

Introduction

When thinking of autonomy in dentistry, typically it is in reference to the ethical principle of Patient Autonomy—allowing the patient to determine what is best for themselves. But there is another aspect which must not be ignored. That is the autonomy of the dentist practitioner. The traditional model in dentistry was initially that of a small, private practice where clinical decisions are made by the doctor in partnership with the patient. New practice models and technologies have been challenging and continue to challenge that paradigm. A perception exists where dentists feel their clinical decision-making is increasingly under attack. This white paper is presented as a means to identify several of the areas where clinical decision-making is perceived to be at risk and to provide an ethical framework for making clinical decisions. The reader is encouraged to use the various sections of this paper as a starting point for conversations on these topics.

A World Medical Association policy states “Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. Professional autonomy and clinical independence are essential for the delivery of high-quality health care and therefore benefit patients and society.”¹

It is important to define what is meant by the term clinical autonomy. For the purposes of this discussion, clinical autonomy is defined as *the freedom for the attending dentist to create and provide a patient-centric care plan without undue third-party interference or influence.*

It is also important to distinguish between reasonable clinical autonomy and absolute autonomy. A dentist's first and foremost primary consideration is the needs and desires of the informed patient. There are also standards of care, evidence-based care, federal and state regulations, peer review, and ethical considerations. That said, years of education and experience as dental professionals qualify dentists to provide the best plan and treatment for their patients. Ultimately, the providing dentist is responsible for determining and providing the best treatment possible as well as taking responsibility for the outcomes of our clinical decisions, with the benefit for the patient as our primary goal.²

Third-Party Payers

Private third-party payment of dental treatment began in the mid-1940s³, and the federal government began providing public money in the form of Medicaid coverage for children in 1967. As third-party payment systems became prevalent nationally, many patients came to see them as the primary means of seeking and paying for treatment. Although personal plans exist, dental benefits coverage is most often employment-based. While protection from catastrophic medical costs is perceived as a necessity, coverage of dental services, from its origin, was conceived as a benefit⁴ outside of federally- and state-funded Medicaid and Medicare coverage. This fact is often poorly understood. When dealing with third-party payers, it is of the utmost importance the provider understands any contractual terms which may limit clinical autonomy prior to joining a benefit plan, as well as any potential amendments throughout the agreement. It is also important the patient understands the contractual limitations as well. Many dentists have experienced situations where a treatment recommendation is denied by third-party payers and the patient believes the treating dentist was at fault. Clear communication before, during, and after treatment is always beneficial and ethically sound. Providers should not allow anything to create a rift between them and their patients.

The American Dental Association (ADA) has had a long⁵, often uneasy, and occasionally adversarial^{6,7} relationship with third-party payers. The ADA has supported legislation at the federal and state level championing the ability of dentists to exercise individual clinical judgement and render appropriate treatment to their patients without undue influence by third-party business entities.⁸ The ADA has adopted a policy entitled “Infringement on Dental Judgment,” which identifies the treatment plan for a patient as the exclusive prerogative of the attending dentist, as agreed to by the informed patient.⁹

The ADA’s *Principles of Ethics and Code of Professional Conduct (ADA Code)* is very clear regarding a dentist’s duties and obligations as they relate to clinical judgment. Section 3, the Principle of Beneficence, provides, “The most important aspect of the dentist’s obligation under Beneficence is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration being given to the needs, desires and values of the patient. The same ethical considerations apply whether the dentist engages in fee-for-service, managed care or some other practice arrangement. Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient’s welfare first.”¹⁰ Dentists have an ethical duty to provide what is best for a patient, regardless of who pays for the treatment.

The Dentist as an Employee

A growing number of dentists are seeking to provide dental care in the position of an employee. Some of these practice settings include employees of a group practice/dental support organization (DSO), Federal Qualified Health Center (FQHC), itinerant location, or as an employee in a solo-practice dental office in the position of an associate dentist. Regardless of the practice setting agreement, the ethical obligations to our patients remain the same.

Dentists must have the freedom to create patient-centric care plans and deliver treatment without undue third-party interference. Interference in clinical decision-making violates the ethical principles of Patient Autonomy, Justice, and Veracity, and has the potential to contribute to an environment that is counter to Beneficence and Nonmaleficence. Interference can come in many forms, including performance metrics, pressure from non-clinically-trained office staff and supervising dentists, unavailability of appropriate materials and instruments, and lack of access to administrative manuals and protocols.

PERFORMANCE METRICS: Performance metrics include normal monthly business information such as production numbers, but can also include procedure mix and comparisons between the types of direct and indirect restorations placed. This data may be collected by owners to assist in evaluating dentists’ clinical performance but can appear to employee dentists as a threat if they do not perform, their employment may be in jeopardy. Dental offices provide care, but they are also businesses, and as such, there will be data that that business needs to interpret and act on to remain viable. However, conflict arises when the interpretation of that data becomes the driver of clinical decision-making. The desire or pressure to meet production goals and to “make the numbers look good” will directly influence treatment planning in high-pressure circumstances.

OFFICE STAFF: Office staff can exert influence on employee dentists in numerous ways. In some circumstances, staff members can receive additional compensation based on office production metrics. Consequently, staff may be incentivized to encourage dentists to complete higher fee procedures. Employee dentists who practice in a corporate environment or large practice setting may also be influenced by management or supervisory staff. Organizations with multiple practice locations may employ managers to oversee multiple offices. In looking out for the business's overall health, these individuals may influence the employee dentist to produce more dental services than the dentist deems necessary.

Other examples may include daily schedules formulated in ways that do not allow sufficient time for adequate completion of procedures, limiting or disallowing employee dentists to direct other office staff regarding proper protocols such as infection control, and incorporating a treatment environment that permits staff to engage in procedures beyond the scope of their licensure or training.

SUPERVISING DENTISTS: Similar influence can come from supervising dentists. Employee dentists, especially newer graduates, can be pressured to perform procedures they are not comfortable with or in a shortened amount of time. A balance should be maintained between the business needs of the practice and the growth and development of practitioners.

CEBJA's November 2013 "Statement Regarding Employment of a Dentist" reads, "An employee dentist should not be disciplined or retaliated against for exercising independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management." The dentist is the licensed professional responsible for patient care, including the formulation of care plans, and bears the weight of consequences from that care. Fear of discipline or retaliation from making a clinical decision can lead to the employee dentist violating portions of the ADA's *Principles of Ethics and Code of Professional Conduct*. Ethical principles at the highest jeopardy of being violated include the principles of Veracity and Nonmaleficence.

The ethical principle of Veracity, that "The dentist has a duty to communicate truthfully," can be affected by outside influences. When a dentist is under pressure to complete a certain number of procedures within a set timeframe to boost metrics or is encouraged by office management to complete higher fee tooth restoration procedures in order to increase production, the truthfulness of the dentist's treatment plan presentations may be adversely affected. Presenting risks, benefits and alternate treatment to patients are consequently compromised.

The ethical principle of Nonmaleficence, that "The dentist has a duty to refrain from harming the patient," will come into play when a dentist is pushed beyond their clinical abilities. This does not mean employee dentists should not attempt new procedures; it means the dentist should attempt new procedures with proper training and case selection.

The employee dentist is a growing constituency of our profession. As practice models evolve, we continue to recognize the value of applying our principles of ethics to deter circumstances and clinical environments that apply undue interference in patient care.

The Dentist as Head of Staff

Another concern with clinical autonomy is the use and supervision of the dental team. As in any team, there needs to be a leader. In traditional solo practitioner dental practice, the dentist is the owner and the employer. In many group practices, the dentist may or may not be the owner, and therefore may or may not be the direct employer. How does the dentist have clinical autonomy with other team members when they are not the direct employer?

The principle of Beneficence speaks to the professionalism of the dentist. Section 3.F. of the *Principles of Ethics & Code of Professional Conduct* states, “Dentists have an obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care.” This obligation clearly lies on the dentist, and, as such, the dentist has the right to be supported in the pursuit of a respectful and collaborative workplace. This obligation is present whether or not the dentist is the employer of the team member. If conflict arises, the dentist should have the responsibility of making sure the environment remains respectful.

The principle of Justice can also be applied in this situation. This principle is described as the “duty to be fair in their dealings with patients, colleagues and society” (Section 4). This implores the dentist to be fair when dealing with team members, and it also expects that fairness to be reciprocated. If there is a division, the dentist needs to be the leader and assert whatever authority the situation requires so that Justice can be achieved.

In both principles, the dentist who is providing care for their patients should have the confidence that their own clinical autonomy and also clinical authority is to be respected. Team members are present to support and care for patients as well, and the care provided should not be influenced by whom the employer may be, only by what is the best care for the patient.

The Dentist as an Employer

Another potential ethical challenge arises when a practice owner observes a shift in an associate dentist’s diagnostic approach after transitioning to a percentage-of-production compensation model. The associate, once conservative in treatment planning, now demonstrates a noticeably more aggressive style, trading their patient-centric approach to a plan that is production-driven.

This pattern not only jeopardizes patient trust and well-being but also raises concerns under the American Dental Association’s Code of Ethics. The Code of Ethics emphasizes the importance of the doctor-patient relationship, which is vital to the profession. Specifically, the Principle of Nonmaleficence (“Do No Harm”) and the Principle of Beneficence (“Do Good”) require the dentists to prioritize patient welfare and avoid actions that could cause harm. Furthermore, the Principle of Veracity (“Truthfulness”) underscores the obligation to provide honest, evidence-based diagnoses and treatment recommendations.

Scenario: An example can arise for a salaried associate dentist at a busy group practice. This associate is known for the conservative treatment approach, prioritizing preventive care and recommending minimally-invasive procedures when clinically appropriate. For example, the associate often opted to monitor borderline cases of early decay instead of immediately recommending restorative work. The associate is

paid a salary, and compensation is fixed, so the income remains stable regardless of the number or type of procedures performed.

After switching to a percentage-of-collections model: Once the practice shifted to compensating dentists based on a percentage of collections (e.g., 30% of all revenue generated from completed treatments), the associate's treatment patterns noticeably change. The associate begins recommending more crowns, root canals, and multi-surface restorations, even in cases where less aggressive treatment (like fillings or continued monitoring) had previously been recommended. Specifically, when reviewing a new set of bitewings, the associate recommended four restorations on incipient lesions. Not only is this more aggressive than usual, but these lesions have been monitored for the past three years and have not radiographically or clinically changed.

The associate also begins scheduling patients more frequently and often suggesting optional cosmetic procedures such as veneers or whitening. Over time, the monthly collections increase significantly, and so does the associate's compensation. While all the recommendations are within the bounds of clinical justification, some team members note the associate's treatment planning had clearly become more aggressive and noticeably more revenue-driven than before.

In navigating this dilemma, the practice owner must uphold their ethical responsibility to patients while managing internal dynamics and compensation structures. Solutions may include conducting regular chart audits, implementing peer review protocols, and offering continuing education on ethical treatment planning. Additionally, compensation models can be modified to incorporate quality-of-care metrics alongside production, thus reducing the incentive to over-treat. Addressing the issue directly with the associate in a constructive, documented manner while reinforcing the ethical standards expected in the practice can help preserve both professional integrity and patient trust. Ultimately, a transparent, ethics-driven approach supports the long-term health of the practice and the community it serves.

Artificial Intelligence (AI)

While it may seem odd to include a technological advancement in this white paper, AI presents some unique challenges to clinical autonomy.

AI is with us, and its use will only grow. The use of images with deep learning AI algorithms shows potential to function as a reliable tool in the early detection of oral cancer,¹¹ and more recent iterations of Open AI have shown increasing ability to produce plausible differential diagnoses and correct final diagnoses.¹² However, FDI's white paper on AI makes the following statement: "Current applications focus on diagnostic support, mainly image analysis. Users should critically appraise the accuracy of diagnostic support systems, the data underlying the trained model and its testing as well as the resulting generalizability. Explainability of any application should be demanded, as the final responsibility for any decisions emanating from using a diagnostic support system remains with the user, i.e. the oral healthcare provider."¹³

The World Health Organization states, "The principle of autonomy requires

that the use of AI or other computational systems does not undermine human autonomy. In the context of health care, this means that humans should remain in control of health-care systems and medical decisions. Respect for human autonomy also entails related duties to ensure that providers have the information necessary to make safe, effective use of AI systems and that people understand the role that such systems play in their care.”¹⁴

AI is not a substitute for clinical training, knowledge, and experience. It is a tool, a virtual instrument in our armamentarium. As such, it must be used wisely. The principle of Justice implies that use of AI systems in diagnosis and treatment must be truthful, informed, and justifiable. Applying the principle of Veracity, use of AI must be disclosed to the patient. Our patients come to us, not to computer models, for their treatment. To defer clinical decision-making to AI reduces the practitioner from a healthcare professional to a technician. This is not hyperbole. A study at the Massachusetts Institute of Technology suggests that reliance on AI decreases critical thinking skills,¹⁶ a key element of complex problem-solving and professional behavior in dentistry.

Conclusions

Clinical autonomy is an essential part of proper patient care. Undue influence or pressure on a practitioner, no matter the source, violates some of the basic principles of ethics. A dentist must be vigilant in recognizing those situations in which their autonomy is at risk. These at-risk situations are often obvious but can be subtle. The primary duty of a dentist is to the patient. When external forces create a situation challenging that duty, it is important to step back and evaluate the situation before beginning treatment. It is a breach of our duty to our patients to allow undue influence to impact treatment and take precedence over ethically based, patient driven care.

¹ <https://www.wma.net/policies-post/wma-declaration-of-seoul-on-professional-autonomy-and-clinicalindependence/>

² https://www.ada.org/about/principles/code-of-ethics?gad_source=1&gad_campaignid=22504667186&gbraid=0AAAAADiJP0YoOQCETXpxVOdyDFK_e81oW&gclid=Cj0KCQjwss3DBhC3ARIsALdgYxPLmNRq1Ux6pDXRJAfFbYvTSo619-zoq4D7w1AfGBq6aEvWct050J0aAnETEALw_wcB

³ Reisine ST, Bailit HL. 1980. History and organization of pretreatment review, a dental utilization review system. *Public Health Rep.* 95(3):282-290.

⁴ Simon, L. 2016. Overcoming Historical Separation between Oral and General Health Care: Interprofessional Collaboration for Promoting Health Equity. *AMA J Ethics.* 18(9): 941-949.

⁵ ADA Trans: 1963. p. 286.

⁶ <https://law.justia.com/cases/federal/appellate-courts/ca11/09-12033/200912033-2011-02-28.html>

⁷ <https://kffhealthnews.org/morning-breakout/dr00019456/>

⁸ ADA Trans: 1997. p. 705. Dentist’s Freedom to Exercise Individual Clinical Judgment

⁹ ADA Trans: 1991. p. 634. Infringement on Dentists’ Judgment

¹⁰ https://www.ada.org/about/principles/code-ofethics?gad_source=1&gad_campaignid=22504667186&gbraid=0AAAAADiJP0YoOQCETXpxVOdyDFK_e81oW&gclid=Cj0KCQjwss3DBhC3ARIsALdgYxPLmNRq1Ux6pDXRJAfFbYvTSo619-zoq4D7w1AfGBq6aEvWct050J0aAnETEALw_wcB

¹¹ Sahoo RK, Sahoo KC, Dash GC, et al. 2024. Diagnostic performance of artificial intelligence in detecting oral potentially malignant disorders and oral cancer using medical diagnostic imaging: a systematic review and metaanalysis. *Front Oral Health*. 5:1494867.

¹² Danesh A, Danesh A, and Danesh F. 2025. Advancing dental diagnostics with Open AI's o1-preview: a follow-up evaluation of ChatGPT's performance on diagnostic challenges. *JADA*. 156(7): 555-562.

¹³ Schwendicke F, Blatz M, Uribe S, Cheung W, et al. 2023. *Artificial Intelligence for Dentistry*.

¹⁴ Ethics and governance of artificial intelligence for health: WHO guidance. Executive summary. Geneva: World Health Organization; 2021. License: CC BY-NC-SA 3.0 IGO.

¹⁵ Kosmyna N, Hauptmann E, Yuan YT, et al. 2025. Your Brain on ChatGPT: Accumulation of Cognitive Debt when Using an AI Assistant for Essay Writing Task. <https://arxiv.org/abs/2506.08872>.

¹⁶ Martin D. 2020. A guide to critical thinking: implications for dental education. *Br Dent J*. Jul;229(1):52-53.

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