Professional Ethics Review 3-4

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What is meant by the “best interests” of our patients?

Professionals to put patients' **interests first**, before any **financial**, **personal** or **other gain**’. You must raise a concern if you think patients are at **risk** because of a **colleague**, **the environment where treatment is provided**, or if you're asked to do something that conflicts with your responsibilities to **patients' interests** and **safety**.
This obligation comes before any concerns you might have about your position or influence, as well as any professional or **personal loyalties**.

Patient safety

These principles apply to the wider aspects of the care of patients, not just to the clinical treatment itself, and involve patient safety both within and outside the surgery. For example, if you had a concern that a child or a vulnerable adult was being abused at home or in an institution, you would have an ethical duty to act by **raising your concern** and ensuring it was properly addressed.

Clinical treatment

In relation to the clinical treatment itself, the treatment given to patients must be in their **best interests**, providing them with **appropriate dental health advice** and **following any clinical guidelines** that are relevant to their individual circumstances.
There's also often a need to **weigh up their health needs** with what they want to get from the treatment, and if this isn't achievable or is not in the best interests of their oral health, you need to help them reach a decision by explaining the various risks, **benefits and outcomes**.

Treatment plans

Only appropriately qualified and experienced dental professionals have the training to formulate a dental treatment plan. This plan should of course take into account the patient's requests and desired outcomes, and they have the right to accept or reject it.

If the treatment requested by the patient is considered not to be in line with current accepted practice and teaching, and not in the patient's best interest, it simply should not be provided, and the dental professional should explain the reasons for their decision. In such a situation, sometimes offering the patient an independent second opinion can be helpful.

Concerning consent, as a result of the Montgomery judgement, patients with capacity have a right to know all the available options for treatment, and the material risks of each option to which a reasonable patient would attach importance.

If the patient lacks capacity for whatever reason, then the provisions of the Mental Capacity Act 2005 apply. The underpinning principles are:

- a person must be assumed to have capacity unless it is established they lack it
- a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
- a person is not to be treated as unable to make a decision merely because they make an unwise one
- an act done or decision made under the Act for or on behalf of a person lacking capacity must be done in their best interests
- the least restrictive option - anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Paternalism:

Paternalism is closely related to the **principles of nonmaleficence** and beneficence and **arises from the Hippocratic tradition of writings**.

The Hippocratic approach is interpreted as the clinician doing what he or she believes is best for the patient according to ability and judgment.

This approach requires the **dentist** or **hygienis**t to undertake a role **similar to that of a parent**, thus the term. Paternalism means the health care professional acts **as a parent** and **makes decisions for the patient on the basis of what the professional believes is in the best interest of the patient**.

Paternalism **should never** be **applied primarily to benefit the professional** at the **expense of the patient**. Thus **paternalism** and **autonomy** may be seen as **in conflict**.

A dentist or hygienist **cannot unilaterally act on behalf of the patient** without **denying the patient's right** to exercise **autonomy**. Paternalism is now commonly called **parentalism, reflecting the dual parent roles**

Patients today are well-informed about health, **treatments**, and **their rights as patients** and **want to participate in the decision-making process**.

In the past, **paternalism was a common practice partly** because the health care provider had **knowledge** and **skills** and **partly** because patients expected the health care provider to make **decisions in their best interests**.

Patients often **had no knowledge that alternative care options were available**.

Furthermore, even if patients did know other options existed, many placed the professional in a parental role by asking the professional what they should do. Patients frequently had so much trust in the provider that they would do whatever was suggested.

Such **paternalistic acts** were carried out with good intentions to benefit the patient and often became second nature to the clinician.

The responsibility of the **dentist and dental hygienist** is to educate the patient about **the balance of benefits** and **risks of treatment**, which often **creates a conflict** between **autonomy** and **beneficence**.

This aspect of **providing ethical care** is most important and requires the clinician to take the time and effort to ensure the patient has all the knowledge required to make health decisions.

Many dentists have been asked by a **patient**–and **have refused**–to **remove a healthy dentition merely** because the patient believes that taking care of dentures would be easier than caring for their natural teeth

Risk management in dentistry:

Once upon a time there was only the dentist and the patient. **No one came between the dentist and patient** and the **relationship** was unencumbered by any third parties.
Then, in the mid 1950s, California introduced the first actual dental insurance plans.
Then into the '70s, dentists were becoming compelled to sign contracts and become "preferred providers." Dentists now had to deal with dental plan administrators and consultants, who emerged as among the **first intermediaries** between doctors and patients
Some called these times "the golden age of dentistry."
But with this boom came the realization that **dentists no longer had the same control over the doctor/patient relationship**. Someone was looking over their shoulder. Submissions for "preauthorization" had to be made. **Right or wrong**, dentists were being judged, but perhaps more importantly, dental insurers were collecting claims data.

It's safe to say that *dental insurers started to know more about our practices than we did.*

Dentists should not guarantee anything. I maintain that the four most dangerous words we can utter to patients is, "I can do that." (It's a great song from a great Broadway play.) If you say it, you better deliver, and if you don't deliver to the patient's sense of expectation and the accepted standard of care, the consequences and ramifications can be very costly in terms of time, dollars, and reputation.

Outstanding dentistry is performed every day, preserving dentistry's reputation as a noble profession. But it's not getting any easier

Proactive risk management and **a return to sound ethical thinking must be in place to protect patients and doctors from the harms that lurk in everyday practice**. The degree to which we honor our ethical oath can be reflected in the amount of risk we encounter in our practice and how we manage that risk. Can you protect your own self-interests and still act ethically?

What about compromising quality?

Quality of care has long been synonymous with the quality of practice, but a model adopted from the industrial field has gradually developed in the health field to meet the expectations of patients and other partners involved in care. Dentists, like other health professionals, are required to put in place systems that help improve the quality and safety of their care: this is called the **quality assurance approach.**
Developing baseline quality measures for dentistry as a way to **improve health outcomes**, reduce costs and enhance patient experiences.

Some of these measures **have been tested** and **validated for various population groups**. However, there are some unintended consequences and challenges with quality measurement in dentistry as observed from our previous work on refining and transforming **dental quality measures into e-measures**
As our medical counterparts have embraced quality measurement for improved health outcomes, so too must the dental profession.
population health outcomes

Our ultimate goal is to ensure the delivery of high quality, **patient-centered dental care** and **effective quality measurement is the first step.**

By continuously monitoring the performance of dental quality measures and their continued refinement when unintended consequences are observed, we can improve patient and population health outcomes.

Thank you

What are codes of ethics?

Work within your knowledge and competence; do not attempt treatments you have not been trained for, always refer a patient if necessary. Always obtain the patient's valid informed consent to the treatment proposed. Maintain the confidentiality of information which you hold about your patients.

The dentist **should be ever ready to respond to the wants of his patients** and **should fully recognize the obligations involved in the discharge of his duties toward them**.

The dental code followed medicine’s lead in laying out the primacy of the patient as the fundamental premise.

The introduction to the code begins with the statement that **trust is special** and **critical to the position that dentistry holds within society**.

The code mentions the profession is granted privileges and that in return the profession will adhere to “high ethical standards of conduct.”

The preamble again calls upon dentists to keep patients as their primary goal highlighting that knowledge, skills and competence and traits of character define the professional person.

Code of the ADA is divided into **three components:**
principles of ethics,
code of professional conduct, and a
dvisory opinions.

The principles of ethics component sets out the aspirational goals of the dental profession, which are similar to the aspirational goals for other health care professions.
The code is based on the **five fundamental principles** of **autonomy**, **beneficence, nonmaleficence**, **justice** and **veracity**, the major **premises of the profession**.

ection	Principle	Topics Addressed
1	Patient autonomy	Patient involvement; patient records
2	Nonmaleficence	Education; consultation and referral; use of – support personnel; personal impairment; bloodborne pathogens; patient abandonment; Personal relationship with patients
3	Beneficence	Community service; government of a profession; research and development; patents and copyrights; abuse and neglect; professional demeanor in the workplace
4	Justice	Patient selection; emergency service; Justifiable criticism; expert testimony; rebates and split fees
5	Veracity	Representation of care, fees; disclosure of conflict of interest; devices and therapeutic methods; professional announcement; advertising; name of practice; announcement of specialization; general practitioner announcement of credentials

Should I care more about being legal or being ethical?

People sometimes confuse **ethical** and **legal problems**.

Both the **ethical** and the **legal** involve **evaluations**. **Ethical evaluations**, however, appeal to what is believed to be an **ultimate standard of right and wrong**.

Legal evaluations appeal to the **evaluations of a particular society**. It may be **legal for a general dentists to provide comprehensive orthodontic care without adequate training** but **unethical to do s**o.

Ethical issues faced by **dentists:**

- **Quality of care:**

Care might be deemed **inadequate if it involves the delivery of substandard of care without** the **patient‟s knowledge**, **without consideration of the patient‟s wishes**, **without justification by virtue of special circumstances**, and **motivated by motivational gain.**

- **Advertising:**

The ADA **code of ethics states** that “no dentists shall advertise or solicit patients in any form of communication in a manner that is **false or misleading in any material respect**”.

- **Patient autonomy:**

Issues of **informed consent** and the need to put **the patient‟s interest first** are considered very important.

Informed consent is a **significant dental challenge to the dentist** because of the large number of different materials and different techniques available for the same or similar problems.

Conflicts with patients:

One category of conflicts deals with those precipitated by the dentist. For example consider the **patient who is unable** or unwilling to comply with the home care expectations of the dentist while the dentist wonders whether continuation of treatment is justifiable.

Another category of conflicts with **patients includes those precipitated by the patient**.

The most frequent situation is the patient who requests a procedure that is contrary to the training and standards of the dentist. An example is the request for complete mouth extraction by a patient who has an essentially intact dentition that can easily be saved.

Justice:

Several concerns are **over issues of justice**. What are the **obligations regarding treatment** for patients not of record who are **in pain**, for **patients with AIDS**, or for patients whose **prior treatment has failed**.

Is the dentist **obligated provide free services?** If so for whom.

Intra professional relationship: Among the most difficult problems are those where colleagues should be confronted with their incompetence or when incompetence should be reported.

Financial transactions: A final series of ethical issues concerns financial transactions pertaining to patients. Some of these issues involve direct transactions such as requests by patients to falsify billing, decisions on who pays. When treatment fails, the charging of different fees for the **same service under varying circumstances**.

Values in clinical dental ethics: There are six values in dentistry. The values in hierarchical order are as follows:

(1) the patient‟s life and general health,
(2) the patient‟s oral health,
(3) the patient‟s autonomy,
(4) the dentists preferred practice values,
(5) esthetic values and
(6) efficiency.

The patient's life and general health: The sustaining of life and the promotion of overall health is the central concern of all practitioners and patients. Under normal conditions, dentists should not undertake treatment that will significantly jeopardize the life or health of patients. For example, a man with malignant hyperthermia who received serious facial trauma would have risked death had he been given general anesthesia for corrective surgery.

The patient's oral health: Oral health for the purposes of this discussion includes appropriate and pain free oral functioning. What is appropriate functioning on such factors as age, stage of development, general health and the patient‟s requirements for function. In the case of a patient with severe periodontal disease and poor past oral hygiene practices, it is valuable to stress the need for more strict home care standards before any treatment is standard.

The patient's autonomy: A third concept that is valued by patients and dentists alike is autonomy or freedom, in the context of health care, autonomy refers to the ability of patients to make their own health care decisions that reflect their own values and goals. If patient, for example, were to request treatment that would appreciably compromise oral health, “ and if the dentist acted on the patient‟s request out of respect for patient‟s autonomy and did the procedure, **the dentist would be acting unprofessionally**”.

The dentist's preferred practice values: During their formal education, dentists receive powerful messages, regarding choice of treatment that often becomes incorporated in their values of preferred practice. Examples include the restoration rather than amalgam restorations in compromised teeth, and the use of crowns rather than amalgam restorations in compromised teeth.

Esthetic value:
Dentists recognise that facial and intraoral appearances are important to patients, and they routinely consider esthetic factors in their important to patients, and they routinely consider esthetic factors in their treatment recommendations.

Efficiency in the use of resources: Efficiency is something that virtually all dentists perceive as essential for operation of a successful practice. There is nothing unprofessional in a dentists working to control costs- time, effort, or materials provided the other central values are also given their due.

The structure of professions and the responsibilities of professionals: Students who select the profession of dentistry give a variety of reasons for their choice. Among them are the ability to earn a good income, the prospect of independent employment and the opportunity to serve the public.

Do we really have obligations to patients?

General dental practitioners have an ethical responsibility to provide access to advice and emergency treatment for patients, including those under a **private contract**.
General dental practitioners have an **ethical responsibility to provide access to emergency treatment outside normal hours.**

Leaving a practice, : obligations to patients

Whether you have been offering extensive and complex treatment to your patients, or your appointment book has been largely recalls and simple restorative treatment, **your departure from a practice** can be a time of upheaval.
The general principle for patients undergoing active treatment, **irrespective of the reasons for leaving a practice**, is to ensure that **patients are informed of a clinician's departure and have been appropriately referred or handed over to other clinicians for their ongoing care.**

There may be many reasons, both **personal and professional**, that can lead to a **practitioner moving on**. Most are planned, like a further study or retirement, others are unforeseen like illness. Naturally, it is impossible to predict the unforeseen. However, regardless of the reason for the departure, the old adage of keeping your house in order applies.

Do your current records and treatment plans outline the next steps for your patients?
Can someone else pick up your patients' treatment where you last left it?
Incoherent and incomplete records frustrate the next treating clinician and leave one open to criticism, increasing the risk of a complaint. The last thing you want to have to deal with when moving into the next phase of your life is organising shambolic patient care or having to field complaints relating to your prior care of your patients.
This is compounded if you have an **unplanned absence due to ill health.**

Transferring patient records

If you are closing your practice, there needs to be an **arrangement in place to enable patients to have their records** transferred to a new clinician of their own choosing.
If you are leaving a practice it is helpful to discuss your plans for ongoing patients with the practice owner so that they may be able to assist once you have left.

Patients can be disconcerted by the appearance of a new clinician when they arrive for their next check-up or for ongoing treatment.

It is sensible for the practitioner or practice staff to let the patient know that they will be leaving and that the next time they attend, another practitioner will be there to look after them.

Naturally, this is only possible if you know you will not be there next time.

Communicating the change helps avoid disappointment while providing patients with an opportunity to exercise some choice as to who their next clinician will be.
Patients undergoing current treatment will need their records fully updated by the leaving practitioner so that any clinician taking over the treatment has ‘handover’ notes and is aware of what was planned. It is usually a good idea to inform the practice of your contact details so that a new colleague can talk to you if they have any questions.

Handing over complex treatments

For patients undergoing complex treatment, the practitioner should refer the patient to the most appropriate clinician and could consider sending the patient a letter detailing the treatment that has been completed to date, and the treatment outstanding. It is also important to highlight to the patient the importance of ongoing upkeep and to warn of the risks of no further treatment, especially in complex care. These patients may not understand that they need to have further treatment or ongoing care and the risks of not wearing their retainers or having regular hygiene and maintenance appointments may not have not been previously highlighted. Where specific warranty provisions may be in place, these should be clearly documented in the patient record so that there is less room for dispute later should treatment fail.

Some patients may have paid the full fee for their treatment in advance, and the fair apportionment of the payments received should be discussed with the practice owner. Similarly, where a patient has been extended credit, it is wise to discuss your share of these payments once they have been made. There will often be laboratory charges linked to work in progress and these payments require reconciliation. Third party payment schemes in place may need attention too.

Sometimes, the departure of a popular clinician proves to be a catalyst for patients to reconsider their treatment and move on to another practice. **It may be necessary to offer such patients a partial refund where advance payment towards treatment has already been made.**

But what if a denture case is part-way through and a patient doesn't want to continue with a new clinician?

We recommend you exercise discretion in these cases as there may be occasions where continuity of care overrides all other issues.

It is also wise to plan for how the release of copies of patients' records will be managed should patients move on, as this can be a time-consuming administrative process. As always, written consent for record release should be obtained from each patient to ensure compliance with privacy principles, and the practice should not resist or refuse any reasonable request.

What about while I'm on holiday?

If going on a few weeks' leave but keeping your practice open with a locum, it is wise to inform your regular patients of this arrangement. Your locum needs to be able to decipher your treatment plans and your patients may wish to delay complex treatment until your return.

It can be helpful spending some time briefing locums on any problematic patients and your typical approach to managing reworks and emergency care. Locums can be reluctant to perform corrective treatment for gratis given it can affect their earnings, so some understanding of compensation for these events is prudent.

If temporarily closing your practice instead, it is helpful that patients are **abreast of emergency arrangements while you are away**.
Keeping patients informed about your return date is wise, as this can reduce the risk of patients seeking treatment elsewhere. Consider making arrangements for patients to book online or have a member of staff available to take calls, so that you don't return to mayhem or a sea of disgruntled patients in pain.

What if I'm unsure about my plans to return?

You may be unsure when you will return to work from a planned absence such as maternity leave. It is also commonplace to be unsure of what level of workload you may want to commit to, or what hours may fit with the competing demands on your time. Most patients will be understanding in these situations and will remain loyal to you and the practice. Patients will have advance warning of a clinician's absence in these situations and have had ample opportunities to organise appropriate handover. However, the open-ended nature of a return to work can cause uncertainty about how many patients need to be managed and by whom.
In fairness to all, it may be **helpful to discuss a possible phased return to work with the practice owner**. This can reduce the risk of being unable to meet expectations of billable hours at the practice and the risk of having to cancel patients at short notice.

Remember comments made before an event are an explanation, but those made afterwards are an excuse. Effective communication with patients is key to making a departure from a practice a smooth event, even when it is only temporary.

Is Dentistry a Business or a Profession

The most obvious sign of the commercialization of our profession today is the unfortunate **evolution of esthetic restorative dentistry into the cosmetic dentistry business**. It seems that "Bright Smiles" and White Teeth" are the **predominant public face of dentistry today**.

The trust in dental profession is based on ***individual commitment to ethical standards.***
Having said that it again may not be always in lines of ethical conduct and is ever evolving as it is more of a feedback from the interaction between dentist and society.
This can often reinforce the dilemma of considering dentistry as a profession or business.

The dentistry at its commencement was a business which has now emerged as a profession worldwide owing to the ethical treatment provision for prevailing dental ailments after acquiring special skills and training.

The trust of the patients and society in the capabilities of dentist has **granted this occupation the status of profession**. However, in the coming years, future of dentistry may revert back to its roots of business by **"corporatizatio**n" of this noble field by business enthusiast, adamant on earning huge profits at the stake of society and the dawn of which has already risen.

Some sort of **standardization** in treatment protocol as well as the revenue generated from the basic procedures is in order to avoid the "**corporatizati**on" of this profession with high ethics.
Following the standardization the paradigm will shift from generating profits to providing a quality treatment as that will be the **only incentive remaining for those who are truly dedicated to the profession.**

Thank you