Exploring the Ethical Constructs of Dental Patients to Guide Dental Ethics Teaching

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Research Article

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Abstract

Background

Dental ethics as a construct is mostly developed based on the ethics theory and experiences of professionals. Dental patients, as a stakeholder can guide us about their ethical constructs thereby curriculum developer can contextualize ethics to the local needs. The purpose of this study is to explore the ethical constructs of dental patients to guide dental ethical teaching.

Methods

A grounded theory approach, inspired by the socio-constructivist paradigm was used for data collection. The duration of the study was six months and non-probability, purposive, convenience, theoretical sampling was used. Dental patients visiting the various department of dental colleges in Lahore, Pakistan were interviewed to explore their ethical constructs and thematic analysis was done.

Results

Nineteen dental patients were interviewed. Three themes were derived from four hundred and sixty-two codes. Three themes were: dental patient ethical constructs, dental ethics teaching, and ethical context. Under these themes, honesty, good communication ethics and respect for patients were the main ethical constructs of dental patients. Dental patient also emphasized effective ethics teaching and assessment. Finally, for the dental patient, religion and economic condition were two main contextual factors effecting ethical construct.

Conclusion

Dental patient desire honesty, good communication ethics, and respect for patient from dental students. The patient defined ethical context and ethical constructs may help curriculum developer to contextualize and emphasize dental ethics teaching. Religion and the financial aspect are the two contextual factors effecting ethical construct that play key roles.

Background

Dental Ethics is an essential component of professionalism required to develop trust in the dentist and patient relationship (1). Dental education aims to bring positive change in dental student behaviour. Dental ethics teaching is unable to bring desirable change in the behaviour of dental students (2–4). Dental faculty and dental student reflected on this issue and found some probable reasons. The dental ethic as a subject is considered boring (5). Dental students are asked to reflect on a dental ethical issue, but they are not expected to continue these reflective practices. The non-availability of trained faculty to teach dental ethics is another hurdle in the implementation of the ethics curriculum (6). The dental curriculums are overcrowded with knowledge and skill domains leaving little time to teach ethics. Ethics
teachers are teaching experts who define content, although they are not wrong there is another perspective that requires patient input.

Patient-centred care requires patient input to modify patient management. It may be possible that dental patient contributes to redefining the ethical need for society. Although dental educationists have defined the ethical competencies for a dental student; do dental patients think like these experts (7)? To overcome the issue related to dental ethics teaching, dental patient views regarding ethics should be recorded (8). The dental patient ethical constructs can redefine dental ethics teaching and customize dental ethics assessment of dental students (8).

Due to the changing role of the dentist and the perception of the dental patient, the top-bottom approach may not be what the patient desires as ethics may be context-driven. Each context has its strengths and weakness, and rigid ethical standard and expert competencies may not be beneficial for ethics teaching. The local studies and international studies are unable to demonstrate a visible ethical and moral change in students and dentists. If a dental student knows the dental patient ethical construct (bottom-top approach) this may bring a desirable change in the dental student’s behaviour. So, our research question was “What are the ethical constructs of a dental patient to guide dental ethical teaching?” The statement of purpose was “To explore the ethical constructs of dental patients to guide dental ethical teaching”

**Methods**

**Study Setting**

This study has utilized a grounded theory methodology and a socio-constructivist paradigm was used to enhance our understanding of the study findings. Ethical approval was obtained from the University of Lahore where author A was studying as a medical education student, and institutional review board approval from of Fatima Memorial Hospital College of Medicine and Dentistry (FMHCM&D), Lahore Pakistan, where author A work as a full-time faculty member as an assistant professor of oral and maxillofacial surgery for past five years. The qualitative data was collected between December 2018 and May 2019. The study population consisted of dental patients, including the current and potential dental patients. The sampling frame consisted of dental patients that are presented to various dental hospitals but primarily data was collected from FMHCM&D. The non-probability, convenience, theoretical sampling technique was used during this study.

**Data Collection**

Total twenty-two patients consented for interview; three patients declined interview due to personal commitments. Nineteen participants were interviewed after one pilot interview, all interviews were conducted by author A and no repeat interview was carried out. Out of nineteen participants, five participants were female and author A faced difficulty to convince them for interview due to his gender, religious and cultural belief of female participants. The chaperones were allowed during these interviews but their opinions were not recorded. The participants belonged to different diverse background, have
different educational qualification and different professional experiences. Six out of 19 interviews were conducted outside FMHCM&D upon patient request. Five participants of this study were previous patients of Author A, they consented for participation in this study, rest of the participants approached author A via email or WhatsApp as he had displayed a poster for inviting dental patients to participate in this study. The participants understood the research problem and the author’s intention of doing research, they expressed their views freely as they were allowed to give interview in English or Urdu. The interview duration varied from 20 minutes to 120 minutes and field notes were collected during interviews. The data saturation was reached by the fifteenth interview but to achieve theoretical saturation four more interviews were carried out. An interview guide was made at the start of the study which was updated based on previous interviews and interviewee background.

Data Analysis

These interviewees primarily discussed their understanding of ethics and ethical principles. However, some of the desire expressed by dental patients were not related to ethics. A total of 850 minutes of audio recording were transcribed and after member checking open coding was done with Atlas Ti version 7. Authors B reviewed the code generated in the first round, and a partial consensus was achieved after the second round of coding. The generated codes were categorized, and a consensus was achieved on generated codes and categories. Next, author A developed networks out of the categories of codes. By combining several networks, five themes were identified. Two themes were expected as result of this study, three themes other were identified during data analysis. Author B reviewed the networks and ask to edit some relation to bring more clarity. During iteration related to data analysis, three authors agreed on removing two themes; by the end of this data analysis, three themes were identified by mutual consensus. The findings of this study were not communicated to participants. The author A is actively involved in inculcating knowledge and skill in dental students. During assessments, he has observed dental student are not doing enough for their patients, despite they having been taught dental ethics and professionalism. During medical education training, he has seen the attitude component was not emphasized enough despite its importance in healthcare professional education. The author A has no previous experience of conducting a qualitative research, although he has collected quantitative data for a dental ethics related research. The supervisor of this research has done doctorate in education from England, currently working as director medical education and has previously published on matter related to professionalism and ethics. The authors belonged to a diverse background in medical education and have also been teaching ethics in their institutes.

Results

Three themes derived from this study were:

Ethical constructs of dental patients

The dental patients explicitly and implicitly communicated their desires related to ethics and primarily discussed ethical principles. Some dental patients hierarchically categorized ethics; the main category of
ethics was core or essential ethics, and other ethics were ethics that were above core ethics or superlative type of ethics and was discussed by few highly educated participants. The above core ethics described by the patients were beneficence and empathy. The patient said

“So, empathy is basically of very highest value…… (Dental patient19, PDP9, female)”

We operationalized ethics into primary ethics when dental patients explicitly desired a particular ethical value and secondary ethics when patient implicitly communicated their desires related to ethics. The top primary ethics desired by dental patients were honesty, communication ethics, respect of patient and non-maleficence. The dental patients considered honesty as the most important and most desired primary ethical value and one of the dental patients stressed that

“In my opinion ethics starts from the honesty of profession either dentistry, ...... whatever profession .... If we are honest, we can move toward ethics. If you are not then .... you can skip some ethics as well. (Dental patient1, DP1, male)”

Due to a lack of honesty, the trust in a dentist is decreasing

“The most concerning for me ......people don’t use sterilized equipment. Most of ... if you go to suburbs, not in Lahore sterilized equipment is one of the biggest concerns for. (Dental patient2, DP2, male)”

The communication of the dentist is also quite problematic and the patient again stressed the need for better communication ethics

“If you scold the poor patient or insult him. ...... if you go to the periphery especially in public sector hospital... there you can see how they insult the patient, at that time they feel we should have died at our home. (Dental patient18, PDP8, female)”

The dentist should show patience when communicating with their patient but this is being implicitly communicated as

“Sometimes you come across a patient, you can say who is harsh...... so it is good that doctor should control his temperament and should not react similarly. If you deal with this patient in a good way, this is a sign of greatness. (Dental patient9, DP9, male)”

Few dental patients expressed some ethics-related competencies that must be inculcated into dental students and these competencies were related to communication ethics, beneficence respect for patients and satisfied patient. One of them expressed his views as:

“So, I think that in terms of ethics my concern is that you need to let the patient realize and make him sure that we are with you, once you leave the hospital you will go with the smiling face and this kind of surety that we will render the best services anywhere in this country. (Dental patient3, DP3, male)”
A conflict was observed between dental patient and dentist who think a majority of patients, do not know what the significance of ethics is, rather they just want cheaper treatment:

“In Pakistan, a patient comes with a clinical complaint, not with an ethical construct. They expect a certain ethical consideration, but they come in … and of course whatever their initial perception is …. They would expect a level of ethics to be practised if they are going to continue with any practitioner. (Dental patient12, PDP2, male)”

Dental ethics teaching

Dental patients gave varied opinion about ethics teaching which were related to curriculum designing, curriculum development, effective ethics teaching and assessment of ethics. A patient communicated that dental education should sensitize the student to ethical issues; promote social justice and ethical identity formation. A dental patient suggested that the healthcare regulatory authority of a country has a central role in defining ethics curriculum after consultation with the dental professional body

“So, first of all, you will define your strategy that in medical sciences or in medical organizations what ethics other countries are applying and what is important to be implemented here looking on the balance of the life-like in terms of the poverty level and these kinds of things. (Dental patient3, DP3, male)”

The dental patients discussed the outlook of the dental ethics curriculum and give several suggestions. The patient suggested that Initially, ethics program education should be developed around universal ethics and later, ethics education program should be defined ethics-related competencies and contextualized them to fulfil patient’s needs. Patients suggested dental institution environment also help in promoting moral growth through the formal and informal curriculum. The dental patient said that the dental curriculum should have a dedicated dental ethics section.

“If you want, you can introduce it as a small regular subject, you should make it a compulsory subject and make it mandatory to pass. (Dental patient18, PDP8, female)”

Dental ethics should be taught before entering clinical years and procedural ethics should be taught in an integrated fashion. A dental patient suggested that we should set aside profession versus trade controversy and teach our student business ethics. and repurpose religious studies to teach ethics. Prospective dental student intentions should be judged at the time of admission to select the best student to become an ethical dentist.

The dental patient suggested that dental teacher should also motivate dental students to practice ethics during their practice. Every faculty member should be trained to become a good role model for student training.

“So, when they are coming into the workforce follow them and these teachers should also be the role models. (Dental patient13, PDP3, male)”
Patients suggested that ethics education should be started early during dental education and role modeling should be done in presence of the patient. Dental patients suggested that during clinical rotations the ethical scenario should be introduced to them in small groups and they should be taught how to make ethical decisions and later introduce them to how to resolve ethical dilemmas. According to dental patients, the assessment of ethics is a difficult task he added that

“We can only see the behavioral change in the individual and there is no other way to make this judgment (Dental patient16, PDP6, male)”

they have suggested in addition to the traditional assessment method, qualitative observation should be made. Dental patients suggested that a patient can become a partner in the assessment of ethics but dental faculty should make fail and pass decision during assessments. If required remedial of ethical issues should be planned according to ethical competencies for each level or professional year. The dental institutions should exhaust all options before taking stern action.

During, dental vocational training, graduates should be actively assessed and quality feedback about student behaviour should be sought from patients to strengthen the ethical identity and improve professionalism among dental students. The dental patient thinks education should not end at graduation; continued professional development program planner should add attitude related component in professional development courses.

“You do not have to teach ethics in great detail again, principally a polite reminder is required. (Dental Patient16, PDP6, male)”

The dental leadership should deliberate continuously so they can have insight into those issues and recalibrate the future need of the profession.

**Contextual factors affecting ethical construct**

The ethics are context-driven and during the interview dental patient pointed that ethical transformation will be hindered by the adoption of foreign ethics codes by dental colleges, as they may not fulfil local needs as they are situated in their respective contexts.

“See if we go to that advanced level, society has to be up to that level, for a society which is a developing country, if you are expecting such kind of level from a common man. I believe it would not be a fair expectation. (Dental patient1, DP1, male)”

Patients’ satisfaction should be the goal of treatment for the dentists, for these ethics-related changes were desired by dental patients.

“We have the message of Allah and sayings of Prophet Muhammad (PUBH); we can be one of the great nations of the world. We cannot become great by mere speeches or we will become great by acquiring a
large number of atomic bombs. Sorry!! One can only become great by improving our moral attitudes. (Dental patient17, PDP7. Male)"

The predominant contextual factor that modifies ethical construct were religion and economic context. Other contexts were social, cultural, gender, regional, conflict in dentistry and education Dental patients conveyed that ethics is part of religion and ethics exist only in presence of religion and religion protects the rights of the poor

“But our religion does not say that poverty should take away moral values. (Dental patient14, PDP4, female)”

Religions (Islam) believe in universal ethics and it should serve as our reference standard. In contrast, a participant said ethics are larger and superior to religion that modern ethics are not universal especially, in the healthcare environment. The competency of a dentist is not affected religion does not matter, as it does his competency.

“As I have already stated that religion and sect of doctor do not matter. (Dental patient18, PDP8, female)”

A participant communicated that culture is subordinate to religion. Cultural groups give rise to some traditions which are important to a specific cultural group. Participants pointed out that a new set of practices are required for female patients.

Economic context was discussed in great detail by dental patients and they considered corporate dentistry is hurting the rights of people. A participant pointed out that ethics education will not work in presence of commercialization of the profession. A dental patient pointed out that dentistry is not a profession in the true sense.

“One of the crunch problems which we face right now is … taking into consideration dentistry either as a profession or as a trade. So that is the real conflict which…… brings ethics into disrepute…… (Dental patient12, PDP2, male)”

He added that the quality of care in dentistry is largely dependent on the ability to pay. A patient stressed a mechanism need to be developed so they do not have to pay the dentist directly.

A patient said that patient’s illiteracy is an issue that is negatively affecting the context of ethics. Another patient explained that lack of education is not an issue, we have issue in the mindset and society wants accountability of everybody except themselves.

**Ethical construct theory**

This paper starts with the presumption that expert-based content is not bringing out the desired ethical change in the dental student. The patient may be an advisor in medical education related matter. Expert has to listen to them for a contextual issue like ethics. The patient knows the issue with the doctor (they may be peer/consumer who can tell about the blind spot of dental education). The patient may help
medical education in clinical matters (BEME guide, Gordon 2019) and teaching ethics is aimed at bringing ethical change in an individual. Our study shows that ethics are situated in a particular context and teaching patient ethical construct with bringing about desired change and will make assessment authentic. This relationship has been shown as Remake theory of ethics in fig. 1

Discussion

This study is a paradigm shift in our understanding related to ethics. We used a bottom-top approach rather than the traditional top-bottom approach, that is, instead of starting from a theory, we started with presumption that expert derived contents are not bringing desired change and so we assume that patient desire ethics may be different and so we carried out this study and result show dental patient constructs were different, and a new pattern of ethical concerns was visible. The dental patients stressed honesty, communication ethics, respect for patient and non-maleficence and dental patients ethical constructs are different from the western and implemented code of ethics (9–11). The dental patient thinks some ethical attributes are desirable but they can be compromise e.g., autonomy, respect, and trust. Similarly, the competencies defined by dental patients are different and no comparison to what was envisaged by experts for dental students (7). The dentists as potential patients were oblivious of the ethical needs of their patients. There was a disparity in the understanding when the dentist tried to comprehend what the patient understands about ethics (12). Less educated patients believe in utility-based ethics and the more educated who are yet to visit a dentist or expert in their field believe in universal and duty-based ethics.

Ethical constructs of a dental patient can transform dental ethics teaching was a difficult subject to investigate and dental patients cannot tell remedies for all the process involved in the ethics teaching. The implemented dental curriculums have stressed knowledge and skills (13,14). Dental educators have also rated knowledge and skill more important than ethics and critical thinking as developing outcomes related to these aspects are difficult (15). With dental patient insight into dental ethics, a program can be centered around patient defined ethical competencies. Incorporation of these ethical competencies will dilute the tension created by economic context, desire for honesty, beneficence and trustworthiness. Work ethics, team ethics, business ethics and communication ethics are part of the ethics curriculum in the United States of America (16) but we have not incorporated them yet. As religion is important for society and the addition of religious aspect into the ethics curriculum is suggested by patients and the previous regulator had started working in that direction.

Participants suggested dental ethics should be taught before entering clinical years and procedural ethics should be taught in an integrated fashion; however, integration of ethics curriculum is an issue (16) and local researcher suggested that only horizontal integration is preferable (3). The central component of ethics teaching is the availability of ethics teachers, the faculty development program must orientate teacher to become better teachers and ethical role model. A participatory research has developed entrustable professional activities for medical teachers (19). There is a total of nine entrustable professional activities and twelve competencies are associated with these professional activities. There
was a hundred percent among participants on professionalism and communication skills competency (19). In a local need assessment survey related to faculty development, it was found that clinical teachers are more interested in in-patient care as compared to the basic science teacher. Attitude development-related workshops were not explicitly mentioned in the need assessment survey (6). The attitude development in medical teacher is visible blind spot, a medical teacher may be a professional in his or her practice but may not be trained enough to transfer these professional attributes to their student. The patient defined ethics may require contextual ethics teacher training.

The dental patient suggested various teaching methodologies for the development of attitudes. The ethics teaching should first develop a knowledge base and should gradually progress to small group discussion of ethical dilemmas; similar methodologies have been used by dental educators (16). Dental patient’s participation can improve ethics teaching; simulated patient and patient videotaped input into ethics teaching has been used for dental ethics teaching (20). Dental teachers can seek quality feedback about student behaviour from patients to improve professionalism (22). Dental ethics education has several shortcomings and new ethics-related interventions should be added. Dental students should be allowed to practice communication ethics and communicating the cost of care in a controlled environment as give elsewhere (21); these opportunities are currently not available for dental students. Lack of structured house job graduates have also missed the opportunity for the ethical development of dental graduates (23).

Dental curriculums have not explicitly mentioned ethics-related competencies while discussing ethical competence (3, 16). Researchers have tried to identify moral growth and moral reasoning using various research tools at various levels and found dental student and dentist were not able to take a moral decision or have some major issue related to ethics (24–26). Researchers in Pakistan assess the ethical sensitivity of recent dental graduates and dental students (3, 27). The current dental examination system is checking knowledge only, without attitude assessment, this assessment system is inadequate. Dental educationist should devise assessment methods to assess moral reasoning and moral determination in an educational environment.

The work placed based on assessment may solve issues related to ethics assessment however its implementation is difficult without a mandate. Patient, faculty, peer, self-assessment and reflection will lead to better ethics assessment. The validity and reliability of assessment may remain questionable until these assessment schemes are tested in a given environment. In an institution where an ethics course has been implemented, the participant has identified some problem with the ethics curriculum, ethics education can produce ethics-related sensitization but permanent change could not be ensured (3). Although remedial schemes have been discussed by patients, before the implementation, stakeholder should agree on the framework of assessment of attitude. The infrastructure, assessors and money should be allocated for the ethics program.

The ethics of education should consider contextual issues. Every society has its unique context and the incorporation of context make learning and assessment meaningful for the student and
Religious context is the most important context in our society (3,29) and other societies have also given similar importance to religion and have oriented their ethics curriculum and code of ethics to religious context (9). The dentist gives credit to religion for their moral behaviour (30) and dental student's religious orientation will help them to bridge the gap with patients and inculcate some of the ethical attributes desired by patients (30). Although Islam has given great respect to the female gender (31) but Muslim women enjoy limited rights, the informed consent process becomes shared (32) and the care of a female patient is considered different from a male patient (9). The poor dental care of female patient due to religious and cultural aspect should be addressed by policymaker and dental educationist. Providing quality services at reasonable rates has been a challenge for the dentist, and the same problem has been identified on the medical side (29). The corporate dentistry or trade component of the dental profession of healthcare is a shock for patients (33). The dentists are suggesting treatments that are not needed and overtreatment is another ethical dilemma (34). Dental professionals' resort to dishonesty to augment profit (35).

Dental patient input leads to the bottom top approach in dental ethics. The patients shared their constructs and lead to the emergence of shared reality related to dental ethics. Dental patients' ethical constructs may stimulate dental student's behavioural change. The policy and practice of dental institution may change to conform to future needs. Dental professional societies should consider developing a societal lens for ethical related issues. The dental profession has to develop strengths and may consider the local standard in this regard. Remake theory of ethics may be refined and implemented for bringing durable change.

This study has studied a small section of society in a hospital environment and educational institution. Patients belonging to various provinces & minorities were not equally represented. It is expected if the rural population is compared to an urban environment a cultural dimension can be added to the context. Future studies can assess patients ethical construct in another context.

We suggest that dental patients' ethical constructs and ethical context may be incorporated into the dental ethics course. The curriculum developer may incorporate dental patient defined dental ethics related competencies. We recommend a faculty development program for dental ethics teaching. Pakistan Dental Association should develop a code of conduct for a dentist and carry out continued professional development programs to maintain professional growth. Regulators may consider developing their own strengths, so standard for healthcare professional education should be developed considering local context. Finally, medical education should continue dialogue with a patient wherever need arise.

**Conclusion**

Dental patients believe in utility type of ethics whereas experts focus on the highest level of virtues. Self-concept and accountability have defined the role of consequences. Patient desire honesty, good communication ethics, respect of patient and non-maleficence. The transformation of ethical constructs
into curriculum and ethics teaching will require discussions in light of the context. Religion and economic context are the two important contexts in our society.

**Abbreviations**

FMHCM&D: FMH College of Medicine and Dentistry, Lahore, Pakistan,

**Declarations**

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**Ethics approval and consent to participate**

This study was reviewed and approved Institutional review board of FMH College of Medicine and Dentistry, Shadman Lahore, Pakistan (FMH-11-2018-IRB-529-M), and the Ethical review board of UCMD, University of Lahore, Lahore, Pakistan (ERC/02/18/12, 20/12/2018).

**Consent for publication**

Please refer to the methods

**Availability of data and materials**

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request

**Competing interests**

Dr Usman Mahboob is an associate editor of the BMC Medical Education. All other authors declare no conflict of interest.

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**Authors’ contributions**

Dr Muhammad Imtiaz: Principal investigator, Research idea, synopsis writing, data collection, data analysis and manuscript writing

Dr Usman Mahboob: Research supervisor, Research idea refinement, synopsis review, data analysis and manuscript writing, research quality assurance
Dr Rehan Ahmed Khan: Research Co-supervisor, Research idea refinement, synopsis review, data analysis and manuscript writing.

Dr Rahila Yasmeen: Research mentor, Research idea refinement, poster presentation reviewer, data analysis and manuscript writing.

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Figures
Figure 1

Remake theory of ethics