructions and the specific actions.

Successful patients need to understand both their task and its importance in order to have good adherence. Teach-back requires you to remember to use plain language and to speak clearly. Teach-back is not a test of the patient's knowledge, but a test of how clearly you explained the information to the patient. You then ask the patient or staff to teach back to you what he or she learned. If you use teach-back regularly, you can improve patients' satisfaction and positive outcomes.

Try the teach-back method.

- ***Keep in mind this is not a test of the patient's knowledge****. It is a test of how well you explained the concept.*
- ***Plan your approach****. Think about how you will ask your patients to teach back the information. For example:*

--"We covered a lot today and I want to make sure that I explained things clearly. So let's review what we discussed. Can you please describe the 3 things you agreed to do to help you control your diabetes?"
• ***"Chunk and Check."*** *Don't wait until the end of the visit to initiate teach-back. Chunk out information into small segments and have your patient teach it back. Repeat several times during a visit.*
• ***Clarify and check again***. *If teach-back uncovers a misunderstanding, explain things again using a different approach. Ask patients to teach-back again until they are able to correctly describe the information in their own words. If they parrot your words back to you, they may not have understood.*
• ***Start slowly and use consistently***. *At first, you may want to try teach-back with the last patient of the day. Once you are comfortable with the technique, use teach-back with everyone, every time!*
• ***Practice***. *It will take a little time, but once it is part of your routine, teach-back can be done without awkwardness and does not lengthen a visit.*
• ***Use the show-me method***. *When prescribing new medicines or changing a dose, research shows that even when patients correctly say when and how much medicine they'll take, many will make mistakes when asked to demonstrate the dose. You could say, for example:*
--"I've noticed that many people have trouble remembering how to take their blood thinner. Can you show me how you are going to take it?"
• ***Use handouts along with teach-back***. *Write down key information to help patients remember instructions at home. Point out important information by reviewing written materials to reinforce your patients' understanding. You can allow patients to refer to handouts when using teach-back, but make sure they use their own words and are not reading the material back verbatim. Refer to Tool 12: Use Health Education Material Effectively for more information.*

Promote the use of teach-back.

• ***Train non-clinical staff***. *Non-clinical staff members who interact with patients should also use teach-back. For example, staff making appointments may use it to ensure the patients understand what is required of them at the next visit such as arrival time, insurance documentation, bringing medicines, fasting, and details about referrals to other clinicians.*
• ***Share teach-back stories***. *Ask one person at each staff meeting to share a teach-back "Aha!" moment. This serves as a reminder of the importance of using teach-back consistently.*

Here are some important points to consider and recognize:

1. Cultural and linguistic competence and the need for both.

Both cultural competence and linguistic competence are widely recognized by as integral to professional development. Consider the significant challenges that remain to incorporate cultural and linguistic competence in the policies and practices of U.S. health care systems and organizations.

2. Recognize the changing demographics of the U.S. and how cultural competence impacts provision of care.

Even though a direct link between racial and ethnic health disparities and lack of culturally competent care has not been empirically demonstrated, culturally competent services can potentially improve patient health by increasing understanding between health care providers and the patient. This can also potentially increase adherence to treatment. Consider how culturally competent services have the potential to increase the quality of health care when delivered in the context of your patient's cultural beliefs and practices and those of family and community.

3. Consider the process of becoming a culturally competent clinician.

Approaches to acquiring cultural competence can be categorized as fact-centered or attitude/skill-centered approaches. Fact-centered approaches enhance cultural competence by learning about the cultural information about specific ethnic groups that can make your treatment regimens more successful. You can contrast this approach with the attitude/skill-centered approach that usually enhances communication skills and emphasizes the sociocultural context of individuals.

4. Tools and techniques that help achieve cultural competence.

Cultural competence within a dental practice or health care system operates at many levels. Culturally competent care tools and techniques include the development of curricular modules with a patient-centered focus, effective clinician-patient communication, an understanding of alternative sources of care, and others. In addition, language access services, tools and techniques including the use of appropriate interpretation services, training clinicians and your support staff to work with interpreters, language access strategies, and others also improves the communication between the dentist and patient. Organizational supports for cultural competence, includes tools and techniques such as an organizational commitment to cultural competence, community participation, recruitment of minority and community health workers, training and professional development, organizational assessment, and others.

5. Assessment of cultural competence in clinician and patient communication.

While many training materials in cultural competence have been developed, there is little information available regarding the most effective teaching and assessment strategies. Information about cultural competence training in continuing medical/dental and workplace settings is scarce. Many programs feature an emphasis on the application of skills and knowledge. Curricula tend to use case studies, vignettes or direct experiences with simulated or real patients as teaching stimuli. The two important goals of cultural competence assessment are evaluation of participants in real, applied settings, and facilitation of further learning through feedback.

SECTION 3: THE PATIENT CENTERED MEDICAL-DENTAL HOME APPROACH TO PATIENT-CENTERED CARE

Required reading:

1. “Make Referrals Easy: Tool #21” of the “Health Literacy Universal Precautions Toolkit, 2nd Edition” (Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services) (excerpted below)

Primary care practices refer patients to specialists, ancillary health care clinicians, labs and screening facilities, and elsewhere. Making the referral process easy for patients increases the chances that they will follow through, and that both you and the referral destination get all the information you need.

Action

Refer patients to clinicians who coordinate care with you.

• Identifying, developing, and maintaining relationships to whom you refer patients can make the referral process run smoothly.
*• **Try to establish formal referral agreements** with key specialist groups and other clinicians.*
• Don't continue to refer patients to clinicians who do not send information back to you, don't provide timely appointments for your patients, or otherwise fail to coordinate care.

Referral Agreements

Referral agreements spell out mutual expectations and responsibilities, such as:

•Which patients are appropriate to refer.
•What information is needed before and after a referral.
•Roles for both parties after the referral.
•Setting aside appointments for urgent care.

Don’t rely on patients to relay information.

*• **Share important information directly with the other office**, such as the reason for the referral, pertinent medical history, and test results.*
*• **Explore making electronic referrals**. Check whether your EHR has the capability to make referrals directly to other clinicians. If not, self-standing referral management systems are commercially available for purchase.*
*• **Provide a detailed referral** to the other clinician that contains all the information needed. …*
*• **Get information sent directly back to you**. Make sure you get a full report back before your patient's next visit.*

Consider language barriers.

*• When making referrals for patients with limited English proficiency, **identify clinicians who are language concordant or have interpreter services**. …*
***• Include information on your patient's language assistance needs** when making the referral.*

Make sure the patient understands the reason for the referral.

• ***Explain why*** *the patient needs to be seen by someone else, and what might happen if he or she is not seen.*
• *In the case of tests,* ***explain how you and the patient will use the information*** *to diagnose, manage, or decide on treatments for health conditions.*
• *In the case of screenings,* ***give a clear explanation of the risks and benefits****. Ultimately, it's up to the patient as to whether or not to undergo any particular test or screening.*
• ***Use the teach-back method*** *(go to Tool 5: Use the Teach-Back Method) to confirm patient understanding.*
• ***Ask about and address any concerns or fears.***

Offer help with the referral.

• *Ask patients if they would like your office to make the initial phone call.*
• *If staff members are making appointments for patients, make sure they first find out when the patients are available.*
• *Ask patients about transportation and other barriers to their completing the referral. Discuss how they could overcome these barriers. …*

Provide clear instructions.

• *For some referrals, patients will need to prepare in advance (e.g., fast, discontinue a medicine). Provide easy-to-understand instructions verbally and in writing.*
• *Explain the referral process fully (e.g., how you and the other clinician will exchange information, when the patient should return to your office).*
• *Give clear oral and written directions to get to the referral location.*
• *Use the teach-back method (Tool 5) to confirm patient understanding.*

Follow up on referrals.

• *Confirm and document that the patient successfully completed the referral.*
• *Obtain information on the result of the referral and document in the medical record.*
• *Make sure the patient receives the results of any tests or screenings, even normal results.*
• *Provide patients positive feedback for completing referrals. Let patients see how you use the information obtained from tests or specialist visits.*
• *If the patient has not completed the referral, reinforce that you feel the patient could benefit, and review barriers.*
• *Determine whether the patient needs additional referrals.*
• *Get feedback from patients on the quality of the care provided. Stop making referrals to places that consistently receive negative reports.*

Here are some important points to consider and recognize:

1. Oral health care is part of the overall health care system.

Oral Health in America: A Report of the Surgeon General (2000) emphasized that "oral health is essential to the general health and well-being of all Americans." The report reminds us that oral health is a critical component of health and that dental providers must work together with medical providers in order to provide comprehensive health care to our patients.

2. Patient-Centered Medical-Dental Homes

A Patient-Centered Medical-Dental Home (PCMDH) is defined as a model of health care that is designed to emphasize disease prevention and the treatment of chronic diseases. The goal of the PCMDH model is to improve the outcome of care and reduce the overall cost of health care. The American Academy of Pediatric Dentistry (AAPD) developed a policy on dental homes that was first adopted in 2001 and revised in 2004 (Girish Babu, 2012). The definition states: "The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way."

The dental home concept was reviewed and improved by the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) in 2008 with a national leadership conference to define the dental home and look at the associations between the medical home and dental home concepts. The goals of the medical-dental home are to increase access to high quality, coordinated, preventive care to all Americans. While the early emphasis of the patient-centered medical dental home was on early childhood caries, coordinating care for adults with chronic diseases was quickly added to emphasize the importance of prevention and coordination between medical and dental teams to provide quality care for patients with chronic conditions, such as diabetes, heart disease, and pregnancy because of the oral-systemic link with periodontal disease (NMCOH, 2009). Managing chronic diseases requires careful coordination of all the health-care team members with each other and the patient to assure patients can achieve good adherence to their prescription and treatment regimens.

3. Patient-Centered Care

Patient-centered care "is respectful of and responsive to individual patient preferences, needs, and values [and those of family and friends] and ensures that patient values guide all clinical decisions" (IOM, 2001).

The Dental Quality Alliance, an organization of oral health stakeholders that was established by the American Dental Association to develop oral health care measures, describes the strategies designed to implement Patient-Centered Care are to:

- Agree on one patient problem;
- Negotiate reasonable goals to achieve health care improvement;
- Generate options for the patient to consider;
- Decide on a mutually agreeable and feasible plan;
- Test the Patient's knowledge of what to do; and,
- Screen for readiness, using either Ask Me 3 or Teach back (Smiley, 2014).

4. Provider-Provider Referrals

Once the dental provider and patient agree on the patient problem, the dentist may need to make a referral to a primary care clinician, for example on behalf of a patient whose medical history indicates positive risk factors for diabetes. Studies have shown that communication between different types of health care providers is difficult because the providers generally have different processes, electronic health records, and cultures (Hummel, 2015).

5. Challenges to Provider-Provider Communication

In the 2015 Comparative Benchmarking System (CBS) Report provided by CRICO Strategies, a Division of the Risk Management Foundation of the Harvard Medical Institutions, Incorporated reported that 38 percent of general medicine malpractice cases involved at least one communication failure (CRICO, 2015). They estimated that 57 percent of communication errors were provider-provider errors, including miscommunication about the patient's condition, poor documentation, and failure to read the medical record. Utilizing a standard referral form that incorporates the necessary information can help to prevent errors that puts the patient's health at risk.

The National Interprofessional Initiative on Oral Health developed an Oral Health Delivery Framework, which included the key features of a dental referral from Primary Care Practitioners (Hummel, 2015). In Appendix 2 [to this module, provided in the general appendix], we present a modified version, based on the original that involves a referral from the dental provider to a primary care provider, to seek a consult on a patient with risk factors that suggest a chronic condition, diabetes.

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• Communicate Clearly Tool 4. https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool4.html
• Use the Teach-Back Method Tool 5. https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html

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A LEGAL PRIMER FOR DENTAL PRACTITIONERS: I DIDN'T KNOW THAT WAS THE LAW!

Pamela Zarkowski, MPH, JD
University of Detroit Mercy
Phyllis Beemsterboer, EdD, MS
Oregon Health and Science University

Competency covered:

2-18 Graduates must be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.

NOTE TO SUPERVISING FACULTY

The Practice Management Section's intent is that the teaching of each module be interactive. Students will be able to access the student modules only. You can use any of the material that you have access to in the expanded module, the appendix, to lead discussions, and present material. Each appendix represents the author's module before being edited for student use. The appendices are designed to be your resource material.

The evaluation section is for your eyes only. We request that you do not share any of evaluation material. We ask that you use the same procedures you use in protecting your test material.

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A LEGAL PRIMER FOR DENTAL PRACTITIONERS: I DIDN'T KNOW THAT WAS THE LAW!

Manual

Pamela Zarkowski, MPH, JD
University of Detroit Mercy
Phyllis Beemsterboer, EdD, MS
Oregon Health and Science University

Course Objectives

1. Describe the difference between an implied and express contract and its creation in the patient/provider relationship.
2. Identify the contract principles and associated responsibilities in the patient/provider relationship.
3. Describe the difference between intentional and unintentional torts in the dental employment setting.
4. List examples of intentional torts.
5. Describe the three elements necessary to provide an intentional tort.
6. Identify intentional and unintentional tort concepts that apply to the patient/provider relationship including duty, the standard of care, negligence, informed consent, informed refusal, and abandonment.
7. Identify appropriate record keeping requirements.
8. Identify risk management strategies based on an understanding of contract and tort concepts.
9. Identify legal roles and responsibilities inherent in the employer and employee relationship.
10. Identify regulatory concepts relevant to the practice of dentistry including federal and state laws, dental practice acts, and obligations unique to health professions as mandated by state or provincial laws.
11. Identify the following: applicable legal or regulatory principles and/or risk management strategies in case-based scenarios.

I. Legal Issues Encountered in Dental Practice and Oral Health Delivery Settings

A **lawsuit** is a legal action between two individuals, e.g., a patient sues a dentist, or an employee sues an employer. All members of the dental team are subject to lawsuits.

Examples of lawsuits between a patient and provider might include the following allegations:
- Incorrect medical or dental history taking;
- Complications due to a dental procedure;
- Lack of informed consent or informed refusal;
- Failure to diagnose, refer, or treat periodontal disease; and
- Use of defective products.

Examples of lawsuits in which an employee sues an employer include:
- Allegations of sexual or gender harassment;
- Allegations of ethnic harassment or intimidation;
- Failure to pay a fair wage;
- Unlawful termination; or
- Violation of civil rights, e.g., discrimination.

An employer may also file charges against an employee for illegal activity.

In addition to providing oral health services, dental practices are a business entity. Therefore, lawsuits related to the financial and related areas can be filed by employees, third parties, or the state. Business-related lawsuits may involve embezzlement, fraud, or breach of contract.

Dental providers are also subject to state and federal laws and may be charged with a violation related to failure to accommodate persons with disabilities, or follow specific public health mandates or codes, or Occupational Safety and Health Administration (OSHA) or Health Insurance Portability and Accountability Act (HIPAA) violations.

II. Basic Legal Concepts Important to the Provision of Patient Services

Dental providers are governed by a variety of laws, including statutory laws enacted by legislators; administrative laws or regulations created by regulatory boards; and common law or case law determined by court rulings and precedents. The law is divided into civil and criminal categories. A dentist or dental team member can be accused of both a civil and criminal violation at the same time.

- **Civil lawsuit.** A lawsuit brought about in court when one person claims to have suffered a loss due to the actions of another person.
- **Damages.** A monetary award in compensation for final loss; loss of, or damage to, personal or real property; or an injury.
- **Defendant.** A party against whom a lawsuit has been filed in civil court or who has been accused of or charged with a crime or offense.
- **Plaintiff.** A person who brings a legal action, such as a civil lawsuit or criminal proceedings, against another person or entity.

• **Trial.** A formal presentation of evidence before a judge and jury for the purpose of determining guilt or innocence in a criminal case or civil matter.

Civil law regulates relations between individuals or groups of individuals. The offenses include violations of private or contractual rights. In civil law, a lawsuit is brought against one person by another person. The individual bringing the lawsuit, the plaintiff, is alleging a violation occurred by the defendant.

An example is when a patient sues a dentist for failing to refer to a specialist for treatment. In civil law, the legal remedy that the plaintiff wants is to be "whole," since they have been harmed. In the legal system, a person is made whole by receiving monetary damages. The amount of monetary damages is influenced by the extent of the harm that the plaintiff has experienced.

In a civil lawsuit, information is presented in the trial and the jury or judge must decide on guilt or innocence. For civil violations, the level of proof required is a preponderance of evidence: The plaintiff must provide just enough evidence to make it more likely than not that the claim a person is making is true, or 51 percent certainty. Other civil claims may involve clear and convincing evidence, which is that the evidence must be substantially more probable to be true.

Criminal law regulates public conduct and established duties owed to society. In a criminal lawsuit, action is brought by the government against a person who allegedly committed a crime. Criminal violations may include violent acts, deceit, concealment, or wrongful use of force. A criminal charge is prosecuted by an agent of the government, such as a district attorney, and not the victim. There are two types of criminal law: felonies and misdemeanors. A **misdemeanor** is considered a less serious crime and is punishable by a fine or a jail sentence of less than one year. A **felony** is punishable by imprisonment of more than one year, a fine, and/or death.

The standard of proof in a criminal trial is that the prosecution must convince the judge or jury of the defendant's guilt beyond a reasonable doubt.

Administrative law is the body of rules and principles that governs the duties and operations of federal and state administrative agencies, commissions, and boards. In terms of dentistry, administrative law influences licensure and certification programs. The dental practice act of a state outlines the legal requirements to practice dentistry; specific violations of the act and resulting sanctions; and the scope of practice for licensed dental practitioners within the state, and may include additional information about recordkeeping, signage, and continuing education requirements. The level of proof in administrative law varies and may include reasonable or substantial proof or clear and convincing evidence.

III. Divisions of Civil Law: Contract and Tort

While **contracts** are frequently associated with business transactions, courts view the dentist-patient relationship in terms of contract principles. A contract is a written or spoken agreement, intended to be enforceable by law, between two or more consenting and competent parties to do, or not to do, a legal act for which there is sufficient **consideration**, i.e., exchanging something of value. In the dentist-patient relationship, the item of value is services for money.

A contract between a dentist and patient is one of two types: implied or express. An **implied contract** is an agreement through inference by signs, inaction, or silence. It can be created through the performance of a professional act. There is no written agreement. An **express contract** is one in which the terms are expressed and include either a verbal or written agreement. Only individuals with the appropriate mental and legal capacity can enter into a contract. Minors, for example, cannot.

In both situations, the relationship requires specific conditions and obligations that must be honored by each party. Thus, the contract requires specific oral health services to be provided by the dentist and the patient is obligated to reimburse the provider for those services. States frequently have caps on the amount of damages a plaintiff can collect in a contract dispute. There is often a **statute of limitations**, which is a time limit on filing a lawsuit.

Based on the contractual relationship, there are specific obligations on the part of the dental provider. A patient may have the right to sue for breach of contract if the obligation is not fulfilled by the provider.

These obligations apply to the dentist and staff and include:
• Personnel providing treatment being properly licensed and registered;
• Providers exercising reasonable skill, care, and judgment in diagnosis and treatment;
• Use of standard drugs, materials, and techniques;
• Never abandoning the patient;
• Doing only those things consented to by the patient;
• Giving adequate instructions to the patient;
• Charging a reasonable fee;
• Arranging care for the patient during an absence;
• Referring appropriate cases to specialists;
• Maintaining patient confidentiality;
• Employing competent personnel and providing required supervision;
• Not exceeding the scope of practice;
• Keeping accurate records;
• Complying with laws regulating the practice of the profession; and
• Practicing in a manner consistent with the code of ethics.

The patient also has contractual responsibilities:
• Paying the reasonable fee in a reasonable time;
• Keeping appointments;
• Providing accurate history information;
• Following instructions; and
• Keeping the dental provider aware of health status.

In recognizing that a dentist and patient may have a contractual relationship, there are specific legal concepts that allow the dentist to accept, or not accept, a patient for care. A provider has the discretionary right not to accept a patient or to terminate the relationship with the patient if the decision is not based on any protected class such as race, creed, color, or national origin. Thus, a

dentist may end a relationship with a patient of record because the patient is failing to make scheduled appointments, owes a balance, or is being uncooperative in care. A provider **must decline** to provide treatment to a patient if the provider does not have the skill to deliver the care the patient needs.

A **tort** also falls within the civil law area. A tort is a legal wrong that interferes with someone's right to enjoy his or her person, privacy, or property. There are two categories of torts: intentional and unintentional. An **intentional tort** is a civil wrong resulting from an intentional act on the part of the alleged wrongdoer. An intentional tort occurs when a person causes harm to another with the knowledge that harm or injury can occur, such as the following:

• **Assault** (threatening bodily harm): Acting in a threatening manner.
• **Battery** (unwanted touching): Performing a procedure without permission.
• **False imprisonment** (violating someone's liberty): Refusing to allow a patient to leave.
• **Deceit and misrepresentation** (incorrect or false representation): Promising a cure.
• **Defamation** (damage to a person's reputation through the spoken or written word): Making a negative statement about a dentist colleague.
• **Invasion of privacy** (public disclosure of private facts): Sharing information about a patient's health status.
• **Mental distress** (purposeful cause of anguish): Causing distress to someone in front of another.

Unintentional torts do not require a specific mental state intending to cause harm. It is a type of unintended action that leads to injury or property damage. Negligence is an unintentional tort. Negligence is failure of one owing a duty (a dental provider) to another to do what a reasonable and prudent person would do in the same or similar circumstances. If a dental provider is accused of negligence, an attorney will file an allegation on behalf of the patient (plaintiff) against the dental provider (dentist or dental hygienist). The legal principles most commonly used by patients to file suit against providers are within the area of dental negligence.

The plaintiff's attorney must prove three elements of negligence:
• A duty or responsibility that was recognized by law;
• A failure on the part of the provider to satisfy the duty or responsibility; and
• That the patient was harmed as a result of the failure to satisfy the duty.

Additional examples of negligence include:
• Failure to appropriately assess the patient's medical or dental history;
• Medication errors;
• Physical injury to the oral cavity or surrounding bone and tissue; and
• Failure to obtain informed consent.

The term "malpractice" refers to any professional misconduct, evil practice, or illegal or immoral act, not just negligence. Individuals may use the term malpractice when in fact they are describing dental negligence.

IV. Additional Legal Concepts

Dental providers expected to meet the **standard of care**, which is the level of care that a reasonably prudent practitioner would do in the same or similar circumstances, time, and place. The legal definition of the standard of care depends on the jury instructions within a particular state. Most cases allege that a dental provider, either through a specific action or omission, failed to meet the standard of care.

Duty is the responsibility to others to act according to the laws. There are three duties worth emphasizing: informed consent, informed refusal, and abandonment.

Informed consent is a process for getting permission before conducting a health care intervention or oral health care procedure. It is important to note it is a process; an interaction between the provider and the patient. Dental providers should get informed consent from patients and should document the consent in the dental record.

The elements included within an informed consent process include:
• Presenting the treatment in understandable language (non-technical terms);
• Describing the nature and need for the procedure;
• Outlining the benefits of the procedure;
• Stating the material risks to the procedure;
• Describing the prognosis if the procedure is performed or not performed;
• Describing alternatives to the procedure and the risks and benefits; and
• Providing an opportunity to respond to patient questions.

Minors cannot consent to dental treatment. State laws vary concerning the age when a minor can provide consent. Consent is possible from an emancipated minor. (An emancipated minor is a legal mechanism by which a minor is freed from control by their parents or guardians. Emancipation allows the individual to make certain legal decisions on their behalf.)

Informed refusal parallels informed consent and is documentation that a patient has declined a recommended treatment, referral, or professional advice. Patients that decline specific treatment or recommendations by a dentist may be dismissed, as the dentist may be putting themselves at risk for future allegations of negligence.

If a dentist offers a patient the opportunity to refuse treatment, the following elements of the refusal should be documented:
• The recommended treatment or procedure, including necessity and prognosis;
• The educational documents, brochures, handouts, or presentations that were given to or viewed by the patient;
• The oral and general health risks;
• The questions asked and the answers that were provided (by both parties);
• That the patient was informed of the risks of not following the recommendation(s);
• An explanation of the patient's reasons for refusal;
• That the consequences of the refusal were re-explained and the patient still refused recommended treatment or procedures. Note that the patient understood the risks of refusing care; and
• Individuals present and a signature of the patient, witness, and provider.

Abandonment is the termination of a professional relationship with a patient who is still in need of dental care. The dentist-patient relationship can end for many reasons; for example, the patient moves or dies. If a dentist wants to end a dentist-patient relationship, a specific written notification must occur. A letter must be forwarded to the patient indicating the date the relationship will end. The patient should be encouraged to seek another provider. The office should offer to provide emergency care only on an appointment basis. The letter should offer to provide copies of the patient's record for a reasonable fee. Some states have guidance about the cost of duplicating and forwarding dental records. The letter should be sent return-receipt and a copy of the letter maintained within the patient's record. Similarly, if an office is sold to another provider, some states have regulations that require the dental office to notify the office of the transfer of their records to a new dental practice owner. Any transfer of records should meet federal and state requirements for privacy.

Statute of limitations is the length of time an aggrieved person has to enter lawsuits against another for an alleged injury. It provides a time limit on a contract or tort action.

A dental provider should recognize that they are ultimately responsible for the care provided by the dentist or any employee. This is based on the legal concept of ***respondeat superior***. In simple terms, this concept is the legal principle of vicarious liability under which the employer is responsible for the malpractice of his or her employee.

V. Recordkeeping

A dental record provides information to privileged parties such as the patient, providers of care, guardians, and others granted permission to see the record, such as insurance carriers, with the information provided by the patient, other health providers, diagnoses, treatment, and outcomes. It is the source of information for all providers, critical in third-party relationships, and a resource and reference in litigation. Records should be in permanent ink or an acceptable electronic format, and clear and legible.

In the simplest of terms, good records provide a good defense for a provider accused of dental negligence. States provide guidance for the information that must be included in dental records.

Dental records requirements may include an obligation to document:
• Medical and dental history;
• A patient's existing oral health status;
• Results of diagnostic aids used, properly labeled;
• Diagnosis and treatment plan;
• Documentation of informed consent or informed refusal;
• Dental procedures performed, including the date of the procedure or type of treatment and the materials used;
• Dental referrals;
• The identity of the provider;
• Untoward incidents (events or accidents that could have or did lead to unintended harm, loss, or damage to a patient);

• A chronology of the patient progress during treatment;
• Date, dosage, and amount of any medication or drug prescribed, dispensed, or administered to the patient; and
• Number and type of radiographs taken.

State dental practice acts may offer more specificity about dental records, e.g., if a root canal is performed, documentation of the use of a rubber dam might be required. Prescription documentation for drugs as well as controlled substances may be outlined. If there is an exception to the document requirements — that they cannot be met — some states require an explanation from the dentist. States outline the period in which dental records must be retained. Some dates describe the requirements for pediatric patients specifically, e.g., seven years after the patient turns 18. A state may also outline a legal requirement to notify patients when an office decides to destroy a record.

Ownership of dental records belongs to the treating dentist or the owner of a dental practice if provided for under the contract. However, dentists have both a legal and ethical obligation to provide a copy of the patient's dental record upon written request from the patient, the patient's parent or legal guardian, or another properly authorizes person. This is true whether or not the patient owes a balance.

Maintaining the confidentiality of patient records is a legal and ethical obligation. HIPAA rules for privacy, security, and breach notification apply to a dental practice if it meets the definition of a "covered entity." Assuming a dental practice is a covered entity, the practice will need to take steps to comply, starting with the appointments of a HIPAA privacy official and a HIPAA security official. Other steps include, but are not limited to, reading and understanding all of the requirements, creating a HIPAA compliance team, delegating tasks, performing a risk assessment, devising policies and procedures, training workforce members, and maintaining compliance in an ongoing manner.

VI. Risk Management

A **risk** is a behavior that may cause harm, legal action, or other serious outcomes. Risk management includes clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patient, staff, and visitors.

Risk exposures include:
• Personnel malpractice or incompetence;
• Professional actions of employers and employees, e.g., harassment;
• Potential exposure to injuries by patients, staff, and visitors;
• Property and casualty exposures associated with office buildings or surrounding areas;
• Office equipment failures;
• Incomplete or improper office practices and policies, e.g., recall policy, prescription, and medication monitoring;
• Incomplete or incorrect recordkeeping;
• Lack of emergency preparedness;
• Financial fraud and abuse; and

• Violations of public laws, including the dental practice act, state laws, or statutes, e.g., OSHA.

VII. Employer and Employee Relationship

Dentists can be either an employer or employee. Whatever the role, each party must be familiar with his or her legal obligations and protections. An employer cannot ask an employee to do an illegal act. An employee should not be subject to any actions that could be deemed as illegal or discriminatory. If an employee feels they are the subject of unlawful discrimination, they can file an action with the Equal Employment Opportunity Commission (EEOC).

Hiring and termination. There are state and federal laws that protect individuals from discrimination and harassment. State laws may be more inclusive than federal laws. For example, federal laws protect against discrimination based on age, race, color, religion, gender, or national origin. State law may provide similar and/or additional protections based on marital status, height, weight, pregnancy, and gender identity. Federal laws frequently apply to business entities of 15 or more employees; state laws may apply to business entities with one employee. Individuals frequently sue using state laws as the source of the litigation.

Recruitment and hiring of employees. Advertisements or posts for positions should not exclude individuals who are protected by civil rights laws. It is also unlawful during the interview process to ask specific questions (verbally or on an application) that could lead to an illegal decision.

Examples of pre-employment illegal inquiries may include:
• Place of birth;
• Height or weight;
• Religion;
• If the applicant is pregnant, has children, or plans to have children;
• Race or national origin;
• Requiring photographs;
• Marital status;
• Sex;
• Age or date of birth, or other dates indicating age;
• Arrests that did not include a conviction;
• A physical or mental condition, unless related to the job;
• Maiden name, or original name if changed by court order;
• Prior work injuries or, if ever filed, a worker compensation claim;
• Garnishments; or
• Club, society, or lodge membership.

The employee relationship may be of two types: at will or contractual. **At will** is of indefinite duration, described as a relationship that can take place at will of either the employer or employee. The employment can be terminated at any time without a reason, and the employee can quit at any time. A **contractual relationship** is one that is of definite duration with guidelines for termination by either the employer or employee.

There are federal laws that protect employees based on specific characteristics, such as age, gender, and disability status. Some are highlighted below:

• The **Civil Rights Act of 1964** prohibits discrimination based on race, color, religion, sex, or national origin.
• The **Age Discrimination in Employment Act of 1967 (ADEA)** prohibits discrimination based on age against any employee or applicant for employment that is at least 40 years of age; requires 20 or more employees.
• The **American with Disabilities Act of 1990 (ADA)**, under Titles I and II, bans discrimination against disabled persons in the workplace and mandates equal access for the disabled to certain public facilities. Title III protects patients. The ADA protects three categories of individuals: a person who has a physical or mental impairment that substantially limits one or more major activities of that person; a person who has a record of such an impairment; and a person who, while not being disabled, is regarded as disabled. It applies to employers with 15 or more employees working at least 20 hours a week.
• The **Pregnancy Discrimination Act** is an amendment to Title VII of the Civil Rights Act which makes it illegal to fire an employee based on pregnancy, childbirth, or related medical conditions. An employer cannot force a woman to quit her job because she is pregnant, nor can a woman lose her job because she has an abortion. Pregnancy must be covered in an employer's medical plans like any other medical condition. However, if the employee's medical status requires additional time off for work, the absence must be treated as any other request for a medical leave would be by the employer.
• The **Equal Pay Act of 1962 (EPA)** guarantees comparable pay for men and women with similar skills and experience, not to be influenced by gender.
• The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** allows for the continuation of health benefits following termination of employment.
• The **Family and Medical Leave Act of 1981 (FMLA)** allows for leave of up to 12 weeks (if employed for more than one year and having worked at least 1,250 hours) for the care of children, adult children, personal health problems that affect the employee, spouse, or parents. It applies to employers with 50 or more employees.
• The **National Practitioner Data Bank (NPDB)** is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.

State jurisdictions have similar laws offering the same protections. State laws that offer protections may include a law that allows an employee to review his or her personnel records. Some states have protections from ethnic or racial intimidation that prohibits intentional intimidation or harassment based on race, color, religion, gender, or national origin. It can include physical contact, property damage, or verbal threats. There are protections for whistleblowers that shield employees from reprisals by an employer because that employee reported, or is about to report, a violation or suspected violation of a law of the state.

Sexual and gender harassment. State and federal laws protect individuals from sexual or gender-based harassment. Sexual harassment is a form of sexual discrimination that results in an individual working under adverse employment conditions. Sexual harassment occurs when a person is subject to unwelcome sexual advances, requests for sexual favors, or other verbal or

physical conduct of a sexual nature to such an extent that it alters the conditions of the person's employment and creates an abusive working environment.

There are two types of sexual harassment. The first, **hostile environment**, occurs when any type of unwelcome sexual behavior creates an offensive or hostile environment. The harassment does not have to result in tangible or economic job consequences. Examples of actions creating a hostile environment include ill-received jokes or offensive gestures, suggestive facial expressions, and unnecessary or unwanted physical contact.

The second category of sexual harassment, **quid pro quo**, includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a nature that submission to them is used as a basis for hiring, firing, or advancement. Patients or visitors, such as vendors, may also create a climate of harassment through their actions or words. Employers are required to address the harassment promptly and inform the individual alleging the harassment of the actions that were taken and the expected outcome.

VIII. Dental Practice Acts

A dental practice act outlines the legal requirements to practice dentistry and the scope of what can be practiced. It may be referred to as administrative law in some jurisdictions. The act includes definitions pertinent to the practice of dentistry; delegation requirements; scope of practice for specific members of the dental team; requirements for credentialing; dental specialty information; licensure information and renewal; recordkeeping; retention guidelines; and continuing education guidelines.

The act will also define the specific tasks that can be delegated to a dental hygienist or dental assistant. For example, a dentist can delegate a task with "general supervision," allowing the dental hygienist to perform a procedure on a patient of record while the dentist is in the office. Or a dentist may delegate a task to a dental hygienist with "direct supervision," requiring the dentist check the patient before and after the procedure.

Dental practice acts outline violations of the law applicable to dental providers, such as inappropriate delegation, failure to provide emergency care, allowing someone else to use a dental license, incompetence, and immoral behavior or lack of express or implied consent. States may refuse to issue, renew, revoke, or suspend a license; place on probation; or take other disciplinary or non-disciplinary action.

Examples of violations include:

- Fraud or misrepresentation in applying for a license;
- Inability to practice with reasonable judgment;
- Acceptance of a fee for service as a witness;
- Division of fees;
- Making or filing false records;
- Physical or mental illness;
- Failure to provide dental records;
- Convictions, a guilty verdict, or having entered a plea of nolo contendere;

• Advertising goods or services fraudulently;
• Committing an act that would constitute a sexual battery;
• Failure to provide adequate radiation safeguards;
• Being guilty of negligence; and
• Operating a dental office in such a manner as to result in dental treatment that is below minimum acceptable standards of performance for the community. This includes, but is not limited to, the use of substandard materials or equipment, the imposition of time limitations within which dental procedures are to be performed, or the failure to maintain patient records.

IX. Additional Legal Obligations

Often, state laws require additional legal obligations for the dentist, such as the following:

• **Child and adult abuse and neglect.** Dentists are often designated as mandated reporters and are legally and ethically required to report abuse or neglect to proper authorities.
• **Human trafficking.** States may require education and training for health professionals, including dentists, to identify signs of trafficking and know the mechanisms for reporting it.
• **Impaired colleagues.** Dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with firsthand knowledge that a colleague is impaired may have an obligation to report evidence to the professional assistance committee of a dental society or state-coordinated programs to assist health professionals in recovery.
• **Opioid safety and pain management.** States may require education about the dentist's responsibility to understand legal obligations and license requirements for the safe use of opioids and management of dental pain.

DEMONSTRATING COMPETENCY IN THE BUSINESS OF DENTISTRY: PHILOSOPHIES, PRINCIPLES, MODELS OF DELIVERY, AND TEAM LEADERSHIP

David G. Dunning, PhD, MA
University of Nebraska Medical Center
College of Dentistry

CODA competency covered:

2-19 Graduates must be competent in applying the basic principles and philosophies of practice management, models of oral health care delivery, and how to function successfully as the leader of the oral health care team.

NOTE TO SUPERVISING FACULTY

The Practice Management Section's intent is that the teaching of each module be interactive. Students will be able to access the student modules only. You can use any of the material that you have access to in the expanded module, the appendix, to lead discussions, and present material. Each appendix represents the author's module before being edited for student use. The appendices are designed to be your resource material.

The evaluation section is for your eyes only. We request that you do not share any of evaluation material. We ask that you use the same procedures you use in protecting your test material.

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DEMONSTRATING COMPETENCY IN THE BUSINESS OF DENTISTRY: PHILOSOPHIES, PRINCIPLES, MODELS OF DELIVERY, AND TEAM LEADERSHIP

Manual

David G. Dunning, PhD, MA
University of Nebraska Medical Center
College of Dentistry

UNIT 1

1.1: Defining a Practice Philosophy

What is a practice philosophy? Philosophy can be defined as a set of beliefs, values, or principles relating to a particular field or activity. It is a method of thinking based upon rationalism, striving to make no unexamined assumptions or leaps of faith. According to Dictionary.com, philosophy is "the rational investigation of the truths and principles of being, knowledge, or conduct," which together form the basis for core values and life.

Many core values may have been established by guidance from parents and life experiences prior to entering dental school. During dental school, daily challenges surface around a rigorous curriculum and the various disciplines involved in earning a dental degree. Professors also espouse their philosophies, and dental schools reflect either stated or actually practiced values. Students soon discover what they like and dislike about the dental profession and themselves. Most importantly, individual students develop rational reasons answering the "whys" of their likes and dislikes. These beliefs gradually become incorporated into a unique practice philosophy for each person.

Beliefs and values represent part of who we are as healthcare providers. According to a study conducted at Case Western University School of Dentistry, and published in *JADA*,[1] an associateship relationship is more likely to be compatible when practitioners have similar philosophies, among other characteristics.

1.2: Why a Practice Philosophy Is Important

Your philosophy is significant in that it forms a framework and provides meaning as to your identity as a dentist. It provides significance through values and understanding, which are motivational to staff and fellow dentists within the practice. Your philosophy will exemplify the standards and desire to provide the best professional care and do so at the highest level of service culture imaginable.

As noted elsewhere, "[r]elationships are built on emotional intelligence [—] the ability to seek and understand the views of others, in addition to the essential ability to build trust."[2] Sharing your philosophy allows you to engage with others on a level of understanding that is built upon sound principles and strong core values.

Each of us must decide what is important to us in life in a manner that reflects who and what we aspire to become as professionals. At times in our lives, we must do some self-reflection. Those periods of self-reflection may likely occur while we are still in dental school, when we graduate, and/or in private practice. Developing a philosophy requires such a reality check on who you are and who you want to become.

Envisioning the future takes courage, skill, and the ability to explore potential possibilities. It may even lead to the discovery you were wrong in assessing your personal and professional aspirations.

1.3 Components of a Practice Philosophy

The core components of a practice philosophy are **mission**, **teamwork/work climate**, **patient care**, and **community engagement**. These apply to any clinical operation, whether a for-profit dental practice or a nonprofit clinic.

Mission

Mission articulates the purpose of existence of any organization and answers the question "Why?" This can often be communicated in an action-verb statement or phrase such as "Providing the highest quality dental care," "Providing total dental care in a fun atmosphere," or "Helping patients keep their teeth for a lifetime." In a nonprofit context, a mission might be: "Offering hope and healing to people who are hurting." The other components of a practice philosophy should really flow from and out of the mission.

Teamwork/Work Climate

Arguably, the single most important predictor of a "successful" dental practice may be the quality of the relationships enjoyed in the dental team. The work climate of a dental practice, confined as it is in a relatively small space, is almost palpable upon entry. What do the sounds in the practice communicate about the practice? Is there joviality, joking, laughing? Can you sense fun or are team members stressed because of the need to see the next patient or worried about what the dentist might say? A practice philosophy should convey in some sense the centrality and importance of the team.

Patient Care

Clearly, in a health care setting with at least some patients fearful of seeing a dentist, addressing patient care is a critical element in a practice philosophy. Often, this may be expressed in modifiers such as "compassionate," "state of the art," "caring," "pain-free," or "relaxed." Depending on the scope of the practice, specific services might be mentioned such as twilight sedation, teeth straightening, and placing/restoring implants. Descriptions of the team might include the words "dedicated," "customer-focused," "compassionate," or "committed."

Community Engagement

This section of a practice philosophy articulates how a practice integrates with, is immersed in, contributes to, and is engaged with the broader community. Practice team members might, for examples, serve in community organizations, make charitable contributions, participate in a Mission of Mercy, sponsor youth sports teams, or even participate in the global community through a mission trip. The point is that the practice exists within local, regional, and global communities. Being part of a broader community is vital for practice reputation and for a sense of belonging for everyone in the practice.

Below are two practice missions/philosophies reproduced in whole or in part from online websites. Study each philosophy to see which components of a philosophy are addressed and emphasized. (For additional samples, please see the appendix.)

Assure a Smile (http://www.assureasmile.com/practice-philosophy/)

Mission Statement

Assure a Smile is a holistic dental office. This means that we consider each patient's overall health as it relates to his or her oral health. High quality dental restorations, patient education, and prevention are our primary tools. We offer the option of using all biocompatible and natural treatment methods. We are dedicated to helping people of all ages to achieve, and maintain healthy teeth and gums for life. We provide a full range of services in a personal, and caring environment.

Assure A Smile is Miami's longest tenured holistic dental practice. Our top priority is providing patients with comprehensive oral health care that safely improves oral health and wellness.

Show the world your smile! Your smile speaks volumes about who you are, even before you say a single word. For more than 20 years, Assure A Smile has helped South Florida residents create beautiful smiles that enhance their expression of charm, vitality, and self-confidence. Below, learn what makes Assure A Smile different from traditional dental offices by reading more about our philosophy and approach to patient care.

We believe in helping patients to look and feel their best through a holistic application of dentistry that not only improves oral health, but total body health as well. Our mission is to provide superior quality of service with an emphasis on patient education and holistic health awareness. Our ultimate goal is to empower patients to make informed lifestyle choices that build strong teeth, healthy gums, beautiful smiles, and life-long vitality.

Ellis General Dentistry (http://www.dennisellisdds.com/our-philosophy-2/)

Our Philosophy

Welcome to our practice!

We want to extend a warm welcome to you from our Chapel Hill dental practice. Our philosophy is simple. We are committed to providing you with high-quality, state-of-the-art dental care and

to make your visit to our office as pleasant and as comfortable as possible. We provide an atmosphere for our patients to make positive choices for their dental health. We are consistently working to improve our technical skills, with a strong commitment to continuing education.

Based on our philosophy, we believe that the foundation for better dental health is based on mutual trust, respect, communication and understanding. Our practice provides quality care with honesty, excellence and integrity. We are dedicated to a comprehensive approach to dentistry, considering both the functional and esthetic aspects of your smile. We understand that dentistry is a complex art, requiring expertise and experience to properly manage every aspect of your care. We invite you to become a part of our practice. We know you will immediately notice the difference in the way you are taken care of.

Endnotes for Unit 1

1. Halley MC, Lalumandier JA, Walker JD, Houston JH. “A regional survey of dentists' preferences for hiring a dental associate.” *JADA* 2008;139(7):973-979.
2. Chase, Linda K. “Professional Philosophy Statement,” www.lindakchase.weebly.com/professional-philosophy-statement

UNIT 2

2.1: The Two Basic Models of Dental Practice and Common Financial Challenges

Models of Dental Practice

There are essentially two basic models of dental practice: **nonprofit clinics** and **for-profit dental practices**. Nonprofit clinics may take the form of government-sponsored organizations such as county health departments; federally qualified health centers (FQHCs); and clinics affiliated with nonprofit organizations such as churches, synagogues, and other often faith-based “missions.”

For-profit dental practices include solo-practitioners; group practices with two or more dentists; and dental service organizations (DSOs). In recent years, there is an increased growth of both group practices and dental service organizations, though the solo-practitioner model continues to enjoy market share in some parts of the United States.

Regardless of model, all dental clinics/practices face the same basic financial challenge: attracting enough patients and providing enough dental care in order to generate enough revenue to pay the necessary costs of opening/acquiring and operating a dental clinic. Nonprofit clinics and for-profit practices both have to pay for staff; pay for facilities (rent/lease, utilities) and equipment; pay for supplies; pay for laboratory expenses; and compensate dentists. Cash flow is vitally important for both models of practice. Enough revenue must be generated and collected to pay the bills. In a nonprofit clinic, this revenue could come through charitable donations or grants in addition to patient services.

2.2: Fixed Expenses and Variable Expenses

Typical Dental Clinic Expenses

Every dental clinic must pay a common set of expenses. While experts may disagree about the relative costs and percentages these common expenses should occupy on a statement summarizing a clinic's financial performance, this are a composite list of expenses that can be expected, listed as a percentage of every dollar of revenue collected:

Fixed Expenses ("fixed" in the sense that they are constant regardless of the amount of dentistry that is provided):
25-35 percent: Staff compensation (pay, benefits, payroll taxes)
4-10 percent: Office space (rent or lease, utilities, repairs)
4-10 percent: Business taxes, marketing, professional services, dues or memberships, automobile, miscellaneous

Variable Expenses ("variable" because they go up the more dentistry that is provided)
8-12 percent: Laboratory
6-10 percent: Supplies (dental and office)

Accordingly, after adding up all of the possible expense, a very low percentage of overhead would be 50 percent or less — which is rare, but achievable in certain circumstances. So, a practice with $500,000 in annual collections and 50 percent overhead would enjoy $250,000 of revenue beyond expenses.

On the opposite end, a very high percentage of overhead might exceed 70 percent. So, the same practice with $500,000 in yearly collections would have $350,000 in expenses, providing the owner with $150,000 in revenue beyond costs.

Location can be significant factor in driving overhead costs. Costs of labor and office space in some markets are, for example, significantly higher. A practice in Silicon Valley, California, may incur twice the labor costs and triple the costs for office space compared to a practice in a small Midwestern town.

The laboratory range of 8 to 12 percent also assumes a traditional practice working with an external lab. Incorporating technology to fabricate lab work inside the practice would lower the percentage for laboratory. However, the cost to purchase and maintain the technology raises costs. The 8 to 12 figure approximates both situations.

2.3: Differentiating Margin and Profit

Margin

If nonprofit clinics generate enough revenue to cover expenses, any excess is typically referred to as "operating margin" or "margin." This is simply the amount of money above what costs are incurred or paid. For example, a church-affiliated clinic may need to generate $500,000 a year to pay all the costs for a clinic operating at 40 hours per week, including paying all staff, including

a staff dentist. If $525,000 is received annually from patient services and donations, the clinic would be operating at a +$25,000 margin. If yearly revenues fall short of $500,000 — for example, $455,000 — then the difference would be a -$45,000 “operating loss.”

Profit

If for-profit practices generate enough revenue to cover their expenses, any excess can be referred to as either “profit” or “margin [of profit].” This represents the amount of money above and beyond the costs in operating the business. If revenues fail to cover expenses, the practice operates at a “loss”. For purposes here, revenues beyond expenses will be referred to as “profit” in a for-profit setting. Nevertheless, occasionally you may hear “thin margin” or “tight margin,” which means there is little profit left over as a raw dollar amount or as a percentage.

There are various ways of accounting for an owner’s compensation in a for-profit practice, (depending on the type of business entity and complicated tax law, two critically important topics beyond the scope of this module). An example will help illustrate the point. An owner’s “reasonable” compensation of 28 to 32 percent of the collected revenue may be included in the practice’s expenses. In this case, the owner or employed dentist is essentially viewed as another employee paid by the practice; in which case the “profit” as such will be significantly and proportionately lower.

Horizon Dental, a hypothetical practice, incurs costs of operating the practice of $350,000 per year without the owner’s compensation. However, the owner or employed dentist could reasonably receive a compensation package of $150,000. This would raise the operating costs to $500,000. The amount above $500,000 would then be the practice’s profit, which would become part of the owner’s overall taxable income. In a sense, from another perspective, every dollar above $350,000 still goes to the owner and could be viewed as “profit” if the owning dentist is also providing the dental services.

In practices with multiple owners, written agreements should detail how profits will be allocated. In many cases, each dentist will receive a prorated amount of profit equal to the amount he or she contributed to the profit pie based on the individual dental care provided. If the owner generates 35 percent of the practice’s profit, then the owner would receive 35 percent of the practice’s profit as compensation in a guaranteed salary and/or a distribution of the practice’s profits.

2.4. The Financial Parameters of a Phase 1 Practice

A Phase 1 Practice

Dental consultant Dr. Mark Costes offers this basic plumb line or standard to understand the expenses and profit of a “**Phase 1**” practice:

30 percent of all revenue/collections allocated to pay all staff expenses but excluding the dentist (wages, benefits, payroll taxes)
30 percent of all revenue/collections allocated to pay all other expenses (facilities, utilities, lab, supplies, insurance, marketing, continuing education, etc.)

30 percent of all revenue/collections allocated to compensate the dentist, whether the dentist owns the practice or is an employed dentist
10 percent of all revenue/collections allocated to the profit of the practice itself regardless of whether the owner or employed dentist provides the dental services

Using this approach, a practice generating $800,000 in yearly collections would have:

$240,000 or less recommended for all staff costs ($800,000 multiplied by 0.30);
$240,000 or less recommended for all other costs;
$240,000 in compensation to the dentist providing the dental services; and
$80,000 in profit for the practice itself as a business. The $80,000 would belong to the owner regardless of whether or not the owner is actually providing the dental services.

2.5. Profit and Loss Statements

Profit and Loss Statements

Profit and loss statements summarize in a page or two the financial performance of a for-profit dental clinic by month, business quarter (three-month period), or year. The statement typically will list:

Total clinical production
Total clinical collections
Total adjustments and write-offs (discounted dental services)
Total billed to accounts receivable
Total received from accounts receivable
Total expenses/costs and expenses by major category or grouped categories
"The Bottom Line": Total profit or loss for the period of time

Below, Example 2.5A presents a basic profit and loss statement based on Dr. Costes' Phase 1 practice plumb line. Horizon Dental, the theoretical practice, is achieving the financial performance targets recommended by Dr. Costes. Example 2.5B (which appears in the appendix) presents a more detailed profit and loss statement based on the same data from Example 2.5A, but broken out in subcategory detail.

What happens to a practice's profit when a practice suffers from excessive overhead expenses? The simple answer is that the profit decreases proportionately. Using the same revenue numbers from Example 2.5A, Example 2.5C presents Downtown Dental's profit and loss statement using Dr. Costes' simplified overhead formula but with costs exceeding the recommended plumb line expectations. The result: There is $26,400 in profit if the owner is the operating dentist, but $0 profit for the owner if he or she is paying for an associate/employed dentist to provide the dental services.

Example 2.5D presents Sunset Dental's monthly profit and loss statement with expenses even more dramatically higher than the plumb line. Sunset Dental's owner-doctor would realize a profit of $20,900 for the month. However, if the owner-doctor had employed a dentist and paid

him or her $28,500 (30 percent of collections), the owner would actually operate at a loss of -$7,600 — or ($7,600), since a loss is often listed in parenthesis as an accounting convenience.

Finally, Example 2.5E depicts Doomed Dental's monthly numbers in which revenue numbers are lower and expenses relatively very high. The owner-doctor of Doomed Dental would only realize a profit/compensation of $5,000 per month ($60,000 per year); even worse, if Doomed Dental was owned by a dentist employing another dentist, the owner would be operating at a loss of $10,000 per month or $120,000 per year.

In summary, then, whether analyzing a nonprofit or a for-profit clinic, both types of practice models need to bring in enough revenue to pay for expenses or operating costs. If enough revenue cannot be realized, cost-cutting may be required; otherwise, the clinic may not be able to survive financially over the long term. Lest it be overlooked, if the owner of Sunset Dental is providing the dental services, he or she is still earning a nice income of $250,800 annually ($20,900 x 12 months).

Example 2.5A: Horizon Dental's Basic Monthly Profit and Loss Statement Using Dr. Costes' "Phase 1" Plumb-Line Model

Production and Adjustments
Total Production: $110,000
Total Adjustments (including write-offs): $15,000
Net Production: $95,000

Income

Payments from Accounts Receivable: $45,000
Monthly Collections: $50,000
Total Collections: $95,000

Expenses

Total Staffing Costs: $28,500 (30 percent of Total Collections)
Total All Other Costs: $28,500 (30 percent of Total Collections)
Total Costs: $57,000

Profit or Loss including dentist compensation: $38,000 ($95,000-$57,000)

OR

Profit or Loss compensating dentist 30 percent

Dentist compensation: $28,500 (30 percent of Total Collections)

Profit to Owner: $9,500 ($95,000 Total Collections - $85,500 to Staff, All Other Costs, and Dentist Compensation)

Example 2.5B: Horizon Dental's Basic Monthly Profit and Loss Statement Using More Detailed Subcategories (In Appendix)

Example 2.5C: Downtown Dental Basic Monthly Profit and Loss Statement

Production and Adjustments

Total Production: $110,000
Total Adjustments (including write-offs): $15,000
Net Production: $95,000

Income

Payments from Accounts Receivable: $45,000
Monthly Collections: $50,000
Total Collections: $95,000

Expenses

Total Staffing Costs: $34,200 (36 percent of Total Collections)
Total All Other Costs: $34,200 (36 percent of Total Collections)
Total Costs: $68,400

Profit or Loss Including Dentist Compensation: $26,600 ($95,000 - $68,400)

OR

Profit or Loss compensating dentist 30 percent

Dentist compensation: $28,500 (30 percent of Total Collections)

Profit or Loss to Owner: 0 ($95,000 Total Collections - 95,500 to Staff, All Other Costs, and Dentist Compensation)

Example 2.5D: Sunset Dental Basic Monthly Profit and Loss Statement

Production and Adjustments

Total Production: $110,000
Total Adjustments (including write-offs): $15,000
Net Production: $95,000

Income

Payments from Accounts Receivable: $45,000

Monthly Collections: $50,000
Total Collections: $95,000

Expenses

Total Staffing Costs: $36,100 (38 percent of Total Collections)
Total All Other Costs: $38,000 (40 percent of Total Collections)
Total Costs: $74,100 (78 percent overhead without paying dentist)

Profit or Loss including dentist compensation: $20,900 ($95,000 - $74,100)

OR

Profit or Loss compensating dentist 30 percent

Dentist compensation: $28,500 (30% of Total Collections)
Loss to Owner: -$7,600 ($95,000 Total Collections - $102,600 to Staff, All Other Costs, and Dentist Compensation)

Example 2.5E: Doomed Dental Basic Monthly Profit and Loss Statement

Production and Adjustments

Total Production: $60,000
Total Adjustments (including write-offs): $12,000
Net Production: $48,000

Income

Payments from Accounts Receivable: $25,000
Monthly Collections: $25,000
Total Collections: $50,000

Expenses

Total Staffing Costs: $22,500 (45 percent of Total Collections)
Total All Other Costs: $22,500 (45 percent of Total Collections)
Total Costs: $45,000 (90 percent overhead without paying dentist)

Profit or Loss including dentist compensation: $5,000 ($50,000 - $45,000)

OR

Profit or Loss compensating dentist 30 percent

Dentist compensation: $15,000 (30 percent of Total Collections, $50,000 x 0.30)

Loss to Owner: -$10,000 ($50,000 Total Collections - $60,000 to Staff, All Other Costs, and Dentist Compensation)

UNIT 3

3.1: Third-Party Payer Dental Insurance Benefit Programs

Definitions
Indemnity or Direct Reimbursement Plans: A dental benefit plan providing reimbursement at 100 percent of usual fees for covered services.

Preferred Provider Organization (PPO) or Network: A dental benefit plan providing reimbursement ranging from 60 percent or less to 90 percent of usual fees for covered services. PPO is by far the most common type of dental benefit plan.

Capitation/Dental Health Maintenance Organization: A dental benefit plan will great ranges of reimbursement for covered services from 0 percent to 80 percent, plus a monthly payment per patient of ~$5 to ~$7 whether or not patients receive treatment or not.

Medicaid/Title 19 and Children's Health Insurance Program (CHIP): A government benefit plan for those with lower incomes. This is a joint plan between the federal and state government. Children tend to have more services covered than do adults, and reimbursement levels are commonly in the 40 percent to 50 percent range of usual fees for covered services.

A more detailed overview of third-party payers, complete with general guidelines, is listed in the appendix.

3.2: Computing a Practice's Profit and Distinguishing Between Gross Production and Billable Production

The following examples demonstrate the significant differences in comparing gross production to billable production. Remember, gross production is the amount of dental services that *could* be charged *if all* patients paid full fees and the services received. Billable production, in contrast, is the amount that can be legally billed or charged to patients *after* factoring-in adjustments for third-party dental benefit programs such as preferred provider organizations.

Example 1

Practice A has $1 million in gross production and an amazing 100 percent collection rate. The practice's total overhead is $600,000. What is the overhead percentage? 60 percent. What is the profit percentage and dollar amount? 40 percent and $400,000.

Assume the same practice has, on average, a 20 percent adjustment or discount for all third-party plans. Now what is the profit of the practice? $1 million - $200,000 = $800,000. Now the profit is only $200,000. Note that with $200,000 in third-party adjustments, the overhead percentage

jumps from 60 percent to 75 percent if using billable (sometimes also referred to as net) production to compute overhead ($600,000 divided into $800,000).

Example 2

Practice B has $600,000 in gross production and an amazing 100 percent collection rate. The practice's total overhead is $350,000. What is the overhead percentage? 58.3 percentage. What is the profit percentage and dollar amount? 41.6 percent and $250,000.

Assume the same practice has, on average, a 25 percent adjustment or discount for all third-party plans. Now what is the profit of the practice? $600,000 - $150,000 = $450,000. Now the profit is only $100,000 ($600,000 - $150,000 - $350,000). Note that with $150,000 in insurance adjustments, the overhead percentage jumps from 58.3 percent to 77.8 percent ($350,000 divided into $450,000) if using billable (net) production to compute overhead ($350,000 divided into $450,000).

Example 3

Practice C has $1.2 million in gross production and an amazing 100 percent collection rate. The practice's total overhead is $650,000. What is the overhead percentage? 63.7 percent. What is the profit percentage and dollar amount? 36.3 percent and $550,000.

Assume the same practice has on average a 30 percent adjustment or discount for PPO involvement. Now what is the profit of the practice? $1.2 million - $360,000 (30 percent) = $840,000 - $650,000 overhead = profit of only $190,000. Note with $360,000 in third party adjustments, insurance adjustments, the overhead percentage jumps from 63.7 percent to 77.4 percent ($650,000 divided into $840,000 if using billable (net) production to compute overhead).

3.3: Why Dentists Participate in Third-Party Plans

The answer consists of three major points.

1. Percentage of patients with dental benefits. Approximately 65 percent to 77 percent of the population has third-party dental benefits. To ignore that number of patients to build a "fee-for-service" only practice, while possible, is very difficult because the dentist must grow a patient base over time from the remaining smaller piece of the pie of 23 percent to 35 percent of all available patients.

2. Income. Third-party plans described in the table provide ~65 percent of the income to dentists in private practice.

3. Third-party plans drive utilization. Patients with dental benefit plans are more likely to go to the dentist and more likely to have specific types of treatment when that treatment includes a benefit.

UNIT 4

4.1: Key Performance Indicators (KPIs)

KPIs: A Report Card for Financial Performance

Leading dental consultants identify and track KPIs. Total overhead percentages, overhead percentages by broad categories such as staff, and by subcategory are, arguably, the most important KPIs. These topics were covered in Unit 2. A thorough discussion of other KPIs is beyond the scope of this unit. Furthermore, experts may have somewhat varying opinions about the suggested target numbers and percentages. Nevertheless, these are some of the most commonly recommended KPIs and suggested targets include:

Key Performance Indicators Table Beyond Overhead and Targets

Overall Appointment Utilization (total number of available appointments divided into total possible appointments): 90 percent+

Accounts Receivable (money owed to the practice): 1 month's billable (net) production[1]

Collection/Production Ratio (amount of collections divided into billable production): 98 percent+

Hygiene Department

Efficiency: Collections at 3 times total compensation

Percent of General Practice Revenue: 30 percent, plus or minus

Recall/Recare Efficiency (total number of recall patients seen divided into the number of total recall patients due): 90 percent+

New Patients: 1 per business day

Percentage of Total Gross Production from Third- Party Payers[2]: No more than 30 percent to 50 percent, but highly market-driven

[1]*This is the dollar amount owed to a practice from patients and third-party payers such as insurance companies and Medicaid.*
[2]*This is the dollar amount of total production as if every patient were a fee-for-service patient; that is, as if no third-party-payers were involved.*

Reviewing the sample performance information for Horizon Dental in Example 4.1A (below), the following observations can be made:

1. Overall utilization — that is, the number of possible appointments versus the number of realized appointments, was at 85 percent. If the target of 90 percent was realized, the practice would have had 60 more patient appointments (1,200 x 5 percent). The 85 percent utilization may indicate a need to enhance appointment scheduling and confirmation systems. Sixty more patient appointments could have easily generated another ~$10,000 (~$167 per appointment.

While there would be some increased variable costs of perhaps, on the high end, $2,000 in laboratory and supplies, the remaining $8,000 would significantly raise Horizon Dental's profit from $38,000 to $46,000, a 21 percent increase! This illustrates why utilization percentage is so critically important.

2. Accounts receivable billings were $45,000. This is less than the $95,000 in billable production, and so the practice is doing a commendable job in collecting money owed to the practice.

3. The practice collected $95,000, and $95,000 was generated in billable production, resulting in a terrific 100 percent collections divided into production ratio.

4. Dental hygiene collections were $28,000, with $10,000 going to dental hygiene staffing. So hygiene efficiency was at 28 percent, just under the recommended 30 percent. Similarly, hygiene collections were at 29.5 percent of total practice collections, nearly equal to the recommended 30 percent. Similar to the overall practice utilization numbers, the percentage of dental hygiene utilization was at 86 percent.

5. The practice missed the mark of one new patient per business day, with 15 new patients for the month. This may point toward a need to augment the referral system from existing patients and increase internal and/or external marketing efforts.

6. Horizon Dental had 45 percent of total gross production coming from third-party payers.
This is a fairly high percentage. However, judging this percentage requires understanding the market share of third-party plans in the area. If 60 percent of the market includes third-party-payers, then Horizon Dental has done an admirable job in attracting fee-for-service patients. However, if only 30 percent of the market includes third-party payers, then Horizon Dental, arguably, has too high a percentage of third-party patients. Remember that the utilization level for the practice is at 85 percent. It is possible that Horizon Dental's gap in recommended versus realized appointments has arisen because fewer patients from third-party payers are being accepted.

Example 4.A: Horizon Dental Monthly Performance Information

Production and Adjustments

Total Production: $110,000
Total Production from Third-Party Payers: $50,000
Total Adjustments (including write-offs) from Third-Party Payers: $14,500
Total Uncollectibles: $500
Net Production: $95,000
Net Collections from Dental Hygiene: $28,000

Income

Billed to Accounts Receivable: $45,000
Payments from Accounts Receivable: $45,000
Monthly Collections: $50,000
Total Collections: $95,000

Expenses

Total Staffing Costs: $28,500 (30 percent of Total Collections)
Dental Hygiene: $10,000
Clerical, Front Office: $8,000
Clinical Staff: $10,500

Total All Other Costs: $28,500 (30 percent of Total Collections)
Total Costs: $57,000

Profit/Loss including dentist compensation: $38,000 ($95,000 - $57,000)

Key Performance Indicators Table Beyond Overhead and Targets Compared to Actual Amounts

Overall Appointment Utilization (total number of available appointments divided into total possible number of possible appointments)): 90 percent+; 85 percent (1,020/1,200)

Accounts Receivable (money owed to the practice): 1 month's billable (net) production production < month

Collection/Production Ratio (amount of collections divided into billable production): 98 percent+; 100 percent

Hygiene Department

Efficiency: Collections at 3 times total compensation; 2.8

Percent of General Practice Revenue: 30 percent, plus or minus; 29.5 percent

Recall/Recare Efficiency (total number of recall patients seen divided into the number of total recall patients due): 90 percent+; 86 percent

New Patients: 1 per business day; less than 1 per business day (15 per month)

Percentage of Total Gross Production from Third- Party Payers: No more than 30 percent to 50 percent, but highly market-driven; 45 percent

4.2. Third-Party Payer Participation on Practice Profitability

As highlighted in Unit 3, third-party payers occupy a significant market share in dentistry on a national level. Further, the local market may mirror the national market or have a significantly higher or lower market share of patients in third party programs. Establishing limitations of

third-party payers in a practice while maintaining high levels of utilization has a direct and powerful impact on profitability in a practice.

Decades ago, a series of tables were published, including these two: profitability following a reasonable fee increase; and fee cut versus increase of sales and profitability. These are part of a mysterious “Kodak Study,” presumably funded and published by the Eastman Kodak Company. However, after making exhaustive efforts to verify the authorship of the tables and secure permission to publish the tables, the author(s) of the tables could not be located. Therefore, only a few lines from two of the tables are being reproduced in this unit.

Table 1: Fee Cut vs. Increase in Sales and Profitability

Overhead %	Reduction in Fee	% of Increased Sales Required to Break Even in Profit
70	20	300
65	20	233
60	20	200

Think of “Percent of Increased Sales” as the number of dental appointments. A reduction of 20 percent in fees was chosen because this would be a very generous PPO third-party payer plan, given that the national reimbursement level from PPOs is 72 percent of usual/customary fees (see Unit 3). Using 60 percent overall overhead, the lower end of average and the recommended target in Dr. Costes’ Phase 1 practice (Unit 2), note that accepting a 20 percent reduction in fees means that twice as many appointments have to occur (200 percent) to maintain the same level of profitability.

In other words, reduction in fees means that a practice must see significantly more patients to maintain the same level of profitability. The more third-party patients occupy a practice, the more that profit gets pinched, all other things being equal. Of course, all things are not equal! In markets with large percentages of third-party payers, dentists face a very difficult strategic decision: accept fewer patients from third-party payers and probably also have fewer patients and fewer appointments (lower utilization), or accept more patients from third-party payers and probably have more appointments (higher utilization).

This simple comparison demonstrates the impact of PPOs reimbursing at 72 percent for 30 percent of practice revenue in Practice B, compared to Practice A with no third-party payers.

Practice A Yearly Figures

$600,000 Gross Production (All fee-for-service)

$588,000 in Collections (98 percent of $600,000)
-$360,000 Overhead (60 percent of $600)
= $228,000 Profit

Practice B Yearly Figures

$600,000 in Gross Production
-$50,400 ($180,000 of Gross Production from PPO [30 percent of revenue] x 0.28 in adjustments)
= $549,600

$538,608 in Collections (98 percent of billable production)
-$360,000 Overhead
= $178,608 Profit

Practice B has $49,392 in less profit than Practice A. If Practice B could meticulously reduce involvement over time to 20 percent PPO plans instead of 30 percent, replacing PPO patients with fee-for-service patients or retaining PPO patients without being on the preferred list/accepting lower fees, a proportionately higher level of profit could be realized. This is a steep challenge in many markets dominated by PPOs.

4.3. Fee Increases and Practice Profitability

It is absolutely essential in practice to raise fees on an annual basis to at least keep even with the level of inflation. Otherwise, practice profitability will suffer over time with costs increasing and relative revenue from fees remaining the same.

Another fee lines from a second Kodak Study table will demonstrate the astonishing impact of fee increases on profitability. Note, importantly, that the information in Table 2 assumes fee-for-service patients and that utilization remains high (in other words, patients don't leave after the fee increase).

Table 2: Influence on Profit after Fee Increases

Overhead %	% of Fee Increase	Increase in Profit as %
70	5	16.6
60	5	12.5
70	10	33
60	10	25

Reasonable fee increases impact profit so dramatically because if patients stay with the practice and revenue is collected, essentially all of the increased revenue goes right into the practice's profit. Why and how? All the expenses have been paid. Consider what would happen if Practice A increased fees 10 percent and retained all the patients.

Practice A Year 2 Figures After Raising Fees 10 percent

$660,000 Gross Production (All fee-for-service)

$646,800 in Collections (98 percent of $660,000)
- $360,000 Overhead (60 percent of $600)
= $286,800 Profit (compared to $228,000 earlier, an increase of over 25 percent)

And what would a fee increase of 5 percent in Year 2 look like for Practice A, again assuming fee-for-service patients who stayed and paid?

Practice A Year 2 Figures After Raising Fees 5 percent

$630,000 Gross Production (All fee-for-service)

$617,500 in Collections (98 percent of $630,000)
-$360,000 Overhead (60 percent of $600)
= $257,400 Profit (compared to $228,000 earlier, an increase of over 12.5 percent)

4.4. Two Strategies to Control Overhead Expenses

Some dentists have developed and implemented their own discounted dental programs for patients. These are essentially "membership" programs in which patients pay a monthly or annual premium in order to receive free or significantly discounted basic preventative services such as prophies, exams, and radiographs. In addition, other services may be provided at a discount that can vary widely and commonly fall about at the midway between fee-for-service and PPO reimbursement levels. With the average PPO reimbursement level at 72 percent, the discounted programs developed and implemented by dentists may reimburse at 80 percent to 90 percent (a discount of 10 percent to 20 percent). In an increasingly highly competitive marketplace, this strategic option allows a dentist to receive higher levels of reimbursement than offered by PPOs while maintaining and growing his or her patient base.

Dentists are networking with one another to create cooperative consortiums of buyer groups or supply membership groups. As with patients in a discounted service program, dentists may pay an annual fee that entitles them to purchase dental and office supplies at significant discounts. Keep in mind that the expected level of overhead or business expenses for dental and office supplies is 6 percent to 10 percent. This means that $6 to $10 of every $100 in collections pays for supplies. If practice with $1 million in annual collections pays 8 percent to supplies, that amounts to $80,000. Trimming that to, say, 6 percent saves $20,000 in overhead expenses, and increases profitability by $20,000.

UNIT 5

Many researchers, experts, and practitioners have examined issues related to staff/team management over the decades. This unit highlights best practices related to three vital content areas in staff management: hiring, evaluating, and disciplining or dismissing.

5.1: Best Practices for Selecting Dental Staff

1. Conduct a legally compliant, structured employment interview. Employment law varies by state and local jurisdiction. Generally, however, all employment decisions from hiring to training to evaluating to dismissing cannot discriminate on the basis of race, color, national origin, sex/gender, or religion. Consequently, employment interview questions should not directly or indirectly ask about these "protected" areas.

2. Employ group interviews for potential staff members. This may include either having multiple interviewers and/or multiple interviewees in the interview.

3. Check references, including past three employers. Realize that some former employers may only confirm job title and employment dates for fear of a lawsuit. Ask references, "Would you rehire this person to work for you again?" See if the reference will comment on specific aspects of job performance: some will; some won't. Make sure you verify credentials.

4. Utilize a "working interview" (technically a skills assessment) in which a potential staff member works for a few hours or days in the office before hiring. Make sure you have sound legal counsel and malpractice issues covered if you do this.

5. Use integrity testing as part of the hiring process, including background checks.

6. Establish a probationary period of employment (perhaps 3 or 6 months) for new hires.

5.2: Best Practices for Managing Dental Staff Performance

1. Utilize complete and accurate job descriptions.

2. Utilize a meaningful, manageable evaluation/appraisal form.

3. Set individual performance goals/objectives.

4. Conduct standardized appraisals/evaluations at least once every year.

5. Focus performance appraisals/reviews primarily on staff development rather than compensation increases. Why? The rationale is that the main purpose of performance reviews should be staff growth rather than compensation per se, and that compensation increases are contingent upon practice growth in revenue and/or profitability from year to year; in some years, especially in a recession, increases in compensation may not be financially feasible for the practice owner(s).

6. Have staff members self-evaluate their own individual performance.

7. Document critical incidents of staff member performance. A critical incident is simply a case of exceptionally positive or negative work behavior, perhaps about one incident per staff member per month unless documenting for disciplinary reasons (see below).

8. Provide day-to-day feedback that is consistent with what is covered in formal reviews/appraisals.

5.3: Best Practices For Disciplining/Dismissing Dental Staff

1. Document performance shortfalls as a basis for dismissal/discipline.

2. Implement “progressive discipline”:
• First offense results in a verbal/spoken warning;
• Second offense results in a written warning;
• Staff member commits in writing to achieve work standards; and then, if necessary
• Staff member is dismissed at the end of the workweek in most cases and not allowed back in the practice after dismissal. These steps of progressive discipline are for habitual and essentially unimproved performance shortcomings over time.

5.4: Characteristics of an Embezzler

Approximately 50 percent to 60 percent of dentists report having already been victims of embezzlement. And it has been estimated that 80 percent or more of dentists will be victims of some level of significant embezzlement over the course of their career (Harris). Therefore, understanding the characteristics of an embezzler becomes critically important in protecting a dental practice. Some are listed below:

• Financial difficulty;
• Addictions or other compulsive behaviors;
• Being “super-dedicated,” especially working unusual hours or never taking vacation/sick days;
• Being unusually territorial about work or workspace;
• Acting as control freaks, or cocooning: wanting to control communication between patients and practice;
• Conspicuous displays of honesty;
• Resisting practice management software upgrades;
• Resisting increased involvement of consultants and/or accountants;
• Attempting to exert control over choice of practice advisors; and/or
• Possessing a vehicle newer (and bigger) than the dentist.

5.5: Best Practices for Managing Staff and Performance and for Evaluating/Dismissing Staff

The ethical principle of justice embodies policies and behavior related to fairness; the ethical principle of non-maleficence encompasses keeping people from being harmed. The practices for managing staff performance and for evaluating/dismissing staff embrace these ethical principles. For example, employment interview questions should be legally compliant and not discriminate against a person’s civil rights. Similarly, checking references, doing background checks and using integrity testing as vital steps in the employment process helps to validate the credentials and qualifications of the job application, while also helping to protect the employer or practice from hiring someone who may have a history of embezzling dental practices. As part of the

guidelines for evaluating job performance, staff members and their supervisors are both encouraged to evaluate job performance, encouraging self-reflection and responsibility and providing a more level footing toward more fair, thorough and objective feedback. And the guidelines for dismissing staff allow an individual more than one change to make improvements when given specific feedback, offering adequate time and fair chance to enhance performance in areas of weakness before being terminated from a position.

UNIT 6

6.1: Two Variables for Financing a Dental Practice: Credit Rating and Monthly Payments as a Percentage of Monthly Practice Revenue

A solid personal credit rating is required. Up to a point, the higher the credit rating, the lower the loan interest rate; a credit score below ~650 will likely mean loan disapproval or the inability to get financing to buy a practice — or at least make it very difficult. The higher your credit rating above 665, the greater your chances of getting practice financing, and with better terms. A well-developed business plan (with sound pro forma financial projections) will often be required. Loans usually include practice purchase price and working capital (typically the practice value plus another 5 percent to 10 percent of the purchase price; lenders typically require a year or two in practice (and/or supplemental income) before approving a practice loan.

Twelve percent to 16 percent (or less!) of monthly practice revenue is an acceptable range for a monthly payment for a practice.

6.2: Percentage of Annual Revenue/Collections

Wells Fargo Practice Finance, the ADA’s only endorsed lender, typically does not offer loans for a practice purchase if the purchase sales price is above 85 percent of annual collections, and the 85 percent includes working capital to establish needed cash flow. So Wells Fargo usually does not offer financing if the purchase price is above 75 percent to 80 percent of annual collections, given the typical, additional need for a line of credit/working capital. If you are looking at purchasing a practice for more than this amount, proceed with sound counsel by vetting the practice thoroughly. Owner financing may be necessary, and the numbers need to make financial sense and to pass the cash flow formula below.

In addition, it must be acknowledged that there are dramatically different market parameters in play in various regional geographic regions. Dental practices in rural areas often actually sell for much less than the maximum 85 percent loan limit mentioned above, and may be more in the range of 50 percent to 60 percent or less. Conversely, dental practices in major cities, particularly on the East and West coasts, may sell for well above 100 percent to 125 percent of annual collections.

6.3. Debt-to-Service Ratios

Lenders often expect that a practice should generate enough cash flow to be a minimum of a 1.25 ratio or perhaps higher based on information immediately below. You should be able to evaluate a given set of numbers to see if this 125 percent debt-to-service ratio (DSR) criterion is met or not. In other words, the expected net excess cash/profit for the new owner should be, at a minimum, 25 percent higher than the estimated personal living expenses budget. See examples below.

Current loan terms would be for a 10-year loan (commonly fixed for five years and then possibly refinanced) from the 5 percent to 6 percent range, respectively, for great credit ratings and acceptable credit ratings.

A formula for computing the necessary debt-to-service ratio is:

Annual Practice Revenue (Actual Collections)
- Adjusted overhead. This includes all expenses including business taxes and normalized overhead, a term described below)
- Personal Taxes
- Loan Payment
= Net Income or Excess Cash from Practice (the new owner's profit)

The total excess cash from practice total should be 125 percent or more as a ratio compared to the personal living expenses budget (which should be very detailed, including housing, autos, food, travel, utilities, gifts, student loan payments, charitable giving, etc.).

Here are two examples; two others (Exhibits 3 and 4) are listed in the appendix.

Example No. 1:

Revenue from practice of $700,000
- Adjusted overhead of $350,000
- Expected Personal Taxes of $100,000
- Loan Payment of $60,000

Net Income or Excess Cash from Practice (new owner’s profit) = Total excess cash from practice = $190,000

Total Excess Cash from Practice = $190,000
Personal/Family Living Expenses/Budget = $130,000
Ratio is ~146 percent (acceptable to lender; $130,000 x 1.46 = ~$190,000)
Minimum needed Excess Cash from Practice = $162,500 (130 x 1.25)

Example No. 4:

Revenue from practice of $800,000
- Adjusted overhead of $500,000
- Expected Personal Taxes of $90,000

- Loan Payment of $55,000
Net Income or Excess Cash from Practice (new owner's profit) = Total excess cash from practice = $155,000

Total Excess Cash from Practice = $155,000
Personal Living Expenses Budget = $135,000
Ratio is ~115 percent (unacceptable to lender; $135,000 x 1.15 = ~$155,000)
Minimum needed Excess Cash from Practice = $168,750 (135 x 1.25)

Lenders are reluctant to offer financing if a practice cannot reasonably be expected to generate at or above 1.25 times the potential new owner's personal living expenses budget.

6.4: Normalized Overhead

Normalized overhead/normalization of overhead is the process of separating necessary operating expenses (overhead items) from optional operating expenses in order to determine true cash flow, overhead, and profitability.

A number of expenses included in a practice's overhead are essentially perks and at the discretion of the owner, such as maximum contributions to retirement plans, annual continuing education trips to Hawaii, car leases, higher-than-market rental/leasing expenses because the owner also owns the building as part of another corporation. Such expenses are not likely business necessities for a new owner, and so can be removed to determine actual cash flow, overhead, and profit.

In other cases, a current owner may be avoiding typical business expenses by paying lower than market rent/lease because he or she owns the building; or perhaps compensating a spouse below a fair market level of pay. So, in those cases, normalization requires adding to the expenses what the new owner can be reasonably expected to pay. For examples, market-based rent/lease and providing a regular team member (non-spouse) a competitive compensation package.

APPLICATION OF ETHICAL DECISION-MAKING IN DENTISTRY

Pamela Zarkowski, MPH, JD
University of Detroit Mercy
Phyllis Beemsterboer, EdD, MS
Oregon Health and Science University

CODA competency covered:

2-21 Graduates must be competent in the application of the principles of ethical decision making and professional responsibility.

Intent: Graduates should know how to draw on a range of resources, among which are professional codes, regulatory law, and ethical theories. These resources should pertain to the academic environment, patient care, practice management and research. They should guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

NOTE TO SUPERVISING FACULTY

The Practice Management Section's intent is that the teaching of each module be interactive. Students will be able to access the student modules only. You can use any of the material that you have access to in the expanded module, the appendix, to lead discussions, and present material. Each appendix represents the author's module before being edited for student use. The appendices are designed to be your resource material.

The evaluation section is for your eyes only. We request that you do not share any of evaluation material. We ask that you use the same procedures you use in protecting your test material.

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APPLICATION OF ETHICAL DECISION-MAKING IN DENTISTRY

Manual

Pamela Zarkowski, MPH, JD
University of Detroit Mercy
Phyllis Beemsterboer, EdD, MS
Oregon Health and Science University

Course Objectives

1. Examine the concept of professionalism in the delivery of dental health care.
2. Define the ethical principles and values important to the delivery of oral health care, including autonomy, nonmaleficence, beneficence, justice, and veracity.
3. Explain the terms, values, and concepts that are often used in bioethics and health care.
4. Describe the role of a code of ethics for dental professionals.
5. Define the terms used in ethical awareness and ethical decision making such as moral uncertainly, moral weakness, moral distress, and moral courage.
6. Describe the importance of ethical analysis in the provision of dental care.
7. Identify the elements of a decision-making model and apply it to an ethical dilemma.
8. List examples of current ethically and legally based professional responsibilities, e.g., reporting abuse, impaired colleagues, etc.

Course Description

This is a written word self-study module designed for the predoctoral dental student. The content presented is fundamental to understanding and applying ethical decision making in dental practice. A multiple choice test at the end of the module will allow the learner to gage his/her ability in mastering this material.

Introduction

In the delivery of health care, trust is the critical foundation for the relationship that develops between the person seeking services (the patient) and the health care clinician (the professional). Patients must trust the dentist to provide the best care as they generally cannot evaluate the outcome of treatment.

When patients seek care from any health care provider, they expect to receive the very best care from a professional and ethical practitioner. Obviously, providing health care services involves technical skill, appropriate knowledge, and critical judgment. (The patient is aware that the health care provider has certain knowledge and skills.[1]) However, most importantly, it requires empathy and caring. A famous physician, Francis Peabody, wrote in 1925 that “the secret of the care of the patient is in caring for the patient” and it is as true today as it was decades ago.

What is required in the practice of clinical dental ethics is the ability to discern right from wrong and the commitment to act on a decision supporting the appropriate choice. As clinicians providing care and services, every dentist will be faced with many choices, problems, and dilemmas. Some of these choices will be simple issues of right and wrong, whereas others may be ethical dilemmas that require careful decision-making. The clinician must be aware of the ethical issues that can arise and be prepared take appropriate action even when that action is difficult and makes the clinician uncomfortable.

Ethical Principles and Values

Ethical principles guide the conduct of health care providers by helping them identify, clarify, and justify moral choices. A **principle** is a general normative standard of conduct that is derived from morality and traditions in health care. These principles are linked to commonly expected behaviors because they are based on shared standards of thinking and behaving. In health care, the main normative principles are **autonomy, nonmaleficence, beneficence**, and **justice**. Dentistry adds another, **veracity**, for a total of five principles.[2] These principles provide direction about what should and should not be done in specific situations, holding that a particular decision or action is true or right and good for all people in all times and all places.[3]

Autonomy

Autonomy is the principle that embraces respect for persons and their ability to be self-governing and self-directing. An autonomous person chooses thoughts and actions relevant to his or her needs, independent from the will of others.

In health care, autonomy means allowing individuals to make decisions about their own health, which is at the heart of many ethical dilemmas that occur in dentistry.[4] Health care professionals must respect the autonomy of patients and properly inform them about all aspects of the diagnosis, prognosis, and the care being provided. The application of autonomy is based on respect for persons, which holds that the health care professional has a duty to allow patients to make decisions about actions that will affect their bodies. Because dentists have a wide range of knowledge and skills, they must fully and adequately explain the parameters of the services that

can be performed, as well as the consequences of performing or not performing those services. This also includes the duty to provide patients with all the unbiased information they would need to make a decision about treatment options.

Conflict can arise when what the dentist believes is in the best interest of the patient differs from what the patient believes is in his or her best interest. As long as the patient selects from treatment options that are consistent with accepted standards of care, the professional may ethically act on the patient's choice. However, the professional practitioner also has the autonomy to not provide a service requested by the patient if that service is in conflict with the standards of patient care. For example, refusing a patient's request to extract all healthy teeth would be ethical, even though that decision would conflict with the patient's autonomy. Dentists will avoid doing harm to a patient even if the patient is exercising autonomy by asking to receive a potentially harmful treatment or service.

Nonmaleficence

Nonmaleficence is the principle that actions or practices are right insofar as they avoid producing bad consequences.[3,5] This is the foundation of all health care and describes the first obligation that every health care provider embraces: Do no harm. The patient grants the clinician the privilege of access to a portion of his or her body for an explicit purpose, which is a privilege founded in trust. Fundamental to that trust is that the health care provider will do no harm to the patient.

The Hippocratic Oath requires that the health care provider promise to keep the sick from harm and injustice. In reference to nonmaleficence, the American Dental Association's (ADA) Principles of Ethics and Code of Professional Conduct state that:

> [T]he principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate.

For example, practitioners are required to maintain their level of knowledge and skill through participation in appropriate continuing education programs. Other members of the dental team also have an obligation to stay up-to-date with the changing standards of care in the profession. Along the same lines, if a dentist has not performed an endodontic procedure since graduation from dental school 20 years ago, the dentist would be expected to refer patients to a colleague for root canal therapy.

Over time, nonmaleficence has evolved to include preventing and removing harm. Therefore, health care providers have an obligation to do no harm as well as to prevent harm. A narrow interpretation of this principle would hold that complete avoidance of any pain and suffering in patient care must be maintained. Such strict interpretation would mean that invasive diagnostic tests to locate disease, as well as intraoral injections, could never be performed. Consequently, patients could never benefit from treatment that would alleviate current pain, and they could not

benefit from the prevention of future pain and suffering. This is unrealistic. In fact, causing some degree of harm when that harm will lead to a greater good — restoring a patient to health — is maybe desirable as well as necessary. This conflict is referred to as the principle of **double effect**, and it requires the health care provider to consider the risks and benefits whenever treatment is provided.

This principle is referred to in such complex situations as saving the life of a pregnant woman or her fetus, or in difficult end-of-life choices. To be morally acceptable, the clinician intends only the good effect. Frankena clarified that delineation between harm and good in the following classification system:[6]

1. One ought not to inflict harm.
2. One ought to prevent harm.
3. One ought to remove harm.
4. One ought to do or promote good.

The first classification refers to avoidance of harm, which takes precedence over the second, third, and fourth entries, which define beneficence (discussed below), or the promotion of good. This hierarchy of nonmaleficence and beneficence provides the clinician with a guideline to follow in sorting out dilemmas in practice. Not inflicting harm takes precedence over preventing harm, and removing harm is a higher priority than promoting good. Ideally, the clinician would be able to implement all four parts of this hierarchical relationship; however, when faced with constraints and conflict, prioritization is necessary. Avoiding harm and promoting good in the practice of dentistry are not always possible.

Beneficence

Beneficence is the principle that actions and practices are right insofar as they produce good consequences.[5] Whereas nonmaleficence is concerned with doing no harm to a patient, beneficence requires that existing harm be removed. Beneficence requires taking all appropriate actions to restore patients to a healthy state. Dentists have acquired a body of knowledge and corresponding skills that make them uniquely qualified to help identify patient needs and recommend and provide actions to address those needs. Thus, their unique knowledge and skills allow them to benefit the patient by removing existing harm and assisting in the prevention of future harm.

Beneficence and nonmaleficence often are linked because they are both founded in the writing of the Hippocratic tradition, which requires the physician to do what will best benefit the patient. This is a consequentialist approach. Meeting the requirement to do what the physician believes will best benefit the patient implies the need to conduct a consequence analysis to determine the best possible outcome for the patient.

Beneficence is found in all health care codes. By choosing to become a dentist, an individual assumes a responsibility to help others and professes to be a part of a profession. This means that actions, behaviors, and attitudes must be consistent with a commitment to public service. This commitment to help and benefit others defines the healing professions and sets them apart from

other occupations. Failing to increase the good of others, when one is in a position to do so, is morally wrong.

Through various federal, state, and community-based activities, society attempts to meet this need for the good of the general public. The promotion of good becomes challenging when good is defined according to differing values and belief systems. In public health programs, the appropriation of limited resources to meet the medical and dental needs of a given population can be a complex and frustrating exercise.

Justice

The principle of **justice** is concerned with providing individuals or groups with what is owed, due, or deserved. The foundation of justice has frequently been described as the principle of equality: Likes should be treated alike, equals should be treated as equals, and unequals treated as unequals. The obvious problem with this approach is that some mechanism or criteria must determine who is equal or unequal.

Fundamental to the principle of justice is an effort to treat people who have similar needs in a similar or identical manner. All patients who seek treatment for the prevention of a certain disease should receive the same level of care and attention from the dentist regardless of personal or social characteristics. Naturally, this approach does not take money into consideration, which is unrealistic. Placing money aside is easy in a discussion but difficult in application in a capitalistic society. Regardless of age, gender, social status, religion, or other distinguishing factors, each person should be entitled to the same oral health care options when a similar health care need exists. That would be just.

Justice in dentistry is most often discussed in terms of public policy issues. Every society must address the problem of how its resources will be distributed because every society has a scarcity of resources. Resources are scarce, whether referring to materials, specially trained individuals, money, or time. Distributive justice is concerned with the allocation of resources in large social systems. Policymakers must confront the issue of how society distributes its resources. This has implications for national health care policy and is a complex issue.- Questions immediately arise around what kind of treatment will be offered, who will provide the treatment, and who will be eligible to receive the treatment.

If resources were unlimited, the problem of just allocation would be minimal. Unfortunately, that is not the reality. Choices must be made, benefits and burdens must be balanced, and resources justly distributed. A lofty goal for most organized societies would be the just application of health care. However, no legal mandate exists for medical and dental care to be available to all persons, and decisions are made daily according to the ability of the patient to pay for the services rendered. Thus, the provision of dental care is applied unequally. People who present for treatment are, for the most part, granted access to care based on their economic ability and not their dental needs.

The question of who should provide dental care when an economically impoverished individual is in need of treatment is difficult to answer. Many dentists and dental hygienists provide

charitable services on a regular basis, either in a private practice office or through participation in a community-based service clinic, because they recognize their obligation to serve society. **Complementarity** is a term that is defined as doing the greatest good for the greatest number of persons. This term is closely aligned with justice and good stewardship of resources. Any discussion about the use and application of public policy is an example of complementarity, as is consideration of culture and language in health care services.

Veracity

Veracity is defined as being honest and telling the truth and is related to the principle of autonomy. It is the basis of the trust relationship established between a patient and a health care provider. Veracity is what binds the patient and the clinician as they seek to establish mutual treatment goals. Patients are expected to be truthful about their medical history, treatment expectations, and other relevant facts. Clinicians, for their part, must be truthful about the diagnosis, treatment options, benefits and disadvantages of each treatment option, cost of treatment, and the longevity afforded by the various treatment options. This allows patients to use their autonomy to make decisions in their own best interests.

Lying to a patient does not respect the autonomy of the patient and can compromise any future relationships the patient may have with health care providers. This applies to benevolent deception, which is the practice of withholding information from a patient because of the clinician's belief that the information may harm the individual. This practice is in the tradition of the Hippocratic Oath but is not supported by most codes of ethics and then only in extraordinary circumstances. Only a rare case would justify deceit in the dental setting. The interactive health care relationship between patient and clinician functions most effectively when both parties are truthful and adhere to all promises made in the process.

Values and Concepts

Several values and related rules align with the principles of ethics and may help the problem-solving process when a clinician is making ethical decisions. Values and concepts presented are founded in ethical principles and the theory upon which those principles are based. Occasionally, these values or concepts might add to the complexity and conflict of the situation, but the goal is to add clarity when resolving ethical issues.

These terms and concepts are **paternalism, informed consent, capacity, confidentiality, standard of care, scope of practice**, and **hierarchy of central values** and are rooted in the health care principles.

Paternalism

Paternalism is closely related to the principles of nonmaleficence and beneficence and arises from the Hippocratic tradition. The Hippocratic approach is interpreted as the clinician doing what he or she believes is best for the patient according to ability and judgment.[3] This approach requires the dentist to undertake a role similar to that of a parent, thus the term. Paternalism means that the health care professional makes decisions for the patient on the basis of what the

professional believes is in the best interest of the patient. However, paternalism and autonomy are in conflict. A dentist cannot unilaterally act on behalf of the patient without denying the patient's right to exercise autonomy. Paternalism is now more commonly called parentalism, reflecting the dual parent roles.

Patients today are well-informed about health, treatments, and their rights as patients and want to participate in the decision-making process. In the past, paternalism was a common practice partly because the health care provider had superior knowledge and skills and partly because patients expected the health care provider to make decisions in their best interests. Patients often had no knowledge that alternative care options were available. Furthermore, even if patients did know other options existed, many placed the professional in a parental role by asking the professional what they should do. Such paternalistic acts were carried out with good intentions to benefit the patient and often became second nature to the clinician.

However, the responsibility of the dentist is to educate the patient about the balance of benefits and risks of treatment, which often creates a conflict between autonomy and beneficence. This aspect of providing ethical care is most important and requires the clinician to take the time and effort to ensure that the patient has all the knowledge required to make health decisions.

Informed Consent

Informed consent is based on the patient exercising autonomy in decision-making and has both ethical and legal implications in medicine and dentistry. Informed consent has two parts. First, it requires that the professional provide the patient with all relevant information needed to make a decision. Second, it allows the patient to make the decision on the basis of the information provided. Informed consent is a process of providing appropriate information to the patient, the process of understanding and assimilating the information, and making the decision.

Dentists and hygienists must recognize that the patient has a right to informed consent as well as a right to make an informed refusal. Respecting the autonomy of individuals as self-determining agents recognizes their right to make their own choices and determine their own destiny. This includes the right for a patient to assess all the information provided by the professional, yet still make a choice that is not the one most valued by the professional (informed refusal). Although not as dramatic as life-and-death decisions made by clinicians in medicine, dental decisions may involve choices that are potentially harmful to the patient.

When patients give their authorization for a procedure or a comprehensive treatment plan, they grant the health care provider informed consent for that treatment. First, the clinician must obtain and document information and disclosure; second, the clinician must undertake the process of interaction and communication, which produces a truly informed decision.

Not all individuals have the ability to make informed decisions about their dental health. Children and people who are mentally disabled typically have a parent or caregiver who will make decisions on their behalf. Depending on the age and capacity of the child, certain choices can and should be discussed with the younger patient, but actual decisions regarding what types of services are rendered must remain the purview of the legal guardian. Obtaining informed

consent is not possible when a language barrier exists, and steps must be taken to remedy the situation. The use of a translator, family member, or other communication option must be pursued to ensure that the patient fully understands the choices and consequences. To do any less is unethical and possibly illegal. The only exception to this would be if the patient's life were in danger and an immediate procedure was required to save that life.

Capacity

An issue related to autonomy and informed consent is the determination of decision-making capacity. **Capacity** is a clinical term used to describe a person's ability to understand his or her health care conditions, treatment options, and ability to make decisions. For an individual to make informed consent, capacity is a prerequisite. This is a growing concern with an aging population as older adults can exhibit a wide range of cognitive function.

The elements of capacity include understanding, appreciation, and reasoning. These elements are measured by a person's ability to express wishes, understand information, reason, and arrive at a decision. Questioning the patient as to how he or she understands the risks to treatment or why he or she is declining treatment are among the ways to explore the capacity of a patient. There are objective assessment instruments that can be utilized to help with this determination.

Treating a person with a cognitive impairment can present a range of ethical dilemmas. In the dental setting, assuring that a patient has capacity may often require reaching out to the patient's family members, primary care physician, or surrogate decision-maker. It is not uncommon for an individual have transient or diminished capacity, which is the ability to express wishes on one day but not another.

Confidentiality

Confidentiality is related to respect for persons and involves the patient exercising his or her autonomy in providing information to the dental professional. Confidentiality is a critical aspect of trust and has a long history in health care. The requirement for confidentiality is mentioned in all codes of ethics and stems from the Hippocratic Oath. A patient has a right to privacy concerning his or her medical and dental history, examination findings, discussion of treatment options and treatment choices, and all records pertaining to dental and dental hygiene care. This privacy extends to the way in which information is gathered, stored, and communicated to other health care professionals. Patient histories and treatments are not to be shared with spouses, family, or friends, for example. Information about a patient can be given, however, to other health care professionals with the patient's permission.

Conflicts and exceptions will arise surrounding the principle of confidentiality. In certain situations, legal requirements exist to report diseases that can have an effect on the health of the public. Reporting suspected child abuse, which is required in most states, is also technically a violation of confidentiality. In dealing with minor children, divulging confidential information to the parents may be necessary to protect the child from harm. This is especially difficult with adolescents, who may or may not be adults according to the legal system. The patient's right to confidentiality often must be balanced against the rights of other individuals. In any situation, the

health care provider must communicate to the patient the professional and legal responsibilities that exist for disclosure and work toward assisting the patient as much as possible.

Standard of Care

Standard of care is a term that comes from the legal profession. Understanding and practicing the standard of care is the culmination of dental education applied in a careful and consistently up-to-date manner. The absence of appropriate dental care is negligence, as harm or malpractice may have occurred. Providing a treatment or service to a dental patient that is not considered reasonable or prudent by other dentists in the local community could be practicing below the standard of care. To do so would be violating the principle of nonmaleficence as harm could be caused to an individual.

A procedure must be performed at the same level of competence regardless if the dentist is a specialist or generalist, has just three or more than 30 years of experience. Maintaining competence, skills, and judgment in such things as restorative technique, infection control, or antibiotic coverage are the responsibility of a practitioner providing standard of care dentistry. The requirement for continuing education tied to license renewal is to focus on continued competency, an element of honoring autonomy.

Scope of Practice

Scope of practice is described as the services and treatments a dentist may perform, based on the dentist's education, training, experience, and legal adherence, and is defined by each state's dental practice act. Obtaining a license in one state may differ from another, depending on how the practice act reads. In some situations, an additional certification may be required on top of the dental license to practice some skills.

Careful monitoring of the dentist's own skillset is a professional self-regulation responsibility. Impairment of any kind, whether it is physical, mental or related to drugs and alcohol, requires the dentist to step aside from clinical care.

A dentist must know the law in his or her state and is also responsible for the staff hired in the practice. For example, a radiology technician has duties within his or her scope of practice just as a dental hygienist must only perform those duties listed under the scope of a hygienist. A dental hygienist trained in local anesthesia in one state may not practice that skill in another state if it is not legal under the scope of practice.

Hierarchy of Values

David Ozar organized into a hierarchy the central values of dentistry based on his extensive experience in dental education. These values are central to the appropriate practice of dentistry and frame what dentistry strives to as a profession. The six central values of the dental profession are:

1. The patient's life and health;

2. The patient’s oral health;
3. The patient’s autonomy;
4. The dentist’s preferred pattern of practice;
5. Aesthetic values; and
6. Efficiency in the use of resources.

The central values are ranked in an order to assist in clinical and ethical decision-making. In some situations, the ranking may not be very important, but when two or more values are present, the hierarchy can help with treatment planning, ethical decision-making, and clinical judgment.

Code of Ethics

A **code of ethics** is a guideline for members of a professional group and is one of the essential characteristics of a true profession. A major purpose of a professional code of ethics is to bind the members of the group together by stating their goals and aspirations, as well as defining the expected standards of behavior. Codes of ethics are written by and for the members of a group and is a tool for self-regulation. The most important thing about a code is the fact that it is the contract the profession makes with society outlining the standards it will adhere to and uphold.

The first ethical code dates back to the time of the Greek physician Hippocrates, and the influence of the Hippocratic Oath is still reflected today in modern versions of ethical codes. The first dental code was written in 1866. Traditional medical codes of ethics emphasize the physician’s (1) duties in the individual patient-physician relationship, including the obligation of confidentiality; (2) authority and duty of beneficence (i.e., acting for the patient’s good); and (3) obligation to each other.

Three things demonstrate how codes can be effective in shaping professional behavior:

First, when professional schools of health care screen applicants for admission to education programs, integrity and character are important criteria for acceptance. Admissions committees aim to select candidates who are the best qualified academically as well as candidates of good character.

Second, until proven otherwise, each entering student must be assumed to have the character traits needed to be a true professional. Educational institutions actively seek to indoctrinate students to the goals of the profession and expected professional behaviors. Learning what is expected of that professional person reinforces character traits in the developing professional. This often is accomplished by introducing students to the institution’s code of conduct, by familiarizing them with the profession’s code of ethics and professional conduct, by faculty serving as positive role models, and by enforcing adherence to expected professional behaviors when professional codes have been violated.

Third, after entering professional practice, it becomes the obligation of those professionals to help regulate their profession. When violations occur, members of the profession who become aware of these violations have a duty to intervene in a substantive way. This is a serious step and

must be carefully considered, since the reputation of the profession and the well-being of the public ultimately rest on a willingness to engage in meaningful self-policing of the profession.

Codes are powerful ethical statements, but they are not legal mandates. The degree to which codes are effective remains a difficult question to answer completely. However, because health professions invest so much effort in the development and propagation of codes of ethics and standards of professional behavior, an assumption that the professions find them to be extremely valuable is reasonable. When violations of the code occur, the profession is empowered to take action to resolve the problem. Although codes alone do not guarantee that everyone will behave with integrity, they do provide guidance and standards by which professionals can be judged.

The code for dentists is embodied in the Principles of Ethics and Code of Professional Conduct of the ADA, which is maintained and updated by the association through its Council of Ethics, Bylaws, and Judicial Affairs. Members and non-members of the ADA are covered by the code as the ADA is the recognized body representing dentistry as a whole.

The preamble of the code calls upon the dentist to follow high ethical standards which benefit the patient. The code is then divided into three components: principles of ethics, code of professional conduct, and advisory opinions. The principles of ethics component sets out the aspirational goals of the dental profession. The ADA code refers to five fundamental principles mentioned previously in this module. The code of professional conduct delineates conduct that is either required or prohibited. Each section of the code of professional conduct is followed by an advisory opinion. These opinions expand on an issue and often include legal warnings or suggestions for the dentist to seek further information or advice. Guidance is provided in the ADA code for anyone who believes a member dentist has acted unethically, and the code further explains that censure or suspension can result from a fair hearing on any unethical conduct.

Ethical Awareness and Analysis

As a clinician providing care and services, the dentist will be faced with many choices and dilemmas. Some of these choices will be simple issues of right and wrong, whereas others may be ethical dilemmas that require careful decision-making. The dentist must be aware of the ethical issues that can arise in dentistry and take appropriate action when necessary.

How the dental professional responds to ethical issues that arise in practice depends on the ethical awareness of the individual, which is termed “moral sensitivity.” A situation or problem can be perceived by one individual as having an ethical component, but perhaps not by another. It is helpful to understand the terms that are used in the literature and how they categorize the kind of moral problems encountered in life and dental practice.

One category deals with problems of **moral weakness**, in which moral responsibilities point in one direction and personal inclinations in another. Another category is **moral uncertainty**, which is defined as the question of whether a moral obligation exists and its scope. For a dentist, dealing with a noncompliant periodontal patient could raise issues of uncertainty. How far should the dentist go to attain a level of health when the patient is unwilling or uninterested in following good dental health advice and guidance? The category that is composed of complex issues and

problems is referred to as **moral** or **ethical dilemmas**. A moral dilemma exists when obligations or responsibilities are in conflict. A large portion of the bioethics literature deals with moral dilemmas that often involve matters of life and death.

Moral Distress

The term “moral distress” was created to acknowledge situations in which the health care professional is frustrated from feelings of powerlessness when a perceived wrong is occurring, but he or she is unable to act. It is the feeling experienced when an individual cannot do what he or she believes ought to be done because of a system issue, resistance of a powerful person, or a restraint in the situation.

Morally courageous professionals are encouraged to persevere in standing up for what is right even when it means they may do so alone. Murray[7] lists seven critical checkpoints to use in ethical decision-making. His guiding checkpoints start with evaluating the need for moral courage and end with avoiding things that might restrain moral courage.

Checkpoints to apply in ethical decision making:

1. Evaluate the circumstances to establish whether moral courage is needed in the situation.
2. Determine what moral values and ethical principles are at risk or in question of being compromised.
3. Ascertain what principles need to be expressed and defended in the situation – focus on one or two of the more critical values.
4. Consider the possible adverse consequences/risks associated with taking action.
5. Assess whether or not the adversity can be endured. Determine what support/resources are available.
6. Avoid stumbling blocks that might restrain moral courage, such as apprehension or other reflection leading to reasoning oneself out of being morally courageous in the situation.
7. Continue to develop moral courage through education, training, and practice.

Ethical problems arise in professional practice when the dentist is caught between two or more competing obligations. Throughout their lifetimes, professionals face situations that require carefully weighing options. Often no right or wrong answer exists. Instead, a variety of answers may be possible, each of which has an element of rightness about it. Most decisions must be made in the context of professional, social, and economic pressures, which may be in conflict with values and principles. Determining what to do when faced with an ethical dilemma can be a daunting challenge. Making such decisions can be greatly facilitated by an ethical decision-making model.

In a clinical setting, whether it is a small or large group of practitioners, there can be an unwillingness to face the challenge of addressing unethical behaviors. Those who have the courage to stand up and speak out need the support of their peers.

Ethical Decision-Making Model Frameworks

An ethical decision-making model is a tool that can be used by the dentist or other health care professionals to develop the ability to think through an ethical dilemma and arrive at an ethical decision. A number of models are presented in the ethics literature, all of which are somewhat similar in design and content. The goal of each model is to provide a framework for making the best decision in a particular situation with which the health care provider is confronted. Most of these models use principle-based reasoning, an approach derived from the work of philosophers Beauchamp and Childress.

The model provided in this module is a simple six-step approach derived from the decision-making literature as interpreted by Atchison and Beemsterboer and used in the early 1990s with dental and dental hygiene students in a combined ethics course. It is a reasoned approach based on theory and principle.

The process of decision-making is dynamic, evolving as additional information comes into play. Dental professional are confronted with myriad questions to consider, requiring them to factor in the code of ethics and their own values and beliefs before arriving at a decision. The evaluation process involved in an ethical dilemma is not unlike that which occurs when the practitioner is faced with a clinical or scientific problem. Careful attention to and systematic analysis of the evidence, facts, and details will help the clinician reach an appropriate decision. Applying the decision-making model gives the dentist a tool to use throughout professional life.

Six-Step Decision-Making Model

1. Identify the Ethical Dilemma or Problem. Step No. 1 is the most critical step in the process. Many situations are simply never perceived to be ethical problems or dilemmas. Once the problem has been recognized, the decision-maker must clearly and succinctly state the ethical question, considering all pertinent aspects of the problem. If the ethical question does not place principles in conflict, it is a simple matter of right and wrong and no process of ethical decision-making is required. Proceeding to Step No. 2 is not necessary if a clear determination of right or wrong has been made.

2. Collect Information. The decision-maker must gather information to make an informed decision. This may be factual information about the situation as it developed, and it may come from more than one source. Information regarding the values of the parties involved, including those of the health care provider, is needed.

3. State the Options. After gathering all of the necessary information, one may proceed to the third step, which involves brainstorming to identify as many alternatives or options as possible. Often the best decision is not the first one that comes to mind. Also, a tendency exists to think that a question has only one answer. This step forces us to stop and view the situation from all angles to identify what other people might see as alternative answers to the problem. An enlightened and open mind is required to recognize that often more than one answer to a problem exists.

4. Apply the Ethical Principles to the Options. Focus on the ethical principles (autonomy, beneficence, nonmaleficence, justice, and veracity) and ethical values and concepts (paternalism,

confidentiality, and informed consent). In general, one or more of these will be involved in any ethical decision. State how each alternative will affect the ethical principle or rule by developing a list of pros and cons. In the pro column, show alternatives that protect or hold inviolate each principle or value. In the con column, state how an alternative could violate the principle or value. Do this for each option. This process will enable you to see which ethical principles are in conflict in this situation.

5. Make the Decision. When each alternative has been clearly outlined in terms of pros and cons, a reasonable framework is apparent for making a decision. Each option must then be considered in turn, with attention to how many pros and cons would attend each decision. The seriousness of the cons must then be weighed, remembering that, as a professional, he or she is obliged to put the patient's interests first. Simply by examining the options in a careful way, the best solution to an ethical dilemma frequently becomes obvious. Before implementing the decision, the practitioner should replay each principle against the decision to see if the decision holds up to this evaluation.

6. Implement the Decision. The final step involves acting on the decision that has been made. The decision process will have been futile if no action is taken. Many appropriate decisions are never implemented because this step is omitted. Remember that no action represents tacit approval of a situation.

Common Dilemmas

How common are ethical dilemmas in dentistry? That is a very difficult question to answer as the perception and awareness of ethical issues varies with the individuals involved. No studies or evidence exists documenting the volume of problems. However, boards of dentistry often cite ethics as causative in cases considered by these agencies. Each situation involving human beings will be unique as a problem or dilemma will have its own distinguishing aspects. The following listing provides the general categories that have been acknowledged as ethical dilemmas in the dental ethics literature.[7,8]

Categories of Ethical Dilemmas

- Breaches of confidentiality
- Failure to disclose dental mistakes
- Over-treatment and poor quality dental treatment
- Requests for fraudulent documentation
- Requests for narcotic medications
- Requests for inappropriate treatment
- Deceptive dental marketing and advertisements
- Impaired or dishonest colleagues
- Challenges with capacity and informed consent
- Conflict or unethical behavior among clinicians
- Challenges arising from management, financial, or legal issues

The scope and depth of ethical problems in the delivery of dental care will vary greatly. Awareness that an ethical issue is present and then defining the aspects of the problem are always the first steps. Every clinical situation has ethical aspects.

Clinical Case Example

A 4-year-old child presents as an emergency with facial swelling and a history of dental pain. He is accompanied by his mother; both are exclusively Spanish-speaking. A family friend serves as their interpreter as the medical and dental histories are completed, followed by a clinical exam. The examination reveals a severely decayed primary molar as the probable source of infection, although multiple carious lesions are noted throughout the mouth. The patient is placed on antibiotics due to concerns about the ability to obtain adequate local anesthesia and limited opening. The patient is scheduled to return for the extraction in one week.

The dentist determines through the help of the interpreter that the patient has no dental plan or coverage, either public or private, and has limited financial resources. The dentist encourages the family to pursue public insurance coverage so the patient can receive comprehensive care. The mother reveals that they are not citizens and do not have documentation to live in the United States.

The dentist refers the patient to a respected and confidential charitable organization that provides care for low-income, uninsured children regardless of immigration status, hoping that it would be able to pay for comprehensive dental treatment either in the clinic or under general anesthesia. The patient is appointed for an extraction within one week and the dentist assures the family that the treatment would be performed regardless of ability to pay. With the help of the interpreter, the dentist discusses what would happen if the infection is not treated, including facial swelling, pain, and possible spread of infection that could result in death.

The patient does not appear for that appointment. When the dentist contacts the patient, the patient's mother reports that they do not have the money to pay and are afraid to apply for the support of the charitable organization for fear of deportation. The dentist again assures the parent that the extraction would be provided at no charge and that the charitable organization would not reveal their records to authorities. The patient does not appear at the second appointment and the family does not answer the dentist's subsequent phone calls or return messages.

What is the responsibility of the dentist? Using the ethical decision-making model, analyze this case.

Step 1: Identify the ethical question or problem. Does the dentist have an ethical responsibility to report this parent for neglect? Is there a legal mandate?

Step 2: Collect information. The issue of documentation is a barrier and status of the family is difficult to assess. Initial referrals for assistance were not followed and as far as the dentist knows, the child has not been seen for treatment. There is a physical address for the family, but contact has not been successful. Community or social work avenues for assistance do exist.

Step 3: State the options.
Option 1. The dentist has made good faith efforts to get the patient treatment and does not have further obligations.
Option 2. The dentist must continue to seek treatment for the child because of the active infection and possible consequences of the infection.
Option 3. The dentist must report the parent to child protective services.

Step 4: Apply the ethical principles to the options.
Option 1. Nonmaleficence: Doing nothing is an option but violates the duty to put the patient's needs as primary.
Option 2. Beneficence: The dentist has an obligation to care for the child with an infection, regardless of access issues. Additional methods of contacting the family could be explored using social services or other agencies.
Option 3. Justice: Contacting child protective services must be considered to assure that the child is treated appropriately. Most states list the dentist as a mandatory reporter for child neglect.

Step 5: Make the decision. The dentist must chose Option No. 3 if Option No. 2 is unsuccessful. This case focuses attention to the challenging problem for society and health care to care for children and vulnerable populations.

Step 6: Act on the decision.

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INSTRUCTION ON PERSONAL DEBT MANAGEMENT AND FINANCIAL PLANNING

James L. Harrison, DMD
University of Louisville School of Dentistry
John N. Williams Jr., DMD, MBA
Indiana University School of Dentistry

CODA competency covered:

4-7 Student services must include the following:

…

g. Instruction on personal debt management and financial planning.

Intent: All policies and procedures should protect the students and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect the work accomplished and are maintained in a secure manner. Students should have available the necessary support to provide career information and guidance as to practice, post-graduate and research opportunities.

NOTE TO SUPERVISING FACULTY

The Practice Management Section's intent is that the teaching of each module be interactive. Students will be able to access the student modules only. You can use any of the material that you have access to in the expanded module, the appendix, to lead discussions, and present material. Each appendix represents the author's module before being edited for student use. The appendices are designed to be your resource material.

The evaluation section is for your eyes only. We request that you do not share any of evaluation material. We ask that you use the same procedures you use in protecting your test material.

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INSTRUCTION ON PERSONAL DEBT MANAGEMENT AND FINANCIAL PLANNING

MANUAL

James L. Harrison, DMD
University of Louisville School of Dentistry
John N. Williams Jr., DMD, MBA
Indiana University School of Dentistry

Introduction

U.S. college graduates are in debt and this group includes dental school graduates. According to a recent article in *Forbes*, Zack Friedman reports that student loan debt in 2019 is the highest ever. The latest student loan debt statistics for 2019 show how serious the student loan debt crisis has become for borrowers across all demographics and age groups. There are 45 million borrowers who collectively owe more than $1.56 trillion in student loan debt in the United States. Student loan debt is now the second-highest consumer debt category — behind only mortgage debt — and higher than both credit cards and auto loans. Borrowers in the class of 2017, on average, owe $28,650, according to the Institute for College Access and Success.[1]

Writing for *Nerd Wallet*, Teddy Nykiel confirms this above observation, as she states that U.S. student loan borrowers owed almost $1.6 trillion in federal and private student loan debt as of March 2019, according to the Board of Governors of the Federal Reserve System.[2]

For health professions, here are key student loan debt statistics to know: How much borrowers owe, the types of loans they have, and how they're repaying them. Sixty-five percent of the class of 2018 graduated with student debt, according to the most recent data available from The Institute for College Access and Success, a nonprofit organization that works to improve higher education access and affordability. Among these graduates, the average student loan debt was $29,200.

Dental school graduates are some of the most indebted professionals, on average. Here's how the average dental school debt compares with other health fields for the class of 2019, the most recent year all of the data are available:[3]

- Average dental school debt: $292,169
- Average medical school debt: $196,520
- Average pharmacy school debt: $166,528
- Average veterinary school debt: $183,014
- Average bachelor's degree debt: $29,200

More than 80 percent of dental school students in the class of 2019 took on dental school debt, according to a survey by the American Dental Education Association. Among class of 2019 dental school graduates with any type of student debt — including from undergraduate studies — the average student loan balance was $292,169.4

With a $292,000 student loan balance, you'd owe more than $3,390 per month on a 10-year repayment plan, assuming a 7 percent interest rate.

The Commission on Dental Accreditation (CODA) has an expectation that all dental schools provide instruction on personal debt management and financial planning to assist recent graduates and young professionals successfully manage their debt and apply sound financial planning principles. This module will outline a curriculum and provide resources to be used in both debt management and financial planning.

CODA's Position on Debt Management and Financial Planning

The significance of dental student debt prompted CODA to adopt accreditation Standard 4.7 (g) a few years ago, which states:[5]

> **4-7** Student Services must include the following:
>
> …
>
> **g.** Instruction on personal debt management and financial planning

The goal of this accreditation standard is to heighten awareness to this significant national issue of dental graduate debt and take proactive steps to inform student borrowers about debt management and financial planning resources to better manage their debt load. The remainder of this module is devoted to helping students define their financial goals and expose them to basic financial terminology and processes that will enable them to successfully plan their financial futures. Borrowers must be proactive to successfully manage debt and achieve their financial goals.

Defining Financial Goals

Stephen R. Covey said the following in his book *The Seven Habits of Highly Effective People*, "Begin with the end in mind."[6] As you begin the financial planning process you have to understand what your goals and needs will be in the future. More importantly, as you begin to set your goals you have to understand the "why." Setting a goal to buy a home or a car is hollow if it's not attached to a deeper meaning. Why you want to buy a car gives your goal greater meaning, such as driving your immobile parents around, or having reliable transportation. Understanding the "why" you want to achieve your goal will give you the extra effort to achieve it.

The Role of Money

For most people, money is freedom. Money, though, functions on three main levels. Money is used as a form of exchange, a measure of value, and as a store of value. Money's most important function is a medium of exchange to facilitate transactions. Money is the key consideration when making financial goals, but it is not the end result. What people want is the satisfaction received from buying goods and services at a given quantity, quality, or service often defined as "utility." This explains why people will choose different features on the same car. Those choices are based

on the satisfaction either through the usefulness or status that comes with purchasing those features. When planning for the future, it is important to consider utility along with cost when looking at different alternatives qualities of life, spending, and forms of wealth accumulation.

The Psychology of Money

How we think about money determines what we do about money. Our belief system — the important ideals and beliefs that guide your life — will also shape your attitude toward money. If you place a high value on family life, you might sacrifice the type of job you have for one that allows you to spend more time with your family. You also might be the type of person who has plenty of money but lives frugally. The opposite might be true, instead, as buying luxuries and spending a high proportion of your income might make you feel satisfied. It is important to understand your personal values. This allows you to set financial goals and plans to provide for the greatest satisfaction.

Some questions to ask to help you determine your relationship with money: How important is money to me? Why? Am I a risk-taker? Do I need a large savings to feel secure? What types of spending gives me satisfaction? Understanding the answers to these questions will not only help you develop a realistic financial goals, but will help you to draw upon those values, personality, and emotional reactions to money.

Money and Relationships

Money is generally the greatest causes of conflict in marriages. Much of this is due to the values, personality, and emotions that we bring into the relationship as we relate to money. Most people are uncomfortable talking about money with their partners and that leads to a lack of communication and misunderstanding. Learning to communicate to your partner is key to developing a good financial plan. The best way to resolve money disputes is to understand your partner's financial style, communicate openly, and be able to make compromises. Having a good financial plan, though, can go a long way in conflict resolution. Working together is an important part of that plan.

Types of Financial Goals

Financial goals should be specific and expressed in financial terms. Simply saying you want to save money next month doesn't imply how much and for what. A goal to save 5 percent of take-home pay each month to start an investment program states clearly what you want to do. It is important in this process that you set realistic goals. It might be nice to save 25 percent each month to put toward retirement, but that might leave you short on your monthly bills. The same can be true of under-planning. Set a specific goal and then work backward to determine what is needed to achieve the goal. When setting goals, it is important to involve your spouse and family in the process. If everyone is on board it will make it easier to accomplish your goals.

Assigning a timeframe and priorities for your goal is also important to determine what comes first in the process. Divide your goals into three areas:

Short-term goals (one year or less)

Short-term goals work on a 12-month-or-less calendar. These goals could be saving for a purchase or a vacation. Part of this plan should include regular monthly contributions to savings and retirement planning. Having short-term goals allows you to then use them in your monthly budget to accomplish your goal. If you don't accomplish your short-term goals, you are likely to fall short on your long-term goals.

Intermediate goals (2-5 years)

Intermediate goals bridge the gap between short-term and long-term goals.

Long-term goals (6-plus years).

Long-term goals should cover a period anywhere from six to 30 years. Although it is difficult to know what things will be like in 30 years, setting some tentative long-term goals is necessary for financial success. As with any long-term goal, it will be important to evaluate each one regularly to make sure that you are not being overly ambitious or too conservative.

After establishing your goals, determine a priority level (high, medium, low), a target date, and a specific amount.

Financial Planning is a Dynamic Process

Throughout your life, financial goals will change. It is important to make adjustments throughout your life and be prepared for unexpected and expected changes that might occur, such as unemployment, relocation, marriage, and children. With careful planning, you can adjust to these life changes and weather unexpected challenges. The lifestyle situations include, but are not limited to, the following:

- Marital status: single, married, divorces, widowed
- Employment status: employed, unemployed, facing unemployment
- Age
- Number of dependents: children, spouse, parents, other family members
- Economic outlook: interest rates, employment level
- Education: education level of family members, tuition needs for children
- Health status[7]

The Rewards of Sound Financial Planning

Many dental students have a poor understanding of personal finance. Since personal finance isn't a required course in high school, college, or dental school, dentists are often unprepared to handle their high incomes when they become financially successful in practice.[8] Add the imperative to reduce student debt and things can get really messy in a hurry. You need a financial plan to guide your way.

There are numerous rewards to having your financial situation in good order. In addition to reducing the daily stress of being responsible for a large debt, lower debt levels enable dentists to have the freedom to make alternative economic decisions in professional and personal ways. Professionally, it allows for the purchase of new equipment, increases in staff compensation, or acquisition of real estate for a practice expansion. Personally, acquiring a home, saving for retirement, donations to worthy charitable causes, or setting aside funds for a child's college fund are all easy to do when sound financial plans have been adopted and school or practice debt is actively managed.

The Personal Financial Planning Process

Personal financial planning is an organized approach to an individual's financial affairs and ultimately focused on meeting and individuals financial goals. Many people assume that financial planning is only for the wealthy. If you have enough money, it will help you plan and spend your money wisely. If your income seems inadequate, planning your financial activities can help improve your lifestyle. Some people might think they are too young to start the process or too old to catch up. Knowing what you need to do and where you want to go has no age limit and can give you an edge over someone who merely reacts to financial events.

The financial planning process has six steps:

1. Define financial goals.
2. Develop plans and strategies to achieve your goals.
3. Implement financial plans and strategies.
4. Develop and implement budgets to monitor and control progress toward goals.
5. Use financial statements to evaluate results of budgets and plans, making corrective action as required.
6. Redefine goals and plans as life changes.

Budgeting

A personal budget is a financial plan that allocates your income toward expenses, savings, and debt repayment. When people hear the word "budget," they initially think about being controlled. Budgets are sometimes seen in a negative light. While one of the purposes of budgeting is to have control over your money, a better way to view it is to make a plan of how you want your money to work for you.

"Where does the money go?" is a common dilemma faced by many individuals and households when it comes to budgeting and money management. The first step to creating a budget is understanding were you spend your money.

Step One

It is recommended that you track your expenses for a full 30 days, placing each expense into a category (food, housing, car, etc.) This allows you to get a better understanding of where you are

spending your money each week and month. This can be an eye-opening experience, as some individuals and couples are surprised at how much they truly spend in each category.

Step Two

Start by listing all of your expenses. Think about your regular bills and irregular bills, and those bills that are paid bimonthly or quarterly. Add these costs together with your other costs, like food, gas, and entertainment. Every dollar you spend should be accounted for.

Step Three

Set personal and financial goals. Effective money management starts with a goal and a step-by-step plan for saving and spending. Financial goals should be realistic, specific, have a timeframe, and imply an action to be taken. Decide if there are financial goals that you are working toward. Some of these goals might be long-term, like retirement planning. Some of the goals might be short-term, like saving for a car or a family vacation.

Step Four

Subtract your monthly expenses from your income. Every dollar should be accounted for and placed in a category. This is often referred to as a zero-based budget, meaning your income minus your expenses should equal zero. If you are over or under, then adjustments need to be made to equal zero. This budget should include not only expenses, but take into account the financial goals that you have set.

Step Five

Once you start your budget, you still need to stay on top of your expenses. Put a system in place to manage staying within your budget. Some people use spreadsheets to track their spending or online tools. A popular radio host, Dave Ramsey, teaches his clients to spend cash on items such as food, gas, and entertainment. He uses an envelope system to help people manage their day-to-day spending. Once the money has been spent in the envelope, you are done spending in that category.

Special Considerations

Many people work on commissions or are self–employed, which means these people deal with an irregular income. An irregular income comes in at different amounts or different times or both. When you make a budget, base your income on your lowest-paid month from the previous year. Then list your expenses and put an amount next to each item. Once it’s all in front of you, then you can list your expenses according to importance. A priority should be placed on food, shelter, clothing, and transportation.

Once you have a bare-bones budget, it’s time to plan for any additional income you bring in over the worst-case scenario you planned out. You might ask yourself the following question: “If I had enough money for one more thing, what would it be?” Keep a prioritized list of what those

items are. When you have additional money, all you have to do is go to that list and it will guide you as to what you budget the rest of that money for. This list will change and items will move up and down on the list based upon what is important at the time.

Managing Your Credit

Consumer loans can be obtained from a number of sources. Commercial banks dominate the field and provide nearly half of all consumer loans. Other lenders include consumer finance companies, credit unions, sales finance companies, and life insurance companies. They can even be provided by brokerage firms, pawn shops, or friends and relatives. Second to banks are consumer finance companies and then credit unions. About 75 percent of consumer loans are originated by commercial banks, credit unions, and consumer finance companies.10 Once you have decided to use credit, it is important to shop around at different lenders to get the best terms. The following are terms to consider when shopping for a loan:

Finance charges. When thinking of finance charges, think of what it will cost you to borrow the money. Lenders are required by law to provide a Truth in Lending report that states the finance charges as well as other loan fees. Loans can carry a fixed or variable rate. A fixed rate loan has the same interest rate the entirety of the borrowing period. A variable rate loan has an interest rate that changes over time. An advantage to a fixed rate loan is that your payments will stay the same. An advantage to a variable rate loan is that the starting interest rate generally starts lower. This rate can change, though, if the index increases or decreases. The best way to compare finance charges between lenders is to ask for the annual percentage rate. This rate will not only include the interest rate, but also and additional fees that might be required on the loans.

Loan maturity. Your loan maturity is the final payment date of a loan. This date can have an impact on the amount you pay on the loan as well as the finance charges you pay. A longer loan maturity date can lead to a higher interest rate on the loan. Adjusting the maturity date on the loan, though, can help you fit the size of the payment more comfortably into your spending and savings plan.

Total cost of the transaction. When shopping for loans, it's important to consider the total cost of the loan. Many times it can be tempting to just look at the interest rates. Most lending institutions have other fees they charge, such as "origination fees" and "closing fees." The simplest way to compare loans is to add the amount you put down of the purchase to the total of all the monthly loan payments. The one with the lowest total is the one you should pick.

Collateral. Some loans require that you put up collateral in case you default on your loan. This collateral could be a down payment or another asset you own. Putting up collateral often makes sense because it may result in lower finance charges — even up to half a point or so.

Other loan considerations. In addition to the items that have been discussed, it is also important to consider the following: Are there any prepayment penalties? Will extra payments be applied to your principal or to your next payment? What are the charges for late payments? Can you adjust when your payment is due to fit your cash flow?

Student Loan Debt

Student loans are now the second-largest debt category in the United States, trailing only to mortgage debt. As of early 2019, total student loan debt is approximately $1.56 trillion and growing. While student loans for education are seen as a smart investment, it is still important to understand these loans. The following are some things to consider when taking out student loans.

Expected future salary. Based on your expected future salary, figure out what monthly payment you will be able to afford and then use a loan repayment calculator to determine the maximum amount that you can borrow at the expected interest rate of the loan.

Grants and scholarships. Before borrowing, it makes sense to look into grants, scholarships, and loan repayment programs. Public health services and the military provide scholarships and loan repayment programs. Some universities have scholarships for underserved areas or minority groups.

Private vs. public loans. Most students don’t understand the difference between private and public loans. Public loans usually provide more flexibility in providing financial relief. For example, federal programs provide public service loan forgiveness, income-based repayment, and loan repayment assistance programs.

Cost savings. In order to reduce your student loan debt, make sure you are living on a budget. This will control spending and allow you to take out the smallest amount of loans possible. Another cost-savings measure is to look for ways to save money, such as finding a roommate to split the cost of rent or carpooling to save on the cost of transportation.

Student Loan Repayment Plans

Student loan repayment plans can be confusing and difficult to understand. Here is an outline on things you need to know when deciding how to pay back your student loans.

Income-Driven Repayment Plans

An income-driven repayment plan (IDR) is a repayment plan for federal student loans designed to make monthly payments more affordable for borrowers by basing monthly payments on the borrower’s income and family size as opposed to the amount of money owed.

In 2018, there are six different types of income driven repayment plans.

The six plans are:

- Revisited Pay as You Earn (REPAYE)
- Pay as You Earn (PAYE)
- Income-Based Repayment for New Borrowers
- Income-Based Repayment (IBR)
- Income-Sensitive Repayment (ISR)

- Income-Contingent Repayment (ICR)

ICR was introduced in 1993, but is now obsolete. ISR was a derivative of ICR and has been completely phased out. IBR is still available and some older borrowers may still remain in IBR; however, new borrowers should select either PAYE or REPAYE as both plans are superior to both IBR and IBR for New Borrowers. REPAYE, PAYE, and ICR are only available to borrowers with loans made under the Direct Loan Program. IBR is available to borrowers with loans made under both the Direct Loan Program and the FFEL Program.

Are there disadvantages to using an IDR?

Yes, one notable disadvantage is that there is the potential to pay more over the life of the loan if enrolled in an IDR plan that is amortized over 20 or 25 years as opposed to the standard repayment plan that is amortized over 10 years. However, for borrowers with debt loads in the hundreds of thousands, it is possible that significant savings can be achieved through an IDR plan for borrowers with high principal balances at the time of graduation.

Amortization and Negative Amortization

Amortization of loans refers to the spreading of payments over a defined period of time often referred to as the amortization schedule. Upon graduation, dental students enter a standard repayment plan where their graduate student loans are amortized over a 10-year term. Since most graduates have no income on the day they graduate, it is not practical (and in most cases, not possible) to begin making payments that cover their obligation.

With this in mind, the majority of new dentists enter into one of the income-driven repayment plans. The three most notable IDR programs are IBR, PAYE, and REPAYE.

We will discuss the details of PAYE and REPAYE. For now, note that PAYE and REPAYE are superior to IBR.

Negative amortization is an increase in the principal balance of a loan caused by a failure to make payments that cover the interest due. Unfortunately, many dental students will find themselves in a position where their payments in an IDR plan do not cover the interest that accrues on the loans each month. Fortunately, while enrolled in PAYE, REPAYE, or IBR, interest is not capitalized (and therefore does not compound).

Capitalization and Compound Interest

Interest accrues on the principal balance of the loan. Interest does not accrue on outstanding interest while enrolled as a full-time student or during repayment if the borrower is enrolled in an income-driven repayment (IDR) plan. However, there are events that trigger the outstanding interest to be capitalized to your direct loans.

Capitalization is the addition of unpaid interest to the principal balance of the loan. After capitalization, interest will begin accruing on the new (and higher) principal balance.

In the private sector, interest is capitalized daily or monthly depending on your loan agreement. As stated above, when interest is capitalized, interest begins accruing on the new (and often higher) principal balance — a process referred to as compounding. With this in mind, it is extremely important to realize that borrowers utilizing IDR are not subjected to compounding interest.

Eight Events that Trigger Capitalization

If you are experiencing negative amortization while in an IDR plan, you should be aware of what causes capitalization. Capitalization is an event where outstanding interest is added to the principal balance of your student loans.

Below are eight events that trigger capitalization:

1. Default. If you fail to make payments and enter default, outstanding interest is capitalized.
2. The end of a forbearance period.
3. The end of a deferment period.
4. The end of a grace period.
5. Failure to re-certify your income qualifications for an IDR plan.
6. Loss of the "partial financial hardship" that qualified you for an IDR plan.
7. Consolidation.
8. Changing from one repayment plan to another.

Grace Periods

Typically, you do not have to begin repaying your loans immediately after graduation. The period after graduation and before repayment begins is called a "grace period." The standard length for the grace period is six months, but can be extended for up to three years under certain circumstances. For the vast majority of doctors, the grace period ends six months after graduation.

How often can your loans enter a grace period?

Each loan only qualifies for grace just once. So if you graduate from a program and begin repayment, but later decide to return to school, your loans will not re-enter a grace period while in school or after your next graduation. For a student who enters repayment and returns to school, deferment may be an option; however, you should strongly consider making qualifying payments in an IDR plan while a resident.

Does interest accrue during a grace period?

Interest accuses during grace periods for all unsubsidized loans. Graduate students receiving student loans for attending a program beginning on or after July 1, 2012 are no longer eligible for subsidized loans.

What about PLUS loans?

PLUS loans do not qualify for a grace period and students are eligible for a six-month post-enrollment deferment. Payments on these loans will begin at the same time as the direct unsubsidized loans.

Do private loans have grace periods?

Sometimes. You need to read your loan agreement carefully and discuss the details of your loan with your lender. Grace periods are sometimes called "interim periods" by private lenders.

Partial Financial Hardship

Partial financial hardship (PFH) is an eligibility requirement for income-based repayment (IBR) and Pay as You Earn (PAYE). A partial financial hardship is not required for Revisited Pay as You Earn (REPAYE).

For IBR, a borrower qualifies for PFH when the amount due on eligible loans calculated under a 10-year standard repayment plan exceeds 15 percent of the difference between adjusted gross income (AGI) and 150 percent of the poverty level for his/her family size in the state where he or she lives.

For PAYE, a borrower qualifies for PFH when the amount due on eligible loans calculated under a 10-year standard repayment plan exceeds 10 percent of the difference between adjusted gross income (AGI) and 150 percent of the poverty level for his/her family size in the state where he or she lives.

The Basics of IBR, PAYE, and REPAYE

There are now two types of IBR: IBR and IBR for New Borrowers. A new borrower is anyone who received a loan after July 1, 2014. IBR for New Borrowers is designed to give people with loans in the Federal Family Education Loan Program (FFEL loans) access to repayment terms similar to PAYE (where your payment is calculated at 10 percent of your discretionary income).

The FFEL loan program was terminated in 2010, so IBR and IBR for New Borrowers is obsolete for most of us and should not be selected if the borrower is eligible for either Pay as You Earn (PAYE) or Revisited Pay as You Earn (REPAYE).

Who may benefit from IBR for New Borrowers?

It is plausible that borrowers who choose to pursue a PhD or a lengthy specialty program (such as a six-year oral and maxillofacial surgery residency) and who obtained their graduate degrees prior to 2010 and have outstanding FFEL loans may benefit from IBR for New Borrowers as opposed to traditional IBR.

IBR, IBR for New Borrowers, PAYE, and REPAYE

PAYE is similar to IBR but with superior terms. The comparison between REPAYE and PAYE will be addressed later.

• In traditional IBR, payments are calculated at 15 percent of discretionary income.
• In IBR for New Borrowers, payments are calculated at 10 percent of discretionary income.
• In PAYE, payments are calculated at 10 percent of discretionary income.
• In REPAYE, payments are calculated at 10 percent of discretionary income; there is a 50 percent subsidy where the federal government will pay up to 50 percent of your unpaid interest if monthly payments as calculated under REPAYE do not cover the amount of interest that accumulates on a borrower's student loan balance.

• In IBR, loans are eligible for forgiveness after 25 years of on-time payments.
• In IBR for New Borrowers, loans are eligible for forgiveness after 20 years of on-time payments.
• In PAYE, loans are eligible for forgiveness after 20 years of on-time payments.
• In REPAYE, loans are eligible for forgiveness after 25 years of on-time payments.

When an outstanding balance is forgiven in all four IDR plans above, the amount forgiven is considered taxable income.

Parent PLUS Loans and consolidation loans that repaid Parent PLUS loans are not eligible for repayment under IBR or PAYE. If you have Parent PLUS loans, you need to consider extinguishing this debt soon after graduation.

You must qualify for partial financial hardship (PFH) to enter IBR, IBR for New Borrowers, or PAYE. A PFH is not required to enter REPAYE.

PAYE vs. REPAYE

PAYE and REPAYE are the two IDR plans that most new borrowers need to decide between.

REPAYE is the newest IDR plan offered to borrowers, and includes an interest subsidy for unsubsidized loans that many dentists find appealing. However, REPAYE closed some loopholes enjoyed by those enrolled in PAYE. REPAYE also extends repayment by five years before borrowers are eligible for taxable forgiveness.

Deciding between REPAYE and PAYE is difficult and depends on your own personal financial situation. For those who will pursue ownership, work hard, and plan to earn an above-average income as a general dentist or specialist, the additional five years of repayment in REPAYE can be costly and should be included in calculating the total cost of your education when comparing REPAYE to PAYE.

We have discussed the interest subsidy before, but we will revisit it now because it is a fundamental difference between REPAYE and PAYE.

Remember that REPAYE, PAYE, and IBR offer an interest subsidy on subsidized loans.

For subsidized loans, the government will pay the difference between your monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued) for three years under IBR, PAYE, and REPAYE.

For unsubsidized loans, the government will not pay the difference between your monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued) if the borrower is enrolled in IBR or PAYE.

For unsubsidized loans, the government will pay half of the difference between your monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued) while the borrower is enrolled in REPAYE, and this 50 percent interest subsidy is available during the entire repayment period.

For borrowers enrolled in REPAYE who still have outstanding subsidize loans after three years of repayment, the government will pay half of the difference between the monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued). This 50 percent interest subsidy is available during the entire repayment period.

Many dentists are advised to enter into REPAYE because the interest subsidy is appealing. However, PAYE can be a superior plan depending on your own personal financial situation.

Major Differences that Borrowers Need to be Aware Of:

Graduate direct loans in PAYE are eligible for forgiveness after 20 years.
Graduate direct loans in REPAYE are eligible for forgiveness after 25 years.

PAYE has an interest subsidy for three years on subsidized loans. PAYE does not have an interest subsidy for unsubsidized loans.
REPAYE has an interest subsidy as described above.

There is no income requirement for REPAYE. To enroll in PAYE, the borrower must qualify by showing proof of a partial financial hardship.

Both plans limit monthly payments to 10 percent of the borrower’s discretionary income.

PAYE has a cap on the payment amount, where the monthly payment will never be greater than the 10-year standard repayment, even if 10 percent of the borrower’s discretionary income exceeds the monthly payment on a 10-year standard repayment plan. REPAYE closed this loophole and does not have a cap on the payment amount.

For married borrowers, under PAYE, a spouse’s income can be removed from the calculation if the couple chooses to file taxes separately. REPAYE closed this loophole. Under REPAYE, the

household income is used on to calculate the monthly payment regardless of how the couple chooses to file taxes.

How much interest can be capitalized?

We have talked about negative amortization and the events that trigger capitalization before. PAYE caps the amount of interest that can be capitalized onto the principal balance to 10 percent of the original balance when the borrower enrolled in PAYE. REPAYE closed this loophole and the entire sum of outstanding interest can be capitalized if an event that triggers capitalization occurs.

Calculating Payments Under IDR

Two simple formulas to calculate a borrower's monthly payment under REPAYE or PAYE:

A borrower's annual payment = (AGI - 150 percent of FPL) x 10 percent
A borrower's monthly payment = (AGI - 150 percent of FPL) x (.10) / 12

Remember FPL is the "federal poverty level" and is dependent on your family size.

Interest Subsidy

It should be noted that REPAYE, PAYE, and IBR offer an interest subsidy on subsidized loans. However, since July 2011, graduates students no longer have access to subsidized direct loans. Therefore, when we read about an "interest subsidy," the writer is often referring to one of the benefits of REPAYE.

For subsidized loans, the government will pay the difference between your monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued) for three years under IBR, PAYE, and REPAYE.

For unsubsidized loans, the government will not pay the difference between your monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued) if the borrower is enrolled in IBR or PAYE.

For unsubsidized loans, the government will pay half of the difference between your monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued) while the borrower is enrolled in REPAYE, and this 50 percent interest subsidy is available during the entire repayment period.

For borrowers enrolled in REPAYE who still have outstanding subsidized loans after three years of repayment, the government will pay half of the difference between the monthly payment and the amount of interest remaining (if your payment does not cover the amount of interest that accrued). This 50 percent interest subsidy is available during the entire repayment period.

Taxable Forgiveness

It is imperative that borrowers participating in any of the IDR programs understand that whatever balance is forgiven at the conclusion of one of the IDR plans is considered taxable income. This is often referred to as a “tax bomb.” Depending on how much money may be forgiven and which state you reside in, preparing for this tax bomb must be part of your current budget.

How will the IRS know how much of your debt was forgiven?

At the time of forgiveness, the loan servicer and the borrower will submit a 1099-C to the IRS. You can obtain a copy of form 1099-C here: https://www.irs.gov/pub/irs-pdf/f1099c.pdf

Public Service Loan Forgiveness

Public Service Loan Forgiveness (PSLF) is a program where borrowers who make 120 on-time payments in one of the income-driven repayment (IDR) plans or 10-year standard repayment (loan would be paid off) while employed by a 501(c)3 are eligible for tax-free forgiveness of their direct or direct consolidation loans.

To qualify for PSLF, a borrower must work full-time as a W-2 employee, for 10 years, for a 501(c)3 who performs at least one of the following services as their primary service:

1. Emergency management
2. Military service
3. Public safety
4. Law enforcement
5. Public interest law services
6. Early childhood education
7. Public service for individuals with disabilities
8. Public service for the elderly
9. Public health
10. Public education
11. Public library services
12. Other school-based services

It is extremely important to note that you must be employed (as opposed to contracted) with the 501(c)3. If you are a classified as an independent contractor and receive a 1099, your payments do not qualify for PSLF.

It is also imperative to note that you must be employed by a 501(c)3 when you apply and receive forgiveness. Do not leave your position after making 120 payments and then apply.

Tax-Free Forgiveness

The only program that has the benefit of tax-free forgiveness is Public Service Loan Forgiveness (PSLF).

Opportunities for employment that qualify for PSLF are available to dentists, however it is much easier for a physician to find employment that satisfies this program's requirements than a dentist. Nevertheless, PSLF may be an option for some borrowers.

Consolidation

Consolidation is the process of combining multiple loans into a new, single loan. If you are consolidating direct loans, or combining non-direct loans with direct loans, the process is referred to as "direct loan consolidation." Consolidating non-direct loans into a direct consolidated loan, will make the loan eligible for repayment under one of the IDR plans.

Most dental students have multiple loans per academic year due to the high cost of our education; however, a case can be made that dentists with high debt should not consolidate their loans into one loan despite the convenience of having one loan servicer with one monthly payment. The reason that dentists may want to avoid consolidating their student loans is that while enrolled in an IDR plan, you may experience negative amortization (remember that negative amortization occurs when a borrower's monthly payment does not cover the amount of interest that accrues on the principal balance).

One of the downsides to the IDR programs is that payment made in excess of the amount due cannot be applied to the principal balance until all outstanding interest on the loan has been paid.

The amount of interest that accrues on the consolidated loan is much more than the amount of interest that accrues on each of the smaller loans prior to consolidation (even though the sum of the interest that accumulates is the same).

Let's say a borrower has used 10 loans at $25,000 each to pay for a dental education for a total of $250,000 at an interest rate of 6 percent. The borrower has two choices. One, consolidate the 10 loans into one loan at an average interest rate. Two, leave the loans unconsolidated with the possibility of having to manage multiple loan servicers (and therefore multiple payments).

Reasons to Consider Leaving the Loans Unconsolidated

When the borrower above graduates and enters into IDR, it is highly likely that his/her monthly payment calculated in the context of IDR will not cover the amount of interest that accrues on $250,000. Therefore, the borrower will be experiencing negative amortization and the outstanding interest will begin to accrue (remember, the interest does not compound because it is not capitalized. Memorize the eight events that trigger capitalization). If the borrower is comfortable making payments in excess of the percentage of income that is due, the extra payments will always be applied to the outstanding interest before the principal balance.

Practically speaking, what this means, is that if the 10 loans for $25,000 each were left as individual loans (not consolidated), they would each accrue $125 per month in interest.

However, if the 10 loans were consolidated into one jumbo loan of $250,000, the amount of interest that accrues on the loan each month is $1,250.

Let’s imagine that a borrower is currently earning an income where her monthly payments as calculated by IDR are $1,000. This borrower can also afford to make payments in excess of her calculated IDR payment and wishes to put an extra $250 per month towards her loans. If the borrower consolidated the loans into a jumbo loan, her monthly payment of $1,250 would break even (no interest would accrue, but she would not reduce the principal balance and the same amount of interest would accrue next month).

But, if the borrower had declined to consolidate her loans, she could direct the extra $250 per month toward one of the smaller loans (you do not have to spread the extra payment over all 10). In this situation, she would make her $1,000 per month IDR payment that is spread out over all their loans, and then pick one loan to apply the extra $250 toward. Since each loan only accrues $125 per month, the outstanding interest of $125 would be extinguished and the remaining $125 would be applied to the principal. Therefore, the borrower would have reduced her principal balance and the amount of interest that accrues on at least one of the 10 loans would be less next month. Rinse and repeat this process and the amount of interest accruing on your loans will decrease each month, making negative amortization less burdensome.

Unfortunately, consolidation is a one-time event that cannot be redone or undone. So borrowers who already chose to consolidate their loans are stuck.

Refinancing

Refinancing is a private endeavor that can be redone but not undone. A borrower can choose to refinance their student loans with a private institution to obtain either superior terms or more favorable interest rate.

Over the last few years, many borrowers have enjoyed record-low market rates and there has been a “student loan refinancing boom” with the emergence of private lenders marketing their student loan refinancing departments to professionals - especially medical professionals. As interest rates and tuitions rise, it is likely that refinancing will become less popular; nevertheless, refinancing student loans is, and will continue to be, an option for dentists. When a dentist decides to refinance their student loans, two things happen:

1. The dentist will lose access to all of the IDR plans. This is a permanent loss and cannot be undone.
2. The outstanding interest will be capitalized.

Prior to deciding if refinancing your student loans is the right decision for you and your family, you need to calculate your effective interest rate under one of the IDR plans.9

Credit

Credit is a tool that can be used for good, but also can become a problem if it isn’t used correctly or effectively. It’s also important to distinguish between so-called “bad” debt — debt used to buy things just because you want them — and “good” debt, such as a mortgage or student loans that

can help build wealth in the long term. Using credit reliably for educational loans or large purchases such as a home can help you build a good credit score. A good credit score can help you build wealth and allow you to do business with companies. However, you can get into trouble if you don't understand how credit works.11

Here are some helpful tips in managing your credit score and debt:

Check your credit reports. There are three credit bureaus. Annually, you should check each of your credit reports. AnnualCreditReport.com offers this free service. Spread out your requests, making requests once per four month period, so you can catch errors that might come up at different parts of the year and spot potential identity theft. By maintaining these dates over time, you can mark them as a recurring event in your calendar.

Check your credit score. A credit score is a three-digit number that reflects the credit history detailed by a person's credit report. Every year, you should visit MyFICO.com to retrieve your credit score from each of the three credit bureaus.

Lock up cards; don't cancel them. Do whatever it takes to limit your use of credit cards, but don't cancel credit card accounts once they're paid off. Why? Because your credit score relies on the number of credit lines you have open and in good standing and the length of time they're open. Lenders want to see a long record of credit management, and longtime accounts you haven't touched in years may actually help your score by showing you have some restraint. Remember to use them once a year and pay the full amount off immediately to keep credit cards active.

Pay on time. Nothing damages your credit score faster than late payments. It is extremely important to get current and pay in advance of the due date. Electronic bill paying or automatic payment withdraw eliminates mailing delays and gives you the ability to better manage payment dates. If paying by mail, I suggest mailing the payment five to seven days before the due date. Regardless of how you pay bills, it's a good practice to enter all bill due dates in your budget or calendar.

Monitor credit problems. If you file for bankruptcy or have a debt put in collection, it takes years to remove those events from your credit record. Determine the month that data should leave your report and make sure you follow up to make sure that removal happens.

Keep your balances low. If you carry balances that are more than 50 percent of the account's credit limit, it might lower your credit score. To remedy this, use several cards to spread out the balance — and pay them off — or ask the creditor to raise the limit on the card.

Limit your credit inquiries. Credit inquiries from potential lenders, solicited or unsolicited, can actually lower your score. This includes mortgage companies every time you get preapproved and department stores that offer you a 10 percent discount if you open a charge card.

Track your credit card spending. If you've never made a concerted attempt to track your credit card spending, do so starting this credit cycle. It can be as simple as a paper list or as

sophisticated as a spreadsheet or money management software. Whatever tool you choose, tracking your spending will give you a forecast of your upcoming monthly bill. You can also track your recent charge card activity directly at the issuer's website. The goal is to know what your payment will be so that you can plan accordingly.12

Paying Off Loans

Most people would agree that paying off debt is often a good choice. In addition to the financial benefits, there are psychological benefits of being debt-free. Eliminating debt reduces stress and brings peace of mind. Though it might not make sense financially, it's hard to put a price on peace of mind. Here are a few things to consider when making a decision to pay off a loan early or to use the extra cash you have in another way.

The type of loan you are planning to pay off early matters. The high interest rate credit card loans or payday loans are a great place to start. Other loans might not be a clear winner. Federal student loans offer flexible payment plans if finances get tight and allow you to pause payment if you become unemployed. There are also loan repayment programs that allow you to have your loans forgiven or repaid.

The best reason to pay off loans early is to stop paying interest. By freeing up that monthly payment each month, you can begin to improve your financial strength. This extra money can go toward paying down other debts or can be used to save or to invest. Another benefit to paying off loans is that it will improve your debt-to-income ratio, making you more attractive in the future if you need to take out a loan. Improving your credit score is another important benefit to paying down debt.

Once you make the decision to pay down loans, how should you go about doing it? In many cases, simply sending in a lump sum payment or a little extra each month is all you need to do. Contacting your lender to discuss your goals can ensure that your extra payments are going toward the principal and not just delaying your next payment. Consolidating your student loans can help you get a lower interest rate and pay off the loan faster. Be careful if you are consolidating many loans, however, as you might have a higher monthly payment than you did in the past when you were making minimum payments. Also make sure if you are paying off credit cards that you don't just rack up debt again.

The Life Cycle of Financial Planning

As mentioned earlier, financial planning is a dynamic process. Here are some steps to help prepare for unexpected and expected changes that might occur. This next section will walk you through the process outline in the chart below starting with protection planning, investment planning, tax planning and estate and retirement planning.1

1. Protection Planning

This planning is to protect yourself against risk in two ways:

1. Protecting against risk of the unexpected by setting up emergency funds.
2. Protecting against risk by purchasing an adequate mix of insurance that will cover life, disability, health, property and casualty, and automobile.

Emergency Fund

Emergency funds are important to plan for the unexpected, but also give the peace of mind that if problems do arise, you have a plan in place to help. A fully funded emergency fund should consist of three-to-six months' worth of expenses. While this might seem like a lot, in the early stages of planning a smaller amount of $1,000 could be more manageable.

Disability Insurance

Disability insurance is a type of insurance that will provide income in the event a worker is unable to perform his or her work due to a disability.

What you should look for in disability insurance:

1. **"True Own Occupation."** This type of insurance is better than "modified own occupation" or "medical own occupation."
2. A way to increase your coverage in the future without additional medical underwriting. The best version is called **"future increase options."** A lesser version (and often free) is called "benefit purchase rider" or "benefit update rider."
3. A **cost-of-living adjustment (COLA)** that grows your monthly benefit while you are on claim. A compounding COLA is better than a simple COLA and does not cost much more. With compounded increases, each year's percentage of increases in benefit will be applied to the original benefit amount plus any and all prior year's increases. With simple increase, the percentage of increases apply only to the original benefit amount while ignoring any and all prior year's increases.
4. A **partial, or residual, disability rider** that will pay a benefit if your income drops but you can still practice dentistry. This allows you to work as a dentist part-time and still receive your monthly benefit.
5. **Full coverage for mental/nervous disorders**.
6. **Non-cancellable and guaranteed renewable**, which means the insurance company cannot change the policy or pricing in any way.
7. An **independent broker** who represents the client and does not work for a particular insurance carrier.

Policies can be set up with different structures, but most would recommend the following:

1. A sufficient **monthly benefit**, which is how much you get paid each month.
2. A long **benefit period** — to age 65 or age 67 at least. Disability insurance that only pays for five or 10 years doesn't pay long enough.
3. An **elimination period** of 90 days. The elimination period is the time before the insurance starts paying benefits. Most people choose 90 days, but it can be 30, 60, 180, or 365 days as well. The shorter the elimination period, the higher the cost.

<u>Malpractice Insurance</u>

Malpractice insurance is a type of professional liability insurance purchased by health care professionals that protects health care providers against patients who file suit against them under the complaint that they were harmed by the doctor's negligent or intentionally harmful treatment decisions.

What you should look for in malpractice insurance:

1. "**Occurrence form**" instead of "**claims made**." This means that "tail coverage" is built in. On a claims made policy, you buy tail coverage when you cancel the policy.
    a. **Claims made**, however, is good for graduating students who know exactly what their career is going to look like: work in your hometown, then start a practice, sell to a future associate, and retire.
    b. **Transitional** or "**step into occurrence**" policies combine the two types and are expensive, not better.
2. Ask about **consent to settle** rights, especially with large group insurance. Most personal policies give you the control over whether or not the insurance company can settle a lawsuit, but policies for large groups typically do not give you that right.
3. **A carrier (and an insurance agent) that knows dentistry**. If your agent doesn't know what an SRP is, how will the agent know if you should file a claim? If your claims adjuster hasn't handled tons of paresthesia cases, how will they know how much settlement money is normal?
4. Sometimes, employers will make you feel like they'll take care of it for you. That's fine, but you will want a certificate of insurance (COI) each year to keep for your permanent records.

Here are some specific scenarios to consider. If you will be:

- **a resident**, you can get a policy to moonlight.
- **at a large group**, ask about tail coverage and see if they will pay for it.
- **in the military or at a federally qualified health center (FQHC)**, your malpractice coverage is the Federal Tort Claims Act (FTCA).
- **in the state of Indiana**, the Patient Compensation Fund (PCF) is optional.

A caution about conversations with small employers: Sometimes, employers will try to add you to their policy. If its "claims made," ask that they pay for your tail coverage or allow you to choose your own policy.

2. Investment Planning

This planning is to increase your wealth and preserve it against inflation. Investment tools available include common or preferred stocks, government or corporate bonds, mutual funds, and real estate.

3. Tax Planning

This planning is to maximize your tax advantages. Tax planning is the analysis of your financial situation from a tax perspective. Ensure tax efficiency by using your financial plan in the most tax–efficient manner possible.

Tax planning begins by understanding what tax bracket you are in and the progressive tax system. There are seven federal income tax brackets: 10 percent, 12 percent, 22 percent, 24 percent, 32 percent, 35 percent, and 37 percent. Whatever tax bracket you are in, you won't pay that rate on your entire income. There are two reasons for that. First, you get to subtract tax deductions from your income, thus lowering your taxable income. Second, the federal tax system is a progressive system. You will only pay the percent of tax up to the limit on that percent. For example, let's say you're a single filer with $50,000 in taxable income. You would pay 10 percent on the first $9,700 and 12 percent on the income from $9,701 and $39,475 and then you would pay 22 percent on the rest.

There are a number of tax strategies to shelter income or cut your tax bills. You can invest money through an employer's 401(k) plan or put money in an IRA. A 401(k) plan allows you to divert up to $19,000 per year and up to $25,000 if you are 50 or older. The money used on these programs is not taxed, but the growth you earn on your investment will be taxed at your tax rate when you withdraw the funds at retirement. If you plan to be at a lower tax bracket when you retire than you are currently, then this can save you significantly on taxes.

There are two different types of IRA programs: traditional IRAs and Roth IRAs. Traditional IRAs may be tax-deductible. How much you deduct will depend on whether you or your spouse is covered by a retirement plan and how much you make. In this form of IRA, you will pay taxes when you take distributions in retirement. In Roth IRAs, the money used to invest in the IRA has already been taxed and so any investment and growth in this fund grows tax-free. At retirement, when distributions are taken, there will be no tax liability. Roth IRAs do have income limitations when investing. In 2019, married filing jointly allowed for income up to $193,000 and single was $124,000. Both types of IRAs allow for a contribution limit of $6,000 per individual and $7,000 for those 50 and above.

Savings accounts and flexible spending accounts (FSAs) are another tax-savings strategy. Most states operate 529 accounts that allow you to put back money for college for your children. Though you can't deduct these contributions on your federal income taxes, you might be able to on your state income taxes. One thing to pay attention to is the gift-tax consequence. If your contributions plus any other gifts to a particular beneficiary exceeds $15,000, you will be responsible for the taxes.

FSAs and dependent-care FSAs allow you to lower your tax bill by putting money in these accounts to pay for medical, dental, and dependent care coverage. FSAs allow you a limit of $2,700 in 2019 and dependent-care FSAs allow $5,000. Health savings accounts (HSAs) are a tax-exempt account you can use to pay for medical bills. Contributions to these accounts are tax-deductible and withdraws are tax-free. In order to qualify for these accounts, you have to have a high-deductible health coverage.

4. Estate and Retirement Planning

This planning is to provide for a financially independent, comfortable retirement during your later years that will provide the same standard of living that you enjoyed during your working years, as well as an orderly transition and distribution of your assets and wealth.13

Estate planning should include these six steps:

1. *Create an inventory of what you own.* Make sure to include account numbers and contact information. Keep this and other important documents in a secure location (that can be accessed by those who need to).
2. *Develop a contingency plan.* Good estate planning allows you to control what happens to your property and assets if you pass away suddenly. Such documents should also include a living will if you become incapacitated. This allows your family to carry out your affairs without having to go through the courts.
3. *Provide for children and dependents.* Your estate plan should protect those whom you leave behind. Your plan would include provisions for any children, including naming guardians for children under 18.
4. *Protect your assets.* A component to estate planning is protecting your assets for heirs by minimizing expenses and covering estate taxes. Your plan should include strategies for transferring or disposing of unique assets. Consideration should be made on setting up living or spring trusts.
5. *Document your wishes.* If you want assets distributed in a certain way, the best way to insure this is to document your wishes. Designating beneficiaries for life insurance policies, retirement accounts, and other assets are important. A living will should reflect your end-of-life wishes, as well as powers of attorney for health-care and financial matters.
6. *Appoint fiduciaries.* To execute your estate plan, you must designate someone to act on your behalf if you are unable to do so. Assigning an executor of your will, trustee for your assets, legal guardian for your dependents, and power of attorney if you become incapacitated is important to consider. Fiduciaries can be family members, friends, or hired professionals. It is important to make sure your fiduciaries are aware and agree to their appointment.

Using Professional Financial Planners

A financial planner is a qualified investment professional who helps individuals meet their long-term financial objectives. Financial planners do their work by consulting with clients to analyze their goals, risk tolerance and life stages and then identify a suitable class of investments for them. It is best to seek financial counsel from a registered fiduciary. Registered independent fiduciaries are legally obligated to act in the best interest of their clients and cannot benefit from the management of the client's assets.

Registered investment advisers can work as fee-only advisers or on a commission. Fee-only advisers make their money as an hourly rate, annual fixed retainer, or percentage of the investment assets they manage on behalf of their clients. These type of advisors have a fiduciary

duty to their clients over any broker or dealer. Financial planners working off commission generally earn money as payment from companies whose investment products they recommend. They can also earn money by opening accounts for clients.

Before picking a financial adviser, you should interview several and choose the one that's right for you. Here are a list of questions to ask:

1. What are your credentials?
2. What do you charge?
3. What is your area of expertise?
4. What services can I expect?
5. How will we settle disputes?

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