Ethical issues and challenges in dental practice

18-20

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Ethical Issues in Dental Practice

Dentistry has reached great heights in improving diagnosis and treatment of oral health.

Advancement in technology has changed the way the dental professionals' practice.

Like any other profession, the focus on ethical aspects of dentistry is increasing than ever before, and **oral health practitioner is facing ethical issues or dilemmas in everyday practice**

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 since each problem or dilemma will have distinguishing aspects. The following listing provides the general categories that have been acknowledged as **ethical dilemmas in the dental ethics literature.**

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, finance or legal issues

The other top ethical challenge citied was the

1-Inadequate sterilization and waste management in dental clinics. Standard infection control includes a number of specific practices such as PPE, prevention of cross-contamination, proper waste disposal, and worker protection. Dentists were also concerned with needle stick injuries in dental clinics and said "A used needle should be disposed in the correct manner to prevent needlestick injuries. It is the duty of dentist that waste is disposed in a proper manner in the interest of safety."

2-Poor knowledge and attitude toward ethics among our dental practitioners: considering ethics and giving importance only to the technical aspect. Subject expert felt that **"Ethics is extremely important and it differs from doctor to doctor.**

What I feel ethical might not be ethical to others a uniform code is wherein patient interest has to be taken first, his need his finance and before the doctor economic consideration," other subject expert citied that "Dentist who is unaware of ethical issues can land in trouble." Subject expert citied that "Lack of knowledge about the subject as well as lack of commitment leads to under treatment." Dentists should participate in continuing education activities that provide information, strengthen clinical competencies, and enhance professional judgment. While it is not possible for any dentist to be abreast of all advancements, dentists should make every effort to at least be familiar with clinical developments that may potentially affect their practices including the general scientific basis of such developments and related issues and problems. The general dental practitioners who participated in the study were not aware of any programs related to ethics and law. One of the general practitioners citied "I am not aware of an extra course. It would be helpful. We had a chapter on ethics I can't say whether it is sufficient."

3-The third ethical challenge was competence among dental professional. The competent dentist is able to diagnose and treat the patient's oral health needs and to refer when it is in the patient's best interest. Maintaining competence requires continual self-assessment about the outcome of patient care and involves a commitment to lifelong learning. The general dental practitioners said about the incompetence of few dentists that "I thought I should not criticize the other dentist. Or tell the patient it's wrong," "I don't know any law what has to be done in such a situation. Maybe I should seek a lawyer." Incompetence can also lead to over and under treatment "Unhealthy competition is putting unnecessary burden on patient." Dentist not practicing the policy of wait and watch, performing the restoration even in incipient caries lesion, etc., money mindedness. Subject expert regarding the ethical issue of overtreatment said that "it has become a marketing strategy to project to the patient that extreme make over's. In reality it is question as to whether we are doing justice to the patient by subjecting unnecessarily as to extreme treatment modalities."

4-The fourth ethical challenge is the increase in cost of oral health service: rising cost of health care can limit patient access to health care, limited resources can lead to rationing and delaying, and denial of care to people in need. Escalating cost can lead to inverse care law. Regarding the cost factor, the subject expert's cited "The disparity in the economic status forces the budding doctors to opt for a sector where they are highly paid and thus not opting for rural service and thus making them suffer." General dental practitioners defended that "Cost depends on the experience of the dentist too apart from laboratory work." Regarding the high cost of dental care, general dental practitioners feel "Patient demand for a better looking clinic. We have to spend on exterior, so price shoots up. However, in reality, we need to provide quality work. Most of the medical clinics have just got the bench and chairs, and patient goes there but when it comes to dentistry patient expectation changes."

5-The fifth ethical challenge was the poorly informed consent process. Ethical concerns regarding the process of informed consent and refusal extend beyond the level required for compliance with the law. The process of informed consent requires comprehensive knowledge on the part of the practitioner, uncompromising veracity, unbiased presentation of all reasonable alternatives, and consequences including costs and the probability of outcomes. It also requires the ability of practitioner to communicate clearly on a level assuring comprehension by the patient or appropriate authority. Subject experts advice the dentist to work in full accordance with informed consent. "It safeguards the dentist against misuse by patients. At the same time patients are also safe from anything done apart from the treatment committed at the beginning."

6-The sixth ethical challenge is the requirement of consensus about the treatment procedures among dentists: advancement in biotechnology like to do or not to do treatment, choosing of treatment modalities when different

approaches are present has **led to disagreement in treatment procedures among dentists. Hence, the experts cited that** "

The practical experience of each and every dentist varies from one to another. It is always good to incorporate a collective experience and choose the best out of the lot." One of the general dental practitioner was concerned about the faulty treatment of neighboring dentist and stated "Previous dentist had said that he is doing all ceramic crown and charged a very high amount when I examined I found it to be acrylic crown. I did not know what to do." When such issue arises, they were in dilemmas and conflict of what they should do. One of the general practitioner also stated "I was in a middle of a see-saw; we don't know whether to go with patient what he wants or do ethical practice. I could not say that you had been doped." Another general practitioner stated "I thought I should not criticize the other dentist. Or tell the patient it's wrong," general dental practitioners are also in dilemma whom to contact "I don't know any law what has to be done in such a situation. Maybe I should seek a lawyer."

Subject experts felt that when in conflict with the treatment procedure "Obtaining second opinion can make the patient mentally satisfied of receiving correct treatment. Also it gives the doctor boost of his correct decision."

7-The seventh ethical challenge in dentistry is conflict in advertising: Law says advertising by a dentist must not misrepresent fact, mislead or deceive by partial disclosure of relative facts, and create false or unjustified expectations of favorable results. Today's dental practitioners feel that advertisement is needed and stated "I feel the policy of advertising is not for today's scenario, dentistry is practiced in multistoried building and keeping only the small Name board is not sufficient. Using attractive colours and increase font is required so that it is visible to people," "Advertising can also be used as an education tool. It increases knowledge and awareness."

General dental practitioners stated “Advertising make people aware of a clinic or specialty,” “In present scenario patients are in confusion among to which hospital or doctors are best and advertisement can create awareness.” Even though they were not against advertisement, they were against wrong advertising “Claiming superspeciality is misguiding to the patients.” One of the subject experts gave corporate culture as a reason for change in advertisement “In present scenario patients are in confusion among to which hospital or doctors are best and advertisement can create awareness.”

8-The eighth ethical challenge is the clustering of dental clinics in urban areas: issues of fairness are pervasive in dental practice and range from elemental procedural issues such as whom shall receive treatment first, to complex questions of who shall receive treatment at all.

Regarding the practice of location and accessibility of dental care to patients, the general dental practitioners said “The just dentist must be aware of these complexities when balancing the distribution of benefits and burdens in practice. It is the choice of the dentist to choose his/her area/locality of practice,” “Laws can be made by the government to ensure that all population has access to care and also providing employment to dentists.” Dentist population ratio is 80:20 where 80% of dentist practice in place where 20% of population live in urban areas and inversely only 20% of dentist live where 80% of population live. Regarding accessibility of oral health care, inverse care law is still existing even though there is rise in graduating dentist; there is shortage of dentist in few places because of inappropriate distribution of dentist.

Subject experts were concerned that “Dental clinics in shopping malls,” “Dental clinics in high floored buildings,” “Poor accessibility for continuation of treatment.” Advanced dental care setup was in it can have potential financial burden for patients for basic oral health care.

9-The ninth ethical challenge is the disagreement with treatment modalities among dentist and patient: In the era of internet, it is not uncommon to come across patients who already surfed internet about the disease and its treatment options. Subject experts were of the opinion that it the age of internet "Patients these days surf internet for information they are presented with. Situations arise wherein patients challenge the treatment plan of dentists." General dental practitioners were concerned that "Patients are unaware that each situation is different and dentists have learnt it from experience and in profession.

Everything cannot be read in internet," "If patient asks for some inappropriate treatment then we have to educate the patient it's not that we have to blindly follow patient will. Doctor should help the patient to make the informed choice," "Some people had come with pre conceived idea about treatment and when we give the options they don't agree and say some other treatment we try to convince but if patient is not agreeing then we will explain and tell to think about it for some time and if still not convinced we go ahead with the treatment they want." This is particularly true where the normative and felt need of the person varies. Examples to this include extraction versus root canal treatment and orthodontic versus no treatment. General dental practitioner were also concerned that "Children teeth are neglected, most of the parents don't agree with preventive treatment modalities like space maintainers, pulpectomy because of lack of finance or knowledge, so children are not benefited. Milk teeth are not considered important and convincing them is very difficult even among educated parents, it is changing but in very small percentage," sometimes the dentist feel that "People attitude prevents one from practicing ethics and I don't agree establishing clinic's ethics consultation committees." Some general dental practitioners felt that there is a high expectation from patients and stated that "When patient comes to clinic with sensitivity and we diagnose gingivitis I advise scaling and give medication. But the patient will be expecting immediate result which cannot be attained and its put me difficult position since I am not able to convince the patient". Contradicting to this one of the general practitioners stated "I think the patient should demand, he need to ask for a certificate. He should ask for authentication of the work done.

What is the material used. Some times when patient shifts from one place to another certification helps." Subject experts also felt the high expectation because of which there is a high pressure on the practitioners "Doing fixed orthodontics in periodontally compromised patient, here the prognosis is poor but treatment has to be done because of pressure from patient, parent pressure." Meeting patient expectation is a challenge. Patients who used to accept dentists' advice unquestioningly now ask dentists to defend their recommendations.

10-The tenth ethical challenge was the poor medical record maintenance among our dental practitioners: as the consumer negligence cases are increasing, it is important to maintain medical records. Subject experts felt that "Medial Record is a legal document and reference for future cases. It safeguards the dentists against fraud/false statements by patients which are intended to harm/defame them."

Ethical Questions and Legal Questions

The health profession has long been considered as the **'noble profession'.** Becoming a dental health professional is a lifelong process of consistent behaviour affirming the principles of beliefs. The term _professional, _refers to one who practices a learned profession. **The essence of every health profession is service above self**.
[1] A profession as an occupation involving relatively long and specialized preparation governed by a special code of ethics. **[2]** Ethics, as a branch of both philosophy and theology, is the systematic study of what is right and good with respect to character and conduct. **[3]** It seeks to answer two fundamental questions: What should we do? Why should we do it?
Dentist needs to practice dentistry at the certain standard of care. In modern era, more complex structure of society has raised

PRINCIPLES OF ETHICS

Ethical principles are the inspirational goals of the profession, which provide guidance and offer justification for the Code of professional conduct and the advisory opinions. Ethical codes vary from one country to another and even within countries, but they have many common features, including commitments that dentists will consider the interests of their patients above their own, will not discriminate against patients on the basis of race, religion or other human rights grounds and will protect the confidentiality of patient information.

In 1997 the FDI adopted the International Principles of Ethics for the Dental Profession for dentists everywhere.

These International Principles of Ethics for the Dental Profession should be considered as guidelines for every dentist.

These guidelines cannot cover all local, national, traditions, legislation or circumstances.

Ethical principles are the moral rules and foundations of justification source to be applied in order to exercise an ethical practice.

These principles are, **Autonomy, Non-maleficence**, **Beneficence**, and **Justice .**

Each principle is **binding unless it conflicts with another moral principle,** and in that case, we are to choose between them.

Autonomy

Autonomy (―self-governance‖) is the first principle which is derived from Greek; *Autos* (self) and *Nomos* (rule, governance, or law). This principle says the dentist has to respect the patient's rights to self-determination and confidentiality. The dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities. Moreover, others are obligated to protect confidentiality, respect privacy, and to tell the truth.

Non Maleficence

"Non-maleficence" derived from the ancient Latin *maxim "primum non nocere*" means "**first, do no harm".** The principle gives the idea that professionals should protect the patients from harm. The dentists' primary duty is keeping up to date knowledge and skills. Knowing one's own limitations and when to refer to a specialist or knowing when and under what circumstances delegation of patients care to auxiliaries is appropriate are other moral requisites of the dental profession.

Beneficence

Beneficence comes from the Latin word *benefactum*, meaning "good deed‖.It denotes the practice of good deeds and it has a meaning of an obligation to benefit others or seek their good in itself. Beneficence mandates the concept that the dentists as health care professionals, have to practice to benefit their patients and have to consider this as a duty.

Justice

The principle of justice embodies the concept that the dental profession actively pursues the ability to improve access to care for all throughout society. Ozar and Sokol state that society often determines what is just and unjust, therefore it is imperative that dentists rely on cues from society to ensure ethical compliance. Practicing justice includes serving patients without discrimination against race, creed, colour, sex or national origin. **[5] DCI CODE**

Codes of Conduct and Ethics Committees:

It responsibilities **of dentists in maintaining good clinical practice,** dental records, display of registration number, **drugs dependence upon each other**, conduct in consultation**, appointments of substitute** and visiting another case are explained.

Duties and obligations of dental practitioners towards their patients and **their confidentiality**, **treatment prognosis** and **neglect as well as duties of dental surgeons** and **specialists in consultation**, opinion and disclosure of information, **referral of patients** and **fees and other charges with consultants are elaborated**.

Dentist should act as good responsible citizen and work towards public welfare and should promote practice of different paramedical.

Unethical acts related to advertisement, **soliciting**, **publicity and signage**, **patents and copyrights**, **rebates and commissions**, **human rights and unethical practice should be considered.**.

In unethical practice regarding **signing certificates**, use of **abbreviations**, **naming and styling of dental establishments**, **doctor patient's relationship** and **relationship with pharmaceuticals** and **dental companies**. **Prescription drug misuse can have serious medical consequences.**

Increases in prescription drug misuse over the last 15 years are reflected in increased emergency room visits, overdose deaths associated with prescription drugs, and treatment admissions for prescription drug use disorders, the most severe form of which is an addiction.

These impacts can be particularly harmful to a developing adolescent brain and body. Our brains continue to develop until we reach our early- to mid-twenties.

Ethical issues Access to dental care .

A dentist must not unlawfully **restrict access to professional services** and barriers that restrict the access of physically impaired individuals should be eliminated to the extent that this can be reasonably accomplished.

Abuse of prescriptions by patients:

Misuse of prescription drugs means taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high). The term ***nonmedical use*** of prescription drugs also refers to these categories of misuse.

The three classes of medication most commonly misused are:

•opioids—usually prescribed to treat pain

•central nervous system [CNS] depressants (this category includes tranquilizers, sedatives, and hypnotics)—used to treat anxiety and sleep disorders

stimulants—most often prescribed to treat attention-deficit hyperactivity disorder (ADHD) **During adolescence,** the pre-frontal cortex further develops to enable us to set priorities, formulate strategies, allocate attention, and control impulses.

The outer mantle of the brain also experiences a burst of development, helping us to become more sophisticated at processing abstract information and understanding rules, laws, and codes of social conduct. Drug use impacts perception—a skill adolescent brains are actively trying to cultivate—and can fracture developing neural pathways. Additionally, as our brains are becoming hardwired during adolescence, the pathways being reinforced are the ones that stick. If those pathways include addiction, the impact may lead to life-long challenges.

As with any type of mind-altering drug, prescription drug misuse and abuse can affect **judgment** and **inhibition**, **putting adolescents** at **heightened risk for HIV** and other **sexually transmitted infections**, **misusing other kinds of drugs**, and **engaging in additional risky behavior.**

Advertising

While the practice of advertising is considered acceptable by most professional organizations, it must never be false or misleading. Advertising by a dentist must not misrepresent or mislead or deceive by partial disclosure of relative facts. It should neither create false or unjustified expectations of favourable results nor imply unusual circumstances. appropriate health care professionals for educational purposes. For some infectious diseases there may be no community standard regarding the dentist‘s obligation to protect patient confidentiality when third parties are at risk of infection.

Emergency care

The dentist has the ethical and legal responsibility to anticipate emergency situations in correlation with the patient's medical status. He has the obligation to do all in his power to prevent emergencies from happening and to be prepared to manage any emergency that might occur. This article also discusses the importance of monitoring and documentation

arrangements with patients, and therefore improve your bottom line.

Child abuse and the role of a dentist in its identification:

Child abuse, a reprehensible act, pervades all strata of society. Dentists are more likely to **encounter such cases in their daily practice**. However, such cases usually go unreported due to lack of adequate knowledge.

Practitioners flinch from reporting these due to various reasons, and this sets up a vicious cycle which traps the victim leading to grave long-term consequences.

Types of abuse:

The term abuse has varied connotations across different cultures and socioeconomic status. The WHO provides descriptions for different kinds of abuse as follows:

Physical abuse

It is the inflicting of physical injury on a child and includes burning, hitting, kicking, punching, shaking, or otherwise harming a child. The parent or caretaker may not have intended to hurt the child. It may, however, be the result of over discipline or physical punishment that is inappropriate to a child's age.

Sexual abuse

Improper sexual behavior with a child which includes fondling a child's genitals, making the child fondle an adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, and sexual exploitation. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Emotional abuse

It is also known as verbal abuse, mental abuse, and psychological maltreatment. Acts or failure to act by parents or caretakers that have caused or could cause serious behavioral, cognitive, emotional, or mental trauma to a child are included in this.

Veracity

This includes truthful communication without deception and maintaining intellectual integrity. Areas included under veracity are truthfulness in billing issues and referral. Another area in which veracity comes into play revolves around credentials. It is imperative that a dentist be truthful regarding specializations and degrees held.

Financial arrangement

Emergency patients first visit ,Insurance verification timeline and process, Payment plan options, Removable prosthodontic protocols, Crown and bridge protocols ,Secondary insurance policy, Financial discussion process — who, where, when, documentation, Outside financing partner process, Divorced patients and children of divorced patients, Privileged patients: e.g., **staff family, professional courtesy**, list patients who get discounts, **senior discount, etc.**

Disclosure and misrepresentation:

Unfortunate examples of dishonest outlier individuals exist within all professions.
This includes law, **law enforcement**, **medicine**, **education**, and **dentistry.**
These unethical parties harm not only the public welfare, but also the standing of their chosen profession.
Attainment of a professional license **requires years of specialized education**, **training**, and **advanced testing**, not easily accessed by the general public. As such, great trust and responsibility is placed in the hands of all professionals. Dental patients need to retain full confidence that their doctors hold their interests to the fore.

The ADA has been a leader in espousing professional principles and codes of conduct in the best interest of the public.

If trust has broken down and you find it necessary to end the **professional relationship**, you must END IT POLITLEY
You must not use your professional relationship with a patient to pursue a relationship with someone **close to them**. For example, you must not use home visits to pursue a relationship with a member of a patient's family.

Delegation of duties

A dentist's ability to delegate **allows the practice to expand and flourish**, whereas the failure to do so puts too many tasks on the dentist's shoulders and limits the practice's potential. **Delegating responsibilities is not difficult. Certain protocols, however, need to be established.**
Here are some guidelines for effective delegation:
•**Review and upgrade management systems with staff in mind.** With well-designed systems and step-by-step scripts for team members to follow, you can define protocols and ensure they are followed correctly and consistently *without feeling a need to "do it yourself."*

•**Delegate everything you're not legally required to do yourself.** If it isn't clinical care that only a dentist can provide by law, you should let go of it. For a surprising number of doctors, the first and biggest step is delegating hygiene to a hygienist. Also, if you have an office manager, optimize the value of this team member with extensive delegation.

•**Provide all necessary staff training.** As team members take on new responsibilities, they'll need new skills. If you've been a micromanager, you'll probably get impatient if you don't see the right results right away. Proper training will make it possible.

•**Accept the possibility that some tasks will not be done *quite* as well as you could do them yourself.**
•If you're like the many dentists who are perfectionists, this may be the hardest part of delegation. "Perfect" may be out of reach, but you can reasonably expect well-trained staff using well-designed systems to excel and attain high levels of efficiency.

•**Think of delegation as an excellent team-building tool.**
•Delegation empowers team members. By delegating, you'll encourage your staff to take initiative, make decisions, look for ways to improve personal and overall practice performance, and develop other valuable characteristics.

Harassment:

What Is Harassment?
Is serious violence by action or by wording which is prohibited by law such as forcibly kissing a coworker, pulling a chador off the head of a female Muslim employee, or using the some word which causing harm to the other .
Sources of Harassment
While the media has focused on sexual harassment by male bosses against subordinate female employees, there are actually four potential sources of harassment that **dental practices** must address with **preventive measures**: **employee to employee, dental staff to patients, patients to staff, and vendors and other visitors to staff.**

The first source of harassment is not just boss-to-subordinate, but more generally employee-to-employee harassment. A coworker can engage in both hostile working environment and quid-pro-quo sexual harassment just as easily as a boss to a subordinate.

Examples of coworker-to-coworker harassment include telling sexually charged jokes; making references to an employee's looks; or "go out on a date with me (or have sex with me), or I will badmouth you to the boss, and, you know, I have the boss's ear."

The second source of possible harassment is by dental staff to patients. Many dental practices believe that they have this potential source under control because they have installed video cameras in each operatory. While it is a good step towards prevention, it is not a total solution.
Not every corner of a dental office can be covered by video cameras. They do not record voices. Facial expressions caught on video may not accurately indicate what occurred between the patient and the staff member. And, harassment can occur through mobile phone, text message, and other electronic means.

The third source of harassment is the reverse of the second, patient harassment of staff. The fourth, similar source is harassment of staff by vendors and other visitors to the office. Employers have a legal obligation to maintain an harassment-free environment for employees. This includes protecting them from harassment by other individuals who are at the workplace, in addition to other employees. For the dental practice, this includes protecting staff from harassment by patients, vendors, and other visitors to the practice's office (ie, the patient or repairperson who continues to bug a staff member for a date after the staff member has said no or who tries to kiss or otherwise touch a staff member in a sexual manner).

Dental Practice Liability:

To the surprise of most practice owners, there are situations when the practice, as an entity, **can be held legally responsible for workplace harassment**, even when the **owner is not aware that the harassment has occurred.**

When liability is imposed on the practice entity, the practice assets can be attached to **satisfy any judgment awarded** to an harassed employee. In general, **such liability is imposed in two situations.**

The first situation is where practice owners assert that they had no actual knowledge that the harassment had occurred and, therefore, the practice cannot be held responsible for any monetary damages awarded to the employee. But, from the facts of the case, the judge, or more likely a jury, finds that the practice owner "should have known" that the harassment was occurring.
Such liability is imposed in situations where the facts are that the harassment was so widespread, or so well-known by others in the office, that the practice owner is not credible in asserting a lack of knowledge, or a reasonable conclusion is that the owner was "deliberately ignorant" (ie, turned a blind eye) to the ongoing harassment.

A second potential source of liability for the dental practice, when the owner asserts no knowledge of the harassment, is where a "supervisor" is the perpetrator of the harassment or when a supervisor is aware of the harassment, takes no action in response, and/or does not advise upper management or the owners about it. The rationale behind imposing liability on the practice in these situations is that it has placed the supervisor in a position of authority and, therefore, it should be held legally responsible for any misdeeds by its supervisor.

Harassment Prevention Program: Your Best Defense

In its defense, a dental practice can always assert that the **harassment did not actually occur as the employee alleges**. However, recent events have proven that this is generally not an effective defense.

The practice can also assert that it has no responsibility, and hence no liability, for the harassment. Here, again, the above examples of when a practice can be held liable even when the practice owner arguably had no knowledge of the harassment similarly establish that this often is not an effective defense. **Consequently, an harassment prevention policy/program is a dental practice's best defense against a claim of harassment.**

But a dental practice cannot simply adopt a written policy prohibiting harassment, put it on a shelf somewhere in the office, and then expect to trot it out as a defense when a harassment claim is made. In general, the courts have held that to be an effective defense, a policy prohibiting harassment must be backed up by a vigorous program of implementation and enforcement that was effective in addressing and remediating the employee's claim of harassment. Provided a practice can prove that its program was effective, then, in all probability, the lawsuit will be dismissed against the practice, even when it is found that the employee was actually harassed.

There are five components to a complete harassment prevention policy/program:

adoption and circulation to all staff of a written policy,
educating staff about the policy,
implementation,
enforcement, and
remediation when necessary.

A brief sentence or two prohibiting harassment is not sufficient for an effective policy statement. Rather, to be effective, the policy must include a definition/description of the various types of harassment, with examples of prohibited conduct.

It also must include a statement that:

•The practice will not tolerate this type of conduct and that all employees, including supervisors and managers, will be subject to discipline, up to and including termination, for violating this prohibition.

•All employees are obligated to report any incidents of harassment, even when the employee is not the subject of the harassment, and even when the harassed employee requests that the other employee not report the incident.
•Employees are also subject to discipline for failing to so report harassment.

Furthermore, the statement must identify individual practice managers as the policy's compliance officers to whom incidences of harassment must be reported. Best practice is to also identify an outside individual, usually an attorney specializing in employment law, to whom alleged violations can be reported, particularly when an owner is the alleged harasser.

The policy should also include a fairly detailed description of the investigatory process that the practice will employ when a claim of harassment is made, as well as a statement that all employees are required to cooperate with such an investigation and are subject to discipline for failing to do so.
Another major provision is a fairly detailed description of what types of remedial or corrective actions the practice will take, when the investigation confirms that harassment has occurred, to restore a harassment-free work environment. While the policy should include other ancillary provisions, such as confidentiality, not reporting false allegations, and not infringing on employee personal privacy, these are the major provisions for an effective policy.

The policy/program statement is then circulated to all employees and a written record is entered into their permanent personnel files to confirm that each received a copy.
For this purpose, we recommend that each employee execute an Acknowledgment of Receipt form. As new employees are hired, they are also provided with a copy of the statement and are required to execute an acknowledgment form for inclusion in their permanent personnel files.

When it comes to staff and manager training, the best practice is to conduct an in-service training of approximately an hour, with some additional time for questions and answers. Having the outside compliance officer (as previously discussed, usually an attorney specializing in employment law) conduct the training is recommended because it tends to have more impact on employees than a member of the practice conducting it. Also, this attorney is more likely better able to describe the all-important investigatory process that the practice will use when a complaint is made and to explain what is considered legally acceptable remedial/corrective action if harassment is found.
Managers should attend a separate program because their training includes what their responsibilities are in implementing and enforcing the policy. Attendance at these training programs is mandatory for both employees and managers, and written records of attendance are to be kept. These training programs can be videotaped for viewing by new employees and managers as they are hired.

Conducting these training programs is actually the first step in implementing the policy or program. Implementation primarily involves monitoring for continuing employee awareness and compliance with the policy/program. Aspects of implementation include:
•Periodically conducting short, refresher, in-service training of both staff and managers

•Circulating a flyer, or other similarly short document, reminding employees of the essential terms of the policy/program and encouraging them to ask any questions they may have, and/or to report any concerns about possible violations
•Periodically updating the policy due to changes in the law or in the identity of the internal or external compliance officers
•Without violating any confidentiality obligations, reporting on any practice investigations/enforcement actions.
Enforcement essentially involves strictly following the investigatory and other procedures provided in the policy/program when an employee reports a possible violation, or when practice management has any reason to believe that the policy is being violated. No matter how frivolous management may consider any claim, it is best to nevertheless strictly follow the policy's procedures for an investigation.

The results of the investigation are always reported to both the complainant and the alleged harasser. Whether these two parties are satisfied or dissatisfied with the results must be documented, along with the factual and other basis for the practice's disagreement with any such dissatisfaction.

When an investigation finds a policy violation, the final program element essentially involves implementing remedial and corrective actions that are appropriate to the type and seriousness of the violation. Although the practice should consider the remedial/corrective action requested by the harassed employee, it is the practice that ultimately decides whether and what, if any, such action to take.

The remedial/corrective action must always be appropriate to the nature and seriousness of the violation.
The harassed employee's satisfaction or dissatisfaction with the actions taken, or lack thereof, is documented, along with the practice's response to any such dissatisfaction and an explanation of its rationale for those actions, if any, it has taken.

Competence and judgment

Competence

The term competence defined as the ability to perform the tasks and roles required to the expected standard The advantage of this definition is that it can be applied to a professional at any stage in their career, not only to the newly qualified.
The standard expected will no doubt vary with experience and responsibility and take into account the need to keep up to date with changes in practice. It also leaves open the question of who will decide what is to count as competence when different people have different expectations.

This is an essentially political issue.

Dental Competencies

1.Critical Thinking
2.Professionalism
3.Communication and Interpersonal Skills
4.Health Promotion
5.Practice Management and Informatics
6.Patient Care
    A. Assessment, Diagnosis, and Treatment Planning
    B. Establishment and Maintenance of Oral Healt

Health Promotion

Graduates must be competent to:

1-Provide prevention, intervention, and educational strategies.

2-Participate with dental team members and other health care professionals in the management and health promotion for all patients.

3-Recognize and appreciate the need to contribute to the improvement of oral health beyond those served in traditional practice settings.

Practice Management and Informatics

Graduates must be competent to:

1-Evaluate and apply contemporary and emerging information including clinical and practice management technology resources.

2-Evaluate and manage current models of oral health care management and delivery.

3-Apply principles of risk management, including informed consent and appropriate record keeping in patient care.

4-Demonstrate effective business, financial management, and human resource skills.

5-Apply quality assurance, assessment, and improvement concepts.

6-Comply with local, state and federal regulations including OSHA and HIPAA.

7-Develop a catastrophe preparedness plan for the dental practice.

Patient Care

A. Assessment, Diagnosis, and Treatment Planning

Graduates must be competent to:

1-Manage the oral health care of the infant, child, adolescent, and adult, as well as the unique needs of women, geriatric and special needs patients.

2-Prevent, identify, and manage trauma, oral diseases, and other disorders.

3-Obtain and interpret patient / medical data, including a thorough intra/extra oral examination, and use these findings to accurately assess and manage all patients.

4-Select, obtain, and interpret diagnostic images for the individual patient.

5-Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care.

6-Formulate a comprehensive diagnosis, treatment, and/or referral plan for the management of patients.

B. Establishment and Maintenance of Oral Health

Graduates must be competent to:

1-Utilize universal infection control guidelines for all clinical procedures.

2-Prevent, diagnose, and manage pain and anxiety in the dental patient.

3-Prevent, diagnose, and manage temporomandibular disorders.

4-Prevent, diagnose, and manage periodontal diseases.

5-Develop and implement strategies for the clinical assessment and management of caries.

6-Manage restorative procedures that preserve tooth structure, replace missing or defective tooth structure

C-maintain function, are esthetic, and promote soft and hard tissue health.

1-Diagnose and manage developmental or acquired occlusal abnormalities.
2-Manage the replacement of teeth for the partially or completely edentulous patient.
3-Diagnose, identify, and manage pulpal and periradicular diseases.
4-Diagnose and manage oral surgical treatment needs. .
5-Prevent, recognize, and manage medical and dental emergencies.
6-Recognize and manage patient abuse and/or neglect.
7-Recognize and manage substance abuse.
8-Evaluate outcomes of comprehensive dental care.
9-Diagnose, identify, and manage oral mucosal and osseous diseases.

Judgement

The term **judgement** is **less controversial than competence** for most doctors, because it conveys a sense of expertise. More frequently, `judgement' is a term used to describe the highest level(s) of expertise. According to whether they use a broad or narrow definition of competence, they will define judgement either as an advanced level of competence or as that area of expertise which goes beyond competence. The most salient attributes of judgement reported in our consultative interviews concerned making holistic and balanced decisions in situations of uncertainty and complexity. More specifically, descriptions of bad judgement included:

•not integrating all the data
•attending to fine detail, ``the small print'', but missing the big picture
•choosing an inappropriate management plan
•overvigorous intervention

•not taking into account conflict between different therapies
•being competent in all the important aspects of the case, but failing to make a sensible decision on the case as a whole
•making decisions on current evidence alone and disregarding the record.
Good judgement, by implication, is the opposite of bad judgement, but is not always described in the same terms. For example, good judgement could mean:
•discerning the key features of a patient's problem in a more complex way
•going beyond the guidelines
•intuitive but rationally checked out expertise
•making small approximate decisions and readjusting
•being prepared to do nothing.
Situations where judgement (hopefully good) was called for included:
•decisions based on fuzzy logic in situations too complex to fully understand
•ill-defined situations which are complex diffuse and muddled
•high risk situations
•cases combining medical and psychological aspects
•deciding what to tell a patient and how to put it
•prescribing and adjusting drug ``cocktails''
•deciding between maximally invasive and minimally invasive procedures (or doing neither)
•balancing cost and quality

Other aspects of judgement described in the literature concern:
•ethical issues
•the effect of a doctor's feelings and emotions about a particular case-these could concern the patient situation, their own behaviour, the actions of other health care professionals or the health care organisation
Comprehensive patient care is the outcome of complex judgment, **decision-making, treatment choices**, and the **application of a wide range of clinical skills under the uncertainties of everyday clinical practice**.

Clinical judgment is a complex adaptive cognitive process with unavoidable variations in details among practitioners. Clinical judgment and knowledge-based technical skills are acquired by practice experience, frequent feedback, and reflection.
Well-designed algorithms and guidelines, incorporating principles of statistics and evidence-based data, can be useful adjuncts to personal experience and expert opinion. Neither errors in diagnosis nor in treatment planning nor in execution of the treatment plan can be completely avoided because of individual cognitive biases and mistakes in data interpretation, and because of human factors of uncertainty that so often characterize clinical practice.

Confidentiality

The relationship between dentist and patient is based on the understanding that any information revealed by the patient to the dentist will not be divulged without the patient’s consent. Patients have the right to privacy and it is vital that they give the dentist full information on their state of health to ensure that treatment is carried out safely. The intensely personal nature of health information means that many patients would be reluctant to provide the dentist with information if they were not sure that it would not be passed on.

If confidentiality is breached, the dentist/dental hygienist/dental therapist/dental nurse faces investigation by the professional controlling organization like IDA , and may also **face legal actio**n by the patient for damages and, for dentists, by police.

What is THE CONFEDENTIAL personal information?

In a dental context, personal information held by a dentist about a patient includes:

- the patient's name, current and previous addresses, bank account/credit card details, telephone number/email address and other means of personal identification such as physical description
- information that the individual is or has been a patient of the practice or attended, cancelled or failed to attend an appointment on a certain day
- information concerning the patient's physical, mental or oral health or condition
- information about the treatment that is planned, is being or has been provided
- information about family members and personal circumstances supplied by the patient to others
- the amount that was paid for treatment, the amount owing or the fact that the patient is a debtor to the practice

Dating patients:

You must not pursue a sexual or improper emotional relationship with a current patient.

If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary.

The statements below define the entry-level competencies for the beginning general dentist:

1. Critical Thinking:

Graduates must be competent to:

1.1 Evaluate and integrate emerging trends in health care as appropriate.
1.2 Utilize critical thinking and problem-solving skills.
1.3 Evaluate and integrate best research outcomes with clinical expertise and patient values for evidence-based practice.

2. Professionalism

Graduates must be competent to:

2.1 Apply ethical and legal standards in the provision of dental care.
2.2 Practice within one's scope of competence and consult with or refer to professional colleagues when indicated.

3. Communication and Interpersonal Skills

Graduates must be competent to:

3.1 Apply appropriate interpersonal and communication skills.
3.2 Apply psychosocial and behavioral principles in patient-centered health care.
3.3 Communicate effectively with individuals from diverse populations.

Consent

The term consent means voluntary agreement, compliance, or permission. The concept of consent comes from the ethical issue of respect for autonomy, individual integrity and self-determination, also it is the legal issue that protects every patient‘s right not to be touched or in any way treated without the patient‘s authorization‘.

The confidence, co-operation and, critically, the agreement of the patient will contribute to a successful administration of treatment and a satisfactory outcome for everyone. It acts as an evidence that the clinician has sought, and been given, permission to intervene and affect the physical integrity of the patient.

Types of Consent

Depending upon the circumstances, in each case, consent may be implied, expressed, informed, proxy consent, loco parentis or blanket consent.

Implied consent

It implies consent to dental examination in a general sense i.e. when a patient approaches the dentist for treatment; it is presumed that there is consent for routine physical examination. This is the most common variety of consent in both general and hospital practice.

Most dental treatment is carried out while the patient is conscious and they are therefore capable to stop the dentist when they wish Though an implied consent is not written and its existence is not expressly asserted but nonetheless, it is legally effective.

Expressed consent (Tacit consent)

Expressed consent is one, the terms of which are stated in distinct and explicit language. Express written consent should be obtained for all major diagnostic procedures, general anaesthesia, for surgical operations, intimate examinations, and examination for determining age, potency and virginity and in medico-legal cases. When the patient expresses his consent verbally it is termed as _oral or verbal expressed consent' and when express in writing is known as _written expressed consent.

Informed consent

Informed consent is the process of obtaining permission of a subject to participate in research and to give an opportunity to decide about his or her healthcare. Informed consent also implies that a dialogue has taken place about the nature of the decision, reasonable alternatives, relevant risks, benefits and uncertainties of the decision, and the comprehension and acceptance of the health-care decision by the patient / subject. **Proxy consent (Substitute Consent)**

This type of consent is utilized in the event the patient is unable to give consent because he/she is a minor or mentally unsound/ unconscious. In such situations a **parent or close relative can provide proxy consent**.

Loco (consent) parentis

In an emergency situation in case of children, when parents/ **guardians are not available**, consent can be obtained from the person **bringing the child for dental examination** or **treatment (For example: school teacher, warden, etc.)**

Blanket consent

It is a consent taken on a printed form that **covers** (like a blanket) **almost everything a dentist** or a hospital might do to a patient, without mentioning anything specifically. Blanket consent is legally inadequate for any procedure that has risks or alternative.

Valid Consent Valid consent consists of three related aspects:

1. Voluntariness

Patients should give consent completely voluntarily without any pressure either from the dentist or any third party (e.g. relatives).

2. Capacity to consent

The patient should be in a position to understand the nature andimplication of the proposed treatment, including its consequences.

3. Age of consent

The age of consent implies that a person above 18 years of age can consent to medical/surgical/dental treatment Since the dentist-patient relationship is essentially a contract, **it implies that only persons 18 years of age** and above can enter into a doctor-patient contract .

This is a definite safeguard against civil liability.

The primary responsibility for providing care and consent for the child or young person **should lay with his/her parents**. Patients under the age of minority or adults with diminished mental capacity should have treatment consent obtained from a **parent or legal guardian**. The adult accompanying the paediatric patient may not be a legal guardian allowed by law to consent to dental procedures.

Consent may not be obtained in the following situations.

- Person suffering from a notifiable disease.
- Spread of infection
- Examination of immigrants.
- Members of armed forces, handlers of food and dairy products.
- Prisoners and criminals
- Vaccination
- Child offenders-when the Magistrate makes the request.
- Attempted suicide
- Medical emergencies

So, this section will deal with dental negligence, Consumer Protection Act and other acts and professional indemnity insurance.

Dental Negligence

Negligence is the act of omission or submission of an act that is done by a doctor in this case a dentist who has not done his job or who had done his job carelessly.
For an act to be considered negligent, **dentist owed a certain standard of care but did not maintain that standard**. Or if there is an injury resulting from the lack of care and a connection (proximity) between the **negligent act** and the result and injury.
Some of the dental negligence acts are failure to attend emergency, unable to prevent cross infection between patients and health care persons, not fulfilling patients' right to information about the procedure.

THANK YOU