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Bioethics in dentistry: patient autonomy in teaching clinics

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Abstract

This article analyzes the respect for patient autonomy in dental teaching clinics as perceived by professors and students. Data were obtained by means of individual interviews and focus groups with senior students, teachers interviews and participant observation in two public state universities. Results showed that care provision at the analyzed educational institutions oftentimes does not include respect for patient autonomy. The observed professional training reproduces the hegemonic technicist education and is informed by a paternalistic physician-patient relation that contributes to a constant and undesirable violation of patient rights.

Keywords: Bioethics. Personal autonomy. Health human resource training. Dentistry. Informed consent. Morals.

Resumo

Bioética em odontologia: autonomia dos pacientes em clínicas de ensino

Este artigo foi desenvolvido com o objetivo de analisar o respeito ao princípio da autonomia na assistência aos pacientes atendidos em clínicas odontológicas de ensino, do ponto de vista de professores e alunos. Com esse propósito, foram estudadas duas faculdades públicas do estado do Rio de Janeiro. Os dados das pesquisas foram obtidos por meio da realização de entrevistas individuais e grupos focais com alunos do último ano da graduação, entrevistas com professores e observação participante. Os resultados revelaram que os atendimentos nas instituições de ensino analisadas por vezes não contemplam o respeito ao princípio da autonomia dos pacientes. A formação profissional observada reproduz o modelo hegemônico de educação tecnicista e é regida pelo estabelecimento de uma relação paternalista entre profissionais e pacientes, o que contribui para uma constante, e indesejável, violação dos direitos dos pacientes.

Palavras-chave: Bioética. Autonomia pessoal. Capacitação de recursos humanos em saúde. Odontologia. Consentimento livre e esclarecido. Princípios morais.

Resumen

Bioética en odontología: la autonomía del paciente en los centros docentes

Este artículo tiene el objetivo de analizar el respeto al principio de autonomía en la atención a los pacientes de los centros odontológicos docentes desde el punto de vista de profesores y estudiantes. Para ello, se analizaron dos universidades públicas del estado de Río de Janeiro. Los datos de la investigación se obtuvieron de entrevistas individuales y grupos focales realizadas a estudiantes en el último año de graduación, de entrevistas a docentes y observación participante. Los resultados revelaron que la atención en los centros educativos analizados, en ocasiones, no incluyen el respeto al principio de autonomía de los pacientes. La formación de los profesionales reproduce el modelo hegemónico tecnicista y se rige por el establecimiento de una relación paternalista entre los profesionales y los pacientes, lo que contribuye a una constante e indeseable violación de los derechos de los pacientes.

Palabras clave: Bioética. Autonomía personal. Capacitación de recursos humanos en salud. Odontología. Consentimiento informado. Principios morales.

Research

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The 20th century witnessed a surge in demands for individual rights. Milestones during this period include establishing the *Nuremberg Code* and enacting the *Universal Declaration of Human Rights*, both striving to uphold the principles of freedom and human dignity. Starting from the 1960s, increasing focus was placed on the potential impacts of technological advancements on individuals' lives, particularly as research began to address vulnerable populations. Within this framework, principles such as respect for individual autonomy and justice emerged as cornerstone ethical values of contemporary citizenship [1,2].

An important movement emerged to advocate for consumer rights, extending its influence to the realm of healthcare. Consequently, patients began asserting their desire for active involvement in discussions concerning therapeutic options and decisions regarding their health, challenging the notion of medical paternalism, where the physician's authority is unquestionable by the patient. The recognition of the principle of individual autonomy found its place in the legal frameworks of the United States of America, Canada, and Europe [1].

By the late 1970s, Beauchamp and Childress [3] articulated their theoretical framework centered on principles, expounded in their book *Principles of biomedical ethics*. In it, they propose that ethical deliberations in clinical practice revolve around four non-hierarchical principles: autonomy (respecting the decision-making capacity of autonomous individuals), beneficence (weighing benefits against risks and costs), non-maleficence (harm must be prevented), and justice (ensuring fair distribution of benefits, risks, and costs).

This study aims to explore the autonomy of users of dental teaching clinics through a principlist perspective, utilizing the concept *to examine decision-making in healthcare and delineate the boundaries safeguarded by principles such as informed consent*, *informed refusal*, *truthfulness, and confidentiality* [4].

Personal autonomy

The word "autonomy" finds its roots in the Greek words *autos* (self) and *nomos* (law, institution, government, legal convention), originally referring to the self-governance of ancient Greek city-states. Kant grounds the notion of human dignity in the capacity of individuals to legislate for themselves, adopting a universalist standpoint.

An autonomous individual operates according to their own determined plan, whereas reduced autonomy implies some level of external control or an inability to fully deliberate and act following one's desires and intentions. Factors contributing to reduced autonomy may include cognitive limitations or freedom constraints. Autonomous subjects may suffer temporary limitations on self-governance due to illness, ignorance, social pressure, coercion, or manipulation. In healthcare, manipulation usually manifests in the quality of information, through which an individual's understanding of their condition is altered to secure their compliance with the agenda proposed by the manipulating agent [3].

Upholding patient autonomy entails healthcare professionals' obligation to clarify information, confirm comprehension, and ensure voluntary decision-making, thereby empowering individuals to make informed decisions. Individuals demonstrate autonomy when they possess the capacity to comprehend information, evaluate it based on personal values, and freely articulate their intentions to any assisting professionals working on their care [3]. Indeed, ensuring autonomy in the healthcare setting presents a challenging endeavor, as professionals may inadvertently or consciously filter information, which leads to their conveying only that which they perceive as relevant. The individual's ability to make autonomous decisions is thus compromised, as they may not have access to the entirety of information but only to what the informer deems suitable, convenient, or acceptable.

Upholding autonomy entails acknowledging the need for both the health professional and the patient to have an active voice in the relationship, and respecting differences in values, expectations, demands, and objectives. It recognizes that the patient is the focal point of the therapeutic process [5]. Autonomy serves as a foundational concept and core element of health promotion, where any intervention that enhances an individual's capacity to influence the determinants of their health is considered autonomy-promoting [6].

The concept of "free, prior, and informed consent" (FPIC) originated in research to mitigate risks to participants and prevent exploitation of vulnerabilities, while its incorporation into healthcare stems from societal demands for patient rights protection. In both contexts, the primary goal is to reaffirm respect for autonomy, ensuring that individuals *with adequate understanding and minimal external influence knowingly authorize professionals to proceed with interventions*[7].

The consent document must comprehensively outline the proposed intervention, specifying each procedure as intended and expected. Combining multiple authorizations into a single document, a practice often seen in educational institutions, may lead lay and vulnerable patients to believe they must consent to everything listed before commencing treatment. This may not align with reality, as patients have the right to refuse any aspect they do not wish to consent to, such as the use of their image for academic purposes. The consent process should reflect voluntary decision-making following thorough clarification and understanding of the various aspects of care or research. The document should allow for renewal and revocation of consent[3,5,8-11].

The textual component of Resolution 196/1996 of the National Health Council (CNS)[12] was deliberate in not adhering to a direct translation of "informed consent" as *consentimento informado* when setting forth guidelines and regulatory standards for research involving human subjects in Brazil, a choice justified by the fact its intention goes beyond merely informing individuals about a particular matter. Individuals must comprehend the information being conveyed to them. In this process, it is also paramount to ensure that the confidentiality of care is preserved[13].

In professional training, emphasis should be placed on encouraging and developing humanistic skills alongside technical competencies to enable responsible actions. Professionals must engage in critical reflection and adhere to principles of respecting both individuals and society[14-16]. However, a concerning trend observed is the establishment of a paternalistic dynamic between dentists and patients, wherein decision-making authority is concentrated solely in the hands of professionals. Patients are often compelled to undergo treatments as dictated, contravening the principle of respecting the autonomy of healthcare service users. This power imbalance is a significant ethical concern in contemporary bioethics[17].

Professors disclosed to Gonçalves and Verdi[17] their perception that the university and its service to the population supersede the rights of individual patients, thereby justifying any actions taken in clinical care settings in the name of education. From this perspective, patients are perceived merely as a means to achieve the institution's goal: the technical training of students. The focus of care shifts towards academic interests, disregarding the health needs of patients, thus resulting in the "objectification" of individuals[15].

Decisively breaking away from this hierarchical model of professional-patient relationships and from the objectifying approach to training in dental institutions is necessary. Instead, there should be recognition of patients' rights, desires, expectations, and needs.

Method

This article is based on qualitative research conducted at two public dental schools in the state of Rio de Janeiro, identified as Alpha[18] and Beta[15] for differentiation purposes. First, a literature review was conducted, employing a combination of descriptors and keywords to encompass a broad range of documents related to the proposed topic in the Virtual Health Library (VHL), CAPES, and SciELO journals, as well as in specific bioethics publications (books and journal). The search terms used, in Portuguese, Spanish, and English, were: principlism, autonomy, consent, training in dentistry, training of human resources in health, training in health, ethics, bioethics, and dentistry.

Subsequently, individual interviews were conducted using a semi-structured questionnaire with nine professors at the undergraduate course and 20 final-year students. Data collection also included focus groups with students from both institutions and participant observation in Beta—aiming to observe everyday situations, such as contradictions between norms and practices within the observed group or institution.

Each focus group comprised seven final-year students from the Alpha and Beta institutions (totaling 14 students). This method was chosen based on the belief that individuals tend to express themselves more freely and candidly in a group setting, particularly when among peers.

Data collection adhered to the principles outlined in CNS Resolutions 196/1996[12] (applicable during the work phase in Alpha) and 466/2012[19], and were approved by research ethics committees.

Thematic analysis was employed to evaluate the collected material from interviews, focus groups, and field observations—a method commonly utilized in healthcare research, involving the grouping and subsequent examination of data by subject, as described by Pope, Ziebland and Mays[20].

After transcribing the interviews, the following steps were taken: thorough reading and analysis of the content obtained; systematization of information; evaluation and compilation of data; and structuring dialogues between the data and the theoretical references utilized.

To safeguard the identities of research participants, identification codes were employed as follows:

- Students: letter S followed by numbers 1–20;
- Professors: letter P followed by numbers 1–9;
- Focus groups: FG.

Discussion

Formal dental education in Brazil, established in higher education institutions distinct from medical training, commenced in 1884. Over this period, there have been some revisions to the curriculum, primarily focusing on the technical training of dental surgeons and the integration of new technologies. However, as noted by Finkler, Caetano and Ramos[21], training institutions have not placed adequate emphasis on the development of the ethical and humanistic dimensions of healthcare practices.

The data collection process commenced with a focus group at the Alpha institution, during which participants expressed that the research topic prompted individual reflection on the meaning of the concept at hand (autonomy). Some interviewees struggled to articulate its significance, noting a lack of discussion on bioethics concepts during their training. It was evident that the proposed discussions facilitated learning for students in both educational institutions under analysis.

Analysis of respect for patient autonomy

To assess respect for autonomy, observations were made regarding patient participation in care discussions, their decision-making power regarding proposed treatments, consent for examinations, and clarification of their clinical circumstances, empowering them to make informed choices.

During an FG at the Alpha institution, students described the patients they usually assist as "*socially disadvantaged*," presenting an "*extreme need for treatment*." According to the students, this places patients in a position of inferiority relative to the care team, rendering them "*highly susceptible to the influence generated by the clinic*"[18].

When questioned about the preservation of autonomy in the care provided at the teaching clinic, students initially asserted that the principle is respected. However, further discussion on the subject revealed a different scenario:

> *"We sort of talk to them, but I feel like their path is already somewhat established, you know? Because of their condition. But that's already problematic, it's starting on the wrong foot, right? Because maybe they could have some say in it, and we don't know, you see?" It's not just because he came to XX* [name of institution], *you know, I've heard a professor say: 'He came to* [name of the institution], *it says a lot because he can't go anywhere else,' see? So, right off the gate, even if unconsciously, you already have this idea, you know? That (...) 'ah, they're poor, so they must do whatever is available', get it? I personally think that, even though we try to let them know there are other options, their path is somewhat determined, you know? It's biased"* (S3)[18].

In the group discussion, the presence of a hierarchical dynamic in the professional-patient relationship became apparent:

> *"We may give the patient choices, but ultimately the decision lies with us and the professor. The professor holds a higher status; you follow the professor, and the patient follows you. That's a bit biased"* (FG)[18].

"You end up leading them somehow, you know? It's biased, in the end. What I think (...) I don't know (...) I think things go a lot like this: 'Oh, so you don't want that?'. Then you come up with every possible and impossible downside to change their mind, you know?" (S3) [18].

In this context, patients might believe they actively contributed to decision-making when, in reality, they were guided to adhere to decisions made by professors and students, resulting in a violation of their autonomy through manipulative processes, as described by Beauchamp and Childress [3].

According to S5, the options presented to patients are not always feasible: "*We also discuss other possibilities, which, at times, may not be viable, but we still talk about them, you know?* [laughter]. *The patient usually agrees with whatever we propose, even due to a lack of information, I think. As we are 'the professionals,' see? The patient thinks 'Ah, they know what they're doing,' you know? It's like that*" [18].

This statement aligns with the assertion made by Amorim and Souza [14], suggesting that the healthcare system and access to services can potentially limit individual freedom, as deficiencies in service provision may restrict therapy options.

Patients should have access to treatment alternatives regardless of information deficits, as the academic environment provides an ideal setting for receiving technical explanations. Moreover, work in the teaching clinic is overseen by a multidisciplinary team. If the college lacks resources, the team should offer guidance to help patients access external options if they so desire.

Another fact observed was the trend of steering patients towards procedures necessary for students' accreditation in specific clinical disciplines: "*The options are given, but they're always somewhat biased: since the patient is already here, they'll undergo whatever is planned for that discipline*" (S7) [18]. This observation underscores the institutional priority of providing opportunities for the students' technical advancement, aligning with findings by Gonçalves and Verdi [17].

The statement "*they'll undergo whatever is planned for that discipline*" (S7) prompts consideration of situations where the treatment administered could be deemed harmful, as there might be alternative therapies with better prognoses for the patient. For instance, a tooth with extensive coronal damage requiring endodontic treatment could either be appropriately managed within the endodontics discipline (and subsequently restored) or condemned to extraction as provided by the surgery discipline.

Conversations with professors revealed conflicting information compared to that provided by students. According to P1, patients always partake in decision-making, and their autonomy is respected. P2 echoes this sentiment and justifies it based on the economic implications of certain procedures: "*At all times. Especially since they face the issue that we lack a prosthesis laboratory, so we tend to opt for treatments that won't require laboratory costs, allowing patients to receive direct treatment in the clinic. This approach often favors one treatment or another. Due to its cost*" (P2) [18].

Professors and students acknowledge the involvement of all parties in discussing cases to determine therapeutic procedures, but ultimately, decision-making tends to align with the preferences of the professional team. It is feared that adopting a paternalistic approach to the professional-patient relationship throughout the training period, where professionals are seen as sole knowledge holders and decision-makers, may lead students to replicate this dynamic in their future careers. During the formative period of shaping the professionals they aspire to become, it is imperative to consider and discuss patient rights to their respect in everyday professional practices.

Replacing the paternalistic relationship model with one that respects patient autonomy is a recognition of patient rights. Professional interference becomes a violation of autonomy when it is justified under the premise of prioritizing patient well-being or happiness, as perceived by the professional, which often leads to the belief that certain procedures deemed best by professionals are in the patient's best interest [11,22,23]. As stated by Rego, Palácios and Siqueira-Batista [23], professional technical knowledge alone cannot determine what patients perceive as best for themselves.

A (concerning) revelation by S5 was the possibility of dismissal of patients from the teaching clinic if they refuse an optional stage of dental treatment: "*If they refuse, you know? We are there for the service. We've had patients who said, for example, that they wanted to have a restoration done, but didn't want to be anesthetized. So, we talked about how this is a school, that there are procedures that we must follow, and these are clinical steps. We said: 'If you don't want to be anesthetized, we cannot continue with the treatment." In this case, it was a protocol that everyone had to follow, we cannot skip this step, you know? Not because the patient refuses. Since it's a school, we must follow the protocol, see?*" [18].

The prevalence of the notion of unquestioning acceptance among students is so strong that some are unaware of the possibility of refusal: "*Well, we've never come across this situation because we're not even aware (...). We were not even aware that patients could potentially actually refuse. I guess it's the patient's right to refuse, right?*" (S9) [18].

Given these observations, one may question whether patients are adequately informed about their rights and whether the operational system implicitly or explicitly pressures them into accepting all proposed treatments out of necessity. Prioritizing teaching techniques seemed to take precedence over patient well-being, as some patients opt to endure discomfort during procedures rather than receive dental anesthesia. Enforcing a standardized care "protocol" dehumanizes the patient, reducing them from a sentient individual capable of autonomous decision-making to an object utilized for undergraduate student skill enhancement.

Responses from professors at the Beta [15] institution regarding treatment plan preparation varied slightly, reflecting different approaches to case management within their respective teaching and learning environments. Consequently, some students possess greater autonomy in evaluating patients and proposing treatments for collaborative analysis with their professors, while others adhere to treatments prescribed by professors: "*Some professors tell you to take a clinical exam, so you do it. After the exam, they come up with the treatment plan with you. (...) But there are cases where we're more on our own*" (S12) [15].

Regarding patient participation in the process, S12 says: "*It is definitely rare. I suppose we first discuss it among ourselves, and then the patient either accepts it or afterward, once we've explained what it would entail, the patient shares their thoughts*" [15]. Following this, the student elucidates the nature of the patient's involvement in the conversation: "*I believe the primary concern here is money. I mean: 'Oh no, doc. I can't do that here, I'd rather do a cheaper treatment. Then the professor says: 'An, then let's do a cheaper treatment'*" [15]. This is confirmed by S14, S17, S18, and S19 [15].

Thus, it becomes evident that involving the patient in decision-making primarily stems from the financial ramifications of the procedure, given the absence of free care in Beta. Nonetheless, faculty members and students assert that patients retain the right to dissent from the suggestions put forth, possessing the liberty to opt for alternative therapeutic choices.

A statement by S16 was revealing: "*I usually say: 'Look, these are the issues you have and this is what we need to do,' then I say: 'It's this, this, and this, and this is why,' then I explain it, you know? But, really, this thing of giving them autonomy and asking if either they agree or not (...). I ask: 'Is everything okay?'. They always agree, right?* [laughs], *but, like, them interfering with things, not really*" [15].

This approach to dialogue prompts reflection on the degree of transparency provided for the user of the teaching clinic to assert their position and make informed choices. The erosion of patient autonomy within the process, alongside a paternalistic relationship model between the parties, is evident in the selective disclosure of information aimed at securing the patient's compliance with the professional, as described by Durand [1]. S15's discourse lends credence to this interpretation: "*We try to persuade the patient, sometimes inviting the intervention of a more authoritative professor to reinforce the message: 'We understand you may have prior experiences, but during your time here, the student takes the lead. So, if the student advises that this is the optimal course, it truly is.' Typically, when the professor steps in, patients acquiesce*" [15].

According to P4, patients engage in discussions with both students and professors when it comes to making prosthetic choices, enhancing their understanding of the complexity of their required care. In their view, professors and students do not unilaterally determine treatment plans: "*In cases as specific as this one, where the tooth is completely broken and there's no other option, we let them know and everything is fine. But when there's a tooth that still may be saved, even if not of much use to the patient in the long term, particularly for a university patient who* (…) [interrupted] *when the student responsible for the case graduates, leaving the patient without contact for follow-up care, we try our best to discuss and explain the situation better*" [15].

The fact that the individual is a "college patient" should not determine the prognosis of a dental issue. If the training school is committed to providing comprehensive care to the user of the teaching clinic, the continuity of health care, as well as the resolution of ongoing cases, will be made possible regardless of the students available.

Image rights

The research participants were questioned about a common practice in dentistry: the utilization of exams and photographs in educational materials—an encounter from which only one student reported abstaining. While S8 and S9 underscore the importance of obtaining the patient's consent before documenting their case, S1 holds the belief that being treated in an educational setting implies an understanding that one's case may be used for instructional purposes: "*I think it's kind of natural for peoples to be here, within the academic environment, and contribute to the educational process themselves. I feel it's implicit, right?*" [18].

This statement further reinforces the notion that patients can transition from being regarded as individuals with autonomy to becoming objects or mere learning tools within teaching clinics, as observed in previous statements and studies [14,17]. With notable dismay, S2 recounted an incident where a professor disregarded her wishes by filming and photographing a case she was overseeing: "*The conduct of my professor, the one who guided me through the biopsy, was appalling! It felt like she wasn't interested in relieving the patient from a negative diagnosis, but rather in furthering research, you know? She took photos and videos, intending to display them on a panel, which I didn't agree with!*" [18].

While P1 and P2 mentioned that photographic documentation is infrequent, S3 highlighted that it is common for companies to supply aesthetic materials for use in clinics, prompting instructors to photograph patients to document clinical cases pre- and post-restorative procedures. S3 recounted observing such a case during the week of the interview and disclosed: "*No one asked the patient anything*" (S3). This admission was delivered in a subdued tone, with evident embarrassment, and attempted to mitigate with: "*The face wasn't shown, you know? But I suppose it was* (…) *it was an oversight. Now, thinking back, it wasn't one of my patients, but they should've asked them, right? They should have asked 'Do you mind?' But they didn't*" (S3) [18].

S9 also shared an encounter with image documentation at the college clinic: "*Well, typically, it's approached with a tone of, 'Um, let's take some photos of your case, okay?'. It's like the patient doesn't even have the right to say: 'I don't want that.' You've just performed a procedure, let's say, the removal of a hyperplasia. You've got the before and after shots. After you're done, if the patient were to approach you and express discomfort with the idea of being recorded, do you think they'd feel comfortable saying: 'No, I don't want that?' Typically, patients just leave, you know? That's how it goes* (…)*. No, no, there's not much of that* (…)*. It's kind of like this: 'I'm going to record it, okay?', see? The patient is kind of unaware that their case will be documented or exposed by someone else. They have no idea*" [18].

One can imagine that it would be challenging for the patient to interrupt a photographic recording, which is conducted as part of clinical procedures, to raise questions or voice objections, as they are not given any choice in the matter. This approach to handling the situation means that the patient may not even realize that their autonomy is being violated, as it happens within the context of a circumstance that ostensibly benefits them—the dental treatment provided by the institution that they are allowed to access.

Free prior and informed consent

Students and professors classify the FPIC used at the Alfa institution as a simple document. Some students even disregard the necessity of utilizing an FPIC, citing the presence of a clinical form for recording the treatment plan and another for patient history (anamnesis), which the patient signs to verify the accuracy of the provided information. A vulnerability of the document was noted—the potential for fraud: "*It basically says 'I authorize what's written above,' see? Something like that. But it's also relative, you know? You're creating the treatment plan, a lot is written there, and if you wish, you could write it after it's already been signed, you know? So it's not a very safe thing, because, you know, there's actually that space where suddenly* (...) *I don't know, we're not going to do that, but I guess* (...)" (S3)[18].

According to professors, students are expected to read the informed consent form to patients, which, as per P1, facilitates a high degree of understanding. However, S3 reports a lack of guidance from professors on conducting this process: "*They don't tell us to do that, see? The person could just be told, 'Oh, sign here,' and comply, but they wouldn't even know what was written, understand?*"[18].

Faced with a lack of guidance, each student adopts a different approach. S1 says: "*Most of the time, I at least ask them to read it briefly, review the medical history to ensure it matches their responses, and if they wish to add anything* (...). *Nevertheless, many people simply skim over it, without even reading, and sign straightaway. We always ask them to take a look. We don't actually read any written text on the subject*"[18].

In a scenario where the patient reads the clinical record alone, there is a high likelihood of encountering difficulty understanding the technical terms contained in such documents, thereby justifying S1's observation that many patients sign the document without reading. Moreover, some patients may not be literate, exacerbating the situation and potentially leading to unquestioning adherence to professional' decisions, including the undertaking of examinations and photographic documentation for illustrating clinical cases. This underscores the importance of understanding the content of the free and informed consent form, as emphasized by Muñoz and Fortes[11]. To achieve this objective, it is imperative to replace technical-scientific language with terms that are comprehensible to patients.

At the Beta institution, it was noted that the FPIC used in clinics during the final year of training involves the patient in discussions about the planned treatment and grants "*full rights of retention and use for any teaching and scientific improvement purposes*" (document transcription), covering x-rays, photographs, family health history, examinations, and information regarding diagnosis, planning, and treatment. The FPIC also informs patients about the incurrence of assistance costs, as all procedures are carried out upon prior payment, and the charging of pre-established expenses if the patient interrupts treatment. Additionally, it warns patients about the possibility of being "*'eliminated from treatment' if they miss scheduled appointments more than once*" (document transcript)[15].

However, the students interviewed were unaware of the existence of the FPIC among the multiple sheets of medical records they used in the consultations. According to S16's assessment, the forms are confusing and lack standardization between clinics. She speculates that patients complete and sign the forms before their appointments: "*To be honest, I've never actually seen this consent form*"[15]. This sentiment was echoed by others: "*No, we don't actually discuss that with them. In truth, I wasn't even aware it was on the file,*" (S15); "*To tell you the truth, I've never read this consent form. I'm being candid with you* [laughs], *I never read this consent form to the patient*" (S19)[15]. Observations during participant interactions revealed instances where patients signed forms without prior perusal and lacked essential clarifications regarding the terms[15].

Participant S14 indicated that students receive clarification on the FPIC within a single course, yet this instruction has not resulted in a comprehensive grasp of its significance or its proper application within their professional practice[15]. As per S18: "*The terms of consent, that initial section of the form, they fill out there, and that's where it stays, right? The consent form, where they acknowledge being at a university and whatnot, when they come to us that already signed. So, and we don't go over this with them*"[15].

Regarding this matter, it is important to note that the higher education institution is not fostering a relationship with the patient that genuinely respects their autonomy. Despite theoretical instruction emphasizing the need for proper clarification to users of the teaching clinic, practical implementation has been lacking. It is imperative to maintain coherence and recognize the significant influence of the hidden curriculum—encompassing values, implicit norms, attitudes, and beliefs ingrained in educational environments—on the behaviors adopted by students during their training [15,24-28].

Final considerations

The data obtained revealed instances where the autonomy of patients treated in the analyzed higher education institutions is not consistently respected. This lack of consideration occurs when patients face restrictions on their right to freely choose therapeutic options applicable to their case or are pressured into accepting procedures. The inadequate provision of information deprives individuals of the ability to make informed decisions about their treatment. Furthermore, situations arise where patients' images are captured for teaching purposes without their consent.

The professional training of dental surgeons remains primarily technical, viewing patients as mere instruments for learning rather than autonomous individuals. The misconception that patients should surrender unrestricted access to their bodies while receiving care in teaching clinics not only misguides but also undermines the principle of autonomy in educational settings.

The prevailing paternalistic model of care reinforces the erroneous belief that professionals possess sole decision-making authority over the therapeutic process, disregarding patient autonomy. Amid these challenges, a stigma surrounding users of teaching clinics as economically disadvantaged and incapable of decision-making has emerged.

These findings underscore the need for a comprehensive discourse within academia to deconstruct the dominant model of health education, which prioritizes technical skill development and upholds paternalistic professional-patient relationships. Furthermore, undergraduate programs must integrate the ethical dimension of healthcare into their curriculum, transcending the confines of isolated disciplines such as bioethics or deontological ethics. Such integration should permeate both theoretical and practical training to better equip students for ethical decision-making in healthcare practice.

Therefore, integrating ethics into reflective practice in daily care becomes imperative, encompassing the examination of dilemmatic cases encountered by students. This approach fosters the development of critical thinking and encourages regular self-assessment. The goal is to empower students to refine their work processes, promoting ongoing improvement in service delivery and the cultivation of dignified, respectful relationships with patients, colleagues, and society as a whole.

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