Teamwise
New Zealand

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Consent for adolescents seeking dental treatment

Gaining consent to treat adolescents and deciding whether an adolescent is in a position to provide consent on their own accord, or whether the consent or further involvement of a guardian or parent is required, can be challenging. Moreover, the wishes of adolescents and their guardian or parent do not always align.

Many readers will have first-hand experience with the notion that teenagers and their parents do not always see eye to eye.

Consent generally
Except in rare circumstances (e.g. an emergency), health professionals (dentists included) are not permitted to treat an individual without that individual’s consent to such treatment. This applies equally to adolescents. The law relating to the ability of a young person to consent to dental treatment is complex. What is clear is that there is no hard and fast rule that a person must be of a particular age before s/he can give proper consent to any health and disability service, dental treatment included. The focus, rather, is on the competence of the individual.

Informed consent
Valid consent cannot be given by a patient who does not understand what s/he is consenting to. The process of informed consent, as dictated by the HDC’s Code of Health and Disability Services Consumers’ Rights (“the Code”), includes the provision of:

1) Effective communication – that is, it must be in a manner that enables the patient to understand the information provided (Right 5);

2) an environment that enables both patient and oral health professional to communicate openly, honestly, and effectively (Right 5);

3) full information including an explanation of the patient’s condition, options available (including risks, side effects, benefits, and costs of each option), an estimate of time involved and any other information required by other standards (Right 6); and

4) honest and accurate answers from the oral health professional to questions raised by or on behalf of the patient (Right 6).

The rights in the Code are applicable to patients regardless of their age. This includes the right to give informed consent. However, this does not mean that the age of the patient should be ignored because it clearly is a relevant factor for the dentist to consider when assessing whether an adolescent has the competence to consent to the treatment in question.

The level of ability necessary to consent to treatment, sensibly, varies with the risk or complexity of the treatment. Thus, an adolescent will be more likely to be capable of consenting to minor or low risk procedures than procedures that are highly complex or carry a significant risk of an adverse outcome.

Common law
The leading case in this area is the English House of Lords case of Gillick. It was a case involving a child under 16 years of age who sought to give consent on matters involving contraception. The House of Lords held that minors under that age may authorise medical treatment if they are mature enough to understand what is proposed and capable of expressing their own wishes. This has become known as the ‘Gillick competence’ test for determining when a minor is competent to consent to medical or dental treatment.

Premier Awards/Contacts

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The Premier Awards

Congratulations
Jack Colclough, a hygienist from Stoke on Trent (UK) took home the first prize with his project entitled ‘A study into the Personal Protective Equipment and Used by Dentists in General Dental Practice’.

Second prize was awarded to Francesca Mignon, a hygienist from Adelaide, Australia who entered her project ‘Ethics and professionalism: Minimising Risk and Maintaining Societal Trust in the Dental Profession’.

You can read a shortened abstract of Francesca’s entry on pages 9–10 of this issue of Teamwise.

$8,800 prize fund!
We are accepting entries for this year’s awards, which are open to all dental care professionals. Prizes will be awarded at the Premier Symposium on 17 November 2012. Entries must fall into one or more of the following risk management topics:
• Ethics and Professionalism
• Record Keeping
• Cross-Infection Control
• Teamworking and Skillmix
• Consent and Communication
• Health and Safety.

Last entries by 3 September 2012
For further information, an application form or to see previous entries, please visit www.dentalprotection.org/awards2011 or email nicola.photiou@mps.org.uk

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Harry Waaalkens QC reviews the law in New Zealand relating to the ability of adolescents/teenagers to consent to the provision of dental services

Many New Zealand cases have followed Gillick and adopted the ‘Gillick competence’ test to reflect the rights of consumers under the Code. However, unfortunately our Parliament has rather confused matters with a provision in the Care of Children Act 2004.

Care of Children Act 2004
Section 36(1) of this Act specifically affords a ‘child’ over 16 years of age with the right to consent, or refuse to consent, to dental treatments or procedures as if that child were of full age (20 years).

The question then arises as to whether the implication of this statutory provision (i.e. that under 16 do not have the explicit right to consent) overrides the common law approach adopted by the courts and in particular what is referred to above as ‘Gillick competence’.

Sadly, court decisions in this country are not entirely decisive on the point but the preferred view is that a “child” whether under or over 16 years of age has the ability to provide an effective consent (or to refuse treatment) provided they meet the Gillick test of being competent – that is, has the child a sufficient understanding and intelligence to enable him or her to adequately understand what is proposed? This view also aligns with the interpretation of the Code referred to above.

Lack of competence
For those adolescents, or children, who are not capable of consenting, someone else is required to do so on his or her behalf. This is usually the parent or legal guardian (section 36(3) of the Care of Children Act 2004).

The Code also recognises the right of such persons to provide consent on behalf of a child. However, the child still has all other rights and protections under the Code. Thus, even where the adolescent is considered unable to adequately appreciate the consequences of a dental procedure, they must still be provided with information of a type and in a manner that is proportionate to their level of ability to understand.

The other complication is where the adolescent patient does not see eye to eye with a parent or guardian over the proposed dental treatment. As paragraph 4 of the NZ Dental Association’s New Zealand Code of Practice – Informed Consent rightly states: ‘Consent to treatment given by a parent or guardian does not necessarily imply consent by a child or impaired adult. Dentists at all times must be aware that these patients have the right to refuse treatment, and care must be exercised in proceeding should there be doubts about consent. The consumer must still be provided with information proportionate to their level of ability to understand, and retains the right to make informed choices and give informed consent to the extent appropriate to their level of competence.’

Contracting with adolescents under 18 years of age
Generally, a contract entered into with a minor (a person under 18 years of age) will not be enforceable against that minor. However, a court is able to enforce such a contract if it considers the contract to be ‘fair and reasonable’. This in turn depends upon a range of factors, including the circumstances surrounding the making of the agreement and the subject and nature of it as well as the age and means of the minor.

As a consequence, whilst the parents/guardians of children and adolescents have the capacity to form binding contracts and to give consent on behalf of their children, if the adolescent refuses consent for the treatment then the dentist is placed in a very difficult ethical and legal predicament. In such a circumstance the dentist’s overarching obligation is to respect the wishes of the competent minor or adolescent.

It is strongly recommended in such a case of conflict to seek the consent of the adolescent to involve the parents or guardian with all aspects of the treatment, including treatment planning. Negotiating a satisfactory outcome is in the best interests of all concerned but ultimately that may not be achievable. In such a circumstance the adolescent, provided s/he is competent in terms of understanding and consenting to the treatment, has the ultimate right to decline treatment. In such a case the dentist has no option than to heed the patient’s direction.

Privacy
To further complicate this already difficult area, issues of privacy and confidentiality are thrown into the mix. Parents do not automatically have a right to information about their adolescent children. The Privacy Act and the Health Information Privacy Code (the ‘HIP Code’), as with the Code of Health and Disability Services Consumers’ Rights, do not provide a threshold based on age.

Before dentists share information with parents or guardians, consent of the adolescent should be obtained. Rule 11(4)(b) of the HIP Code allows the refusal of a request for information where the adolescent either does not want the disclosure to occur or where the disclosure would not be in his/her best interests.

Where it is considered that an adolescent is not competent to consent to treatment, it may still be important to provide them with information about disclosure of their health information as the individual may have sufficient competency to have an opinion about the use and disclosure of their health information.

Conclusion
New Zealand law relating to the issue of informed consent in the case of adolescents is difficult and continues to develop. The best approach for dentists to take when dealing with adolescents is to provide them with all necessary information relevant to that individual’s level of understanding, make a clinical judgement as to whether the adolescent is ‘Gillick competent’, make adequate notes of the factors taken into account in forming that judgement and, where possible and with the patient’s consent, seek to involve parents/guardians in the consent process and treatment plan.
While traditional dental charting systems have served the profession well for generations, they do have several limitations and in some respects, electronic versions of these records may even have increased the associated risks. This article looks at the importance of recording a variety of tooth surface features that traditional dental charting grids were never designed to capture, and how this can best be achieved.

Uncharted territory

Cavities
The conventional dental charting grid incorporating the familiar designs shown above was designed to record which teeth were present or absent, to facilitate the recording of the site and extent of dental decay, and to provide a diagrammatic representation of the treatment to be carried out. It has been adapted in various ways over the years since it first appeared, often to include periodontal records that integrate the charting of both hard and soft tissues.

When carious cavities were drawn freehand on a standard charting grid on a paper record card, it was possible – at least in theory – to achieve a fairly accurate representation of the extent and shape of the cavity, and which surfaces of the tooth were involved. In practice, however, a clinician would usually call out the clinical findings as the tooth were being examined and a chairside assistant would record this information by means of entering standardised symbols on a charting grid. In many cases the sophistication and accuracy that was possible (and desirable) was not always achieved, especially in busy surgeries where this process was carried out more quickly.

Meanwhile, computerised records have sometimes compounded this lost opportunity by representing every broad type of cavity (for example, a mesio-occlusal cavity or ‘MO’) in exactly the same way, using standardised computer graphics irrespective of the size and shape of the actual cavity.

Early caries
The era of minimum intervention highlighted the inadequacies of the conventional charting grid, because of the difficulties of distinguishing between a carious lesion that required restoration, early (white spot) lesions as well as areas in the process of decalcification or remineralisation.

Being able to monitor the stage of progression of these lesions is central to the minimum intervention approach. Dento-legally it is important to be able to demonstrate:

a) that the clinician had identified and recorded the presence of the lesion
b) that the clinician had correctly identified the status and extent of the lesion
c) that the clinician’s decisions for the management of the lesion were appropriate to the findings at (a) (b) above
d) that the clinician subsequently monitored the progression of the lesion and took appropriate steps to manage it, including any relevant advice to the patient in terms of oral hygiene, diet, topical fluoride etc.

If all the records show is the familiar symbol of a cavity on a charting grid, the question might well be asked why the cavity was not treated as soon as it was identified. Trying to persuade a court that, perhaps months or years later, you recollect clearly that the lesion was actually not a cavity at all, but an early white spot lesion or a remineralising tooth surface, will be an uphill struggle – especially if (as is often the trigger for cases of this nature) the patient has been seen by a second dentist who has diagnosed numerous areas of untreated decay.

Tooth surface loss
Another familiar clinical challenge is tooth surface loss through erosion, abrasion and attrition, and especially, situations where two or more of these factors are working in unison. Here, study models are often a useful adjunct to capture the all-important third dimension in the clinical records of the damage to the teeth in question. But here again, the traditional charting grid is far from ideal as a tool for recording tooth surface loss of this nature, at least not with the necessary degree of accuracy.

Wear facets, chips and fractures
When located on occlusal surfaces, incisal edges, cusps and restorations these changes do not always need much in the way of active treatment, but they do need to be recorded. In the older patient with a heavily restored dentition they may simply reflect a lifetime of wear and tear, but in adult patients of all ages they may be indicative of occlusal problems, bruxism or parafunction. In such cases, these clinical findings are part of the diagnosis and the records would be incomplete without them.

Undereaunt cusp
In the heavily restored dentition, weakened and undermined cusps of posterior teeth are a fact of life. But there are occasions when the survival of the last remaining cusp is closely linked to the prospects for the survival of the tooth itself. Identifying ‘at risk’ cusps and recording them in a meaningful and reproducible way is an important issue in planning in restorative dentistry.

Pits and fissures
The conventional charting grid is not ideally designed to differentiate between smooth-surface lesions and pit/fissure involvement. For example, on the buccal aspect of a lower first molar is the lesion at the cervical margin, or in a buccal groove, or in a buccal pit? A ‘freehand’ charting on a paper record does have the capacity to make this distinction but irrespective of whether paper or computerised records are used, this level of detail is rarely captured.

Cracks
As our patients are keeping more of their teeth later into life, with many of these teeth being heavily restored, clinicians are encountering more cracked teeth. Some of these are hardline cracks that would be difficult to detect without transillumination. Most cracks simply need to be kept under observation, but this is difficult to do unless and until their presence has been recorded in a way which facilitates a meaningful comparison over time.

Surface characteristics
Discolouration, translucencies and opacities are all important characteristics of the appearance of a tooth, that might be relevant to the question of whether or not to restore it, and if so, in what way. Very often, the question that is asked dento-legally is that of whether a tooth was treated appropriately, or indeed, whether a less intervention treatment approach might have avoided the problem that has given rise to the complaint or claim. Clearly, neither the charting grid, nor x-rays, nor study models, are designed to record these important aspects of the status of a tooth, tooth surface or restoration.
A solution
It has been said that a picture is worth a thousand words, and this may well be the case in some of the situations which have been described here. Digital photography is much easier and more convenient than the time-honoured expedient of photography using conventional film. It can transform the quality of clinical record keeping by capturing details that would be difficult or impossible to record in any other way. Clinical images also make the challenge of storage, and communicating with patients and professional colleagues, very much easier. Once they become integrated with other electronic records (text and radiographs), these images can provide a readily accessible, permanent confirmation of the physical appearance of a tooth or tooth surface at a moment in time.

Similarly, the ‘narrative’ of our own records – written or typed at the time ‘freehand’ - can often come to the rescue by filling in the gaps that even a picture could not address. You need to ensure that you have given yourself the best possible chance of remembering what you are looking at in the patient’s mouth today, and if in doubt, confirm in writing anything that would otherwise be unclear.

Our records are often the only means at our disposal for reconstructing the information that was available to us at the time we were actually treating the patient. Not unusually in dento-legal cases, many months or years will have passed between the time of treatment and the moment when you need to piece together what actually happened.

The reconstruction process is not easy, but it is certainly made much easier if you have access to all the raw materials for the exercise. The conventional charting grid may no longer cover all the eventualities that today’s clinician might face, but with a bit of imagination there are many ways in which you can effectively overcome such limitations.

Photography can significantly augment the detail provided in a charting that is either hand-drawn or created with computerised symbols. It has been said that a picture is worth a thousand words, and this may well be the case in some of the situations which have been described here. Digital photography is much easier and more convenient than the time-honoured expedient of photography using conventional film. It can transform the quality of clinical record keeping by capturing details that would be difficult or impossible to record in any other way. Clinical images also make the challenge of storage, and communicating with patients and professional colleagues, very much easier. Once they become integrated with other electronic records (text and radiographs), these images can provide a readily accessible, permanent confirmation of the physical appearance of a tooth or tooth surface at a moment in time.

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Cautionary tales

Whether or not we realise it at the time, there are some situations in clinical practice where we are much more vulnerable to problems of one kind or another arising. This article explains some of these situations and provides some practical advice for increasing our awareness of the additional risks they create and keeping them under control.

Unfamiliarity

a) New patients

When we see a patient for the first time, we obviously know very little about them. In quite a short period of time we have to find out a surprising amount about them – including personal and medical details that they would hesitate to share with most other people that they are meeting for the first time. We need to make some potentially important judgements about the patient’s competence and capacity to exercise their autonomy and free will in making decisions about their dental care. This can be difficult enough when treating longstanding patients and is fraught with risks when dealing with patients about whom we know very little.

We have to learn how best to communicate with them, about their wants and needs, their likes and dislikes, their expectations, fears and concerns. And there is a lot of evidence to show that there are particular risks associated with treating patients who we know little or nothing about. It is also well documented that one of our best sources of protection when things go wrong is the ability to draw upon any historic, positive relationship we have built up with a patient. When we are treating new patients, we do not have this protection, so we face additional risks even when we are carrying out the same procedures. Clinicians who work in out-of-hours walk-in emergency centres, or who work in practices that actively advertise for emergency patients, will know that most of their meetings with patients are brief encounters with people that they may never see again.

Even in a primary care setting, some practices are situated in areas where the local population is very transient and this creates much the same problem in that one is not able to build up any depth of relationship with, or knowledge of patients. Any clinician, who starts working in a new practice or other working environment, will encounter the same problem in that they will be forging fresh relationships with every patient they treat, for several months after starting work. This can be exciting and interesting, but also challenging and quite demanding. It is also a potentially dangerous time dento-legally unless one remains mindful of the risks and careful in their effective management.

b) Physical factors (environment, layout, lighting)

Any clinician who has needed to work in a strange surgery in which they had never worked previously will know how much more difficult everything becomes when the surgery layout is different, the instrumentation design and delivery system is different and unfamiliar and you are struggling to get the operating stool, the patient’s head and the surgery lighting in a position where you can work comfortably and with optimum visibility.

c) Technical factors (equipment, materials, new procedure/technique)

In many areas of life, the systems that work consistently well are those in which there are clearly defined processes. A process is an organised way of carrying out a series of activities and tasks in order that the same steps can be followed time after time. The aim is to achieve consistency of operation, quality of performance and predictability of outcome in compliance with pre-defined specifications. We practice our medical emergency and CPR (cardio-pulmonary resuscitation) techniques as a team, in simulated emergency scenarios. Here we can repeat the processes involved and make them more familiar, consistent and predictable. A genuine emergency is not the moment to be asking what to do or where the emergency equipment is kept.

d) Human factors

When compared to many hospital settings, the dental surgery environment in most primary care dental practices provides the stability of the same group of people working alongside each other, day after day, week after week. But change that mix even slightly by asking a clinician to work with a new or inexperienced chairside assistant and everything can change very quickly. In effective teams, each member learns to rely on the other members because everyone knows their role and responsibility. The days when that mutual understanding and trust is absent, are days where the risk increases exponentially.

Over-familiarity and complacency

Strangely enough, over-familiarity can also create risk in unexpected ways. Carrying out what we see as a very straightforward ‘routine’ procedure, on someone we know very well, can lead us to relax a little too much and take our eye off the ball. As any professional airline pilot will tell you, it doesn’t matter how many times you have flown the same plane over the same route, each occasion needs to be approached as if it were the very first time.
Overconfidence

One of the most dangerous forms of pitfall is the one you don’t see coming and don’t look out for, simply because you have a blind and perhaps misplaced confidence in your own ability. It is important that we should never overestimate our competence – we may be trained and experienced in procedure A which on the face of things, appears to be more difficult than procedure B. But there may still be material differences and this creates the potential for us to be caught unprepared for a complication of procedure B.

Overconfidence carries an additional risk in terms of how we communicate the risks of the procedure in our consent discussions with the patient.

WASP

This acronym stands for ‘Worry, Anxiety, Stress and Pressure’. It is well known that a clinician who is worried or concerned about a complaint or claim made against them in relation to treatment that they have previously provided, remains vulnerable to further problems until the ongoing matter is resolved and out of their life – especially when carrying out treatment of a similar nature to that from which the previous problem arose.

Stress and worry can be insidious in its debilitating effect and its compounding impact upon our performance often goes unacknowledged by the affected individual. Many ‘Type B’ personalities tend to ignore the signs of stress and believe that if they keep pushing themselves hard enough, they can overcome pretty much anything that life throws at them.

Stress also has the potential to disturb our sleep patterns and the restorative effect that such rest is designed to have. Without proper sleep, we start each subsequent day at a further disadvantage, progressively stripped of our ability to perform and cope with additional challenges.

When we are feeling under pressure, especially when this pressure continues for an extended period, our performance will suffer whether we are prepared to admit it or not. A break and a chance to draw breath, clear our head and re-charge our batteries is often the best (and sometimes the only) remedy. If this gives us the ability to address and deal with the cause of the problem, rather than suppressing it or denying that it exists, we will be the better for it. And so (in most cases) will our patients and those with whom we work.

Signs of stress

- An inability to make decisions
- Tendency to procrastinate
- Intolerance
- Short temper and irritability
- Increased alcohol intake,
- Increased smoking.

Accidents waiting to happen (patients with same or similar name, potential confusion over teeth to be treated)

Murphy’s Law tells us that bad things have a habit of arriving in clusters and just when you are least able to deal with them. Some of these ‘accidents waiting to happen’ really don’t need to happen at all and are very easy to eliminate if you design effective systems ahead of time, introducing appropriate safeguards and controls. Staff training and the everyday discipline of following specified procedures, perhaps including the routine use of checklists, should be sufficient to eliminate these avoidable problems.

The huddle: roles and responsibilities

Armed with an appreciation of the predisposing factors described above, a sensible short-term risk management strategy is to break the day up into sessions and to consider the challenges of the people and procedures planned for that session. Involve the other members of your team in this process and let them help you to identify the potential problems and flash points. If everyone has a clear idea of what we are trying to achieve in the session ahead (rather like the team ‘huddle’ used in a sporting context) each person can play their part in keeping you safe through periods or moments of additional risk.

Longer term strategies include planning ahead to balance periods of heavy workload with ‘down time’, holidays and other breaks. Think about how you use your appointment book to avoid scheduling the most challenging people and procedures at times when you are at your most vulnerable. When more of the above factors are working against you, it makes sense to keep things simple and avoid creating extra risks for yourself.
Ethics and professionalism

Maintaining society’s trust in the dental profession

As the profession becomes increasingly preoccupied with new technology, new clinical techniques, materials and equipment and acquiring new clinical skills, it can often be refreshing to ‘go back to basics’ and remind ourselves of what we are (really) here for.

Now, perhaps more than ever before, we need to remind ourselves of the importance of professionalism and the underpinning ethical dimension of the provision of health care. No dental care and treatment – however excellent in a technical sense - has any real value unless it serves the best interests of the patient.

As professional people we can sometimes lose sight of the precious and fragile nature of having the trust and confidence of the society that we serve.

This article is a short extract from a more detailed article that earned the writer Francesca Mignone one of the 2011 Premier Awards – only the third time in eleven years that one of the awards has been won by an entry from a dental health professional in the Southern Hemisphere.

Frequently, the law is specific enough to ensure that we can know and understand how we should and should not behave. But what should we do if we find ourselves in a situation where the law lacks clarity? These ‘grey areas’ can be difficult and even stressful to navigate. However by using ethical principles, we may have confidence that our actions are defensible and minimise risk.

The importance of understanding and implementing ethical principles in daily practise is reinforced by the fact that dental regulatory bodies may remove our registration on grounds of ethical misconduct, even if no legal statute has been broken.

For these reasons, I chose to investigate ethics and professionalism for a project that I submitted for the 2011 Premier Awards. What follows is a summary of my findings including some key ethical principles and a reported framework for resolving ethical issues.

Morality and personal conduct

The profession’s trusted position in society comes with an expectation from both the public at large and dental regulatory bodies for high moral standards. Meeting this expectation involves ensuring that our behaviour upholds the ethical views of society, even if they are not specifically embodied in law.

While we might like to believe that our personal life is private, some overlap with our professional life is often unavoidable. Additionally, our personal conduct may be viewed as an indication of how we behave professionally. When unsure about our actions it is prudent to consider whether a reasonable person, in possession of the facts, would consider our behaviour to be inappropriate (DPL; Wilkins 2005).

Beneficence and non-maleficence

Society reasonably expects that dental professionals will uphold the ethical principles of beneficence (doing and promoting good) and non-maleficence (the prevention and avoidance of harm). This is our ‘duty of care’ and it carries the legal obligation to use reasonable skill and care in the treatment of patients and the ethical obligation to place the patient’s needs as paramount. Failing to uphold our duty of care can result in complaints to regulatory bodies and criminal allegations.

Complaints may arise from a failure to:

• use skill or care
• provide advice or warning about the nature, risk, purpose and/or limitations of the treatment
• recognise the need for referral
• ensure that facilities and/or instruments are suitable for use.

Francesca Mignone
BSc. ADOH won second prize in the DCP category of the Premier Awards in 2011 sponsored by DPL and schülke. She works in an Adelaide orthodontic practice and has served on both the National Council and South Australian Executive of the Dental Hygienists’ Association of Australia Inc.
If we are unable to satisfy duty of care, we must decline or postpone the treatment or limit it to that which can be provided to an appropriate standard.

It is also important to recognise that because we may only provide treatment for which the patient has given informed consent, what is sufficient to satisfy duty of care varies between situations (DPL; Naidoo and Wills 2000; Wilkins 2005).

Veracity

Veracity describes our legal and ethical obligation to tell the truth in both our professional and personal lives.

To ensure veracity in our daily practice we must ensure that:
• financial dealings are honest and transparent;
• action is taken when dishonesty is suspected;
• conflicts of interest are declared;
• research protocols have ethical approval; and
• reasonable steps are taken to verify the content of documents that we sign.

Patient records can be used to demonstrate our good faith and must therefore give an honest, complete and contemporaneous account of events. Honesty is an integral part of professionalism and when dishonesty is perceived it undermines the credibility of our profession (DPL; Dental Board of Australia; Naidoo and Wills 2000; Wilkins 2005).

Justice, respect and autonomy

Justice (the treatment of others with equality and respect) and autonomy (an individual’s right to direct their life through freedom of choice) are ethical principles protected by both human rights and legislation. We are therefore legally and ethically obliged to prevent discrimination. Understanding and meeting the needs of others is key to achieving this.

Because autonomy depends on a person’s capacity to make rational choices and to understand and act in their environment, it is part of ethical practice to ensure that our patients are made aware of (and understand) all of the options available to them. This includes the proposed treatment’s nature, purpose, risks, side effects, costs, consequences and alternatives. Patients who are not provided with sufficient information during their decision making processes are more likely to feel misled and angry, increasing the risk of dento-legal action.

As dental professionals we are ourselves protected by the principle of professional autonomy. This means that we can refuse to deliver treatment requested by the patient if we believe that it is not beneficial and/or may cause harm (ie, it breaches a standard of care). In this situation the risk of patient dissatisfaction may be minimised by displaying empathy for their wishes but explaining why we cannot conduct the treatment. It is advisable to then work with the patient to arrive at an alternative treatment plan that is both acceptable to them and conforms to recognised standards of care.

While the need to treat patients with dignity and respect is obvious, it is equally important to uphold this principle when interacting with colleagues. Overt criticism of another dental professional (or their work) can undermine societal trust in our whole profession. Because we cannot purport to know what occurred during an episode we have not witnessed, if you are asked to express a view on a colleague’s work, it is advisable to comment only on what you have actually seen in person. Any comments must be objective, ensuring that statements of fact are separated from personal opinion (Dental Board of Australia; DPL; Dyronne et al, 2010; Naidoo and Wills 2000; The UN General Assembly 1948; Wilkins 2005).

Competence

Competence distinguishes professionals from amateurs and is an essential factor in maintaining society’s trust in the profession. We must both maintain the standards of our profession and work to acquire new skills and knowledge. In many countries, regulatory bodies have specific requirements for professional development but it is also important that we undertake training to remedy any gaps in our skills.

Attending meetings of professional associations and reading professional journals helps to ensure that we stay informed of current ideas, concepts and the evidence base in dentistry. Sound knowledge in these areas is not only expected by the patient, but also by courts of law. Maintaining competence also obliges us to work within both our scope of practice and own limitations (Dental Board of Australia; DPL).

Rectification

It is a condition of society’s trust in our profession that we can be relied upon to take steps to rectify adverse outcomes. When an adverse event occurs immediate action is required to acknowledge patient distress, provide support and rectify the situation. We must adhere to policies and procedures subject to advice from our indemnity insurer and ensure that patient care is not affected (this may necessitate referring the patient). Reflecting upon mistakes and near misses (including what happened, how it arose and how recurrence can be prevented) helps to minimise risk, but when adverse events do occur, ethical practice helps to maintain societal trust in our profession (Dental Board of Australia; DPL).

Resolving ethical issues

Ethical challenges occur in different aspects of dental practice but always require careful reflection and judgment to resolve. (Wilkins 2005).

A reported framework for reflection

1) Identify the issue and the ethical principles at stake.
2) Seek the advice of relevant authorities (eg, professional bodies and indemnity insurers). Understand the sequence of events and any applicable policies, regulations or laws. Establish who the stakeholders are and what views they hold.
3) Once information has been gathered, clarify what the problem is, the ethical principles at stake and which stakeholders need to be involved in the resolution.
4) Determine the options for how to proceed with resolution of the situation.
5) Consider the options in view of any laws, policies or regulations.
6) Select a plan of action with a clear understanding of how to justify it in regard to the applicable policies, regulations or laws.
7) Instigate the plan with care and convey a readiness to justify the reasons for your course of action.
8) Evaluate the decision in terms of the process of reaching it and its consequences. Reflect upon what went wrong or right and what may be done the same or differently in the future (Dental Board of Australia; DPL; Wilkins 2005).

Conclusion

Societal trust is a privilege that lends integrity to our profession. By ensuring that our actions and behaviour are based on legal and ethical principles we may be confident in the knowledge that we are practicing in a way that protects the integrity of our profession and minimises the risk of dento-legal action (DPL).

The full text of the original paper as well as a complete list of references used to prepare this article can be found at www.dentalprotection.org/awards2012.
Treating adolescents and teenagers

This article examines the dento-legal issues that can arise when treating that group of patients who are no longer children (in the colloquial sense) but not yet adults (in the legal sense).

Body language and communication
Interpreting the body language of teenagers is rarely a simple task and in comparison, betting on horse races can start to seem like a precise science. Many teenagers actually work surprisingly hard at how they present themselves to others and the stereotype of the monosyllabic, permanently moody and slightly world-weary teenager may simply reflect the fact that the individual hasn’t quite worked out where and how they fit into society – or more accurately, where and how society can fit into their world.

So for the time being they are hedging their bets and remaining semi-detached from the rest of us. Their familiar default demeanour is designed as a kind of protective device to hold the world at bay.

It is important to appreciate that although many of the same skills and principles apply, and are still hugely important in effective communication, nuances in non-verbal communication do not necessarily have the same meaning for teenagers as they do in adults. For example, teens tend to make less eye contact when communicating with adults and just because the patient is not looking at you or giving you any active or encouraging feedback, it does not necessarily follow that they are not listening and/or are disengaged. Similarly, while a slumped body posture may (just as in adults) demonstrate negativity, apathy, boredom or disinterest it may on the other hand simply be a sign that the individual has something much more interesting (to them) on their mind and they are actually quite happy. Even if you are successful in attracting their interest and engaging them in a discussion, their body posture may never quite reflect this.

Occasionally, a closer inspection will reveal one or more of the tell-tale earphones or a glimpse of the cable leading to them, to provide an alternative explanation!

Listen to yourself
Our own body language and the way we use our voice is crucially important when communicating with this group of patients. They need to feel important, and to be respected on their own terms. Avoid doing or saying anything that might be interpreted as patronising, or a critical ‘wagging finger’ – they probably get enough of that from everyone else they deal with. Teenagers and adolescents need to accept you before they can start to accept what you have to say, and they respond to being listened to and being given choices. In this respect, reflective listening techniques are particularly useful because you are demonstrating not only that you are listening, but also that you are interested in how the patient is feeling behind the actual words they use.

Caries
The eruption of permanent teeth results in a sudden increase in the number and extent of interproximal tooth surfaces and contacts, many of which are relatively inaccessible. This can be a predisposing factor for an increased risk of caries in this age-group. When coupled with crowding and other factors related to oral hygiene and diet, a number of lesions can appear simultaneously, even in children whose caries experience in the primary dentition was minimal and the clinician may well be asked what s/he did to recognise the risk, to anticipate or prevent this, or to act upon it sufficiently quickly.

Clinicians should be alert to the potential for risk to change in teenage and adolescent years, and the danger of assuming the status quo based on past experience (or sometimes the experience of older siblings who you may also have treated). In fact, parental oversight of oral health tends to diminish when children become teenagers, and their control over factors such as oral hygiene and diet can also change dramatically.

Oral hygiene
Levels of personal hygiene and ‘grooming’ vary widely in this generation of patients. Peer pressure often plays an important part in shaping these attitudes. Oral hygiene is usually (but not always) a reflection of the importance that the individual attaches to these matters. Even in those families where parents had taken a very active role in ensuring that their children’s teeth were brushed regularly and effectively, there comes a time when the responsibility passes to the children themselves. Oral health professionals need to step into that vacuum and ensure that these young patients have the skills and motivation to maintain adequate standards of oral hygiene for themselves. To simply assume that this is the case is a misguided abdication of our duty of care.
Diet
Having a bit more freedom and a bit of money in their pocket, can present a particular problem in oral health terms because of the peer pressures and choices that adolescents and teenagers will often make when left to their own devices. Carbonated drinks are a particular challenge, as is frequent snacking and a preference for ‘junk’ food. It is important to discuss these issues with patients in this age group, and the records should be sufficient to demonstrate what was said and recommended.

Orthodontics
The majority of orthodontics is carried out on adolescents and teenagers, so for anyone treating these patients it is helpful to develop an understanding of what makes them ‘tick’.

Orthodontic appliances also introduce an additional caries risk for patients whose oral hygiene and dietary factors are not under control. If care is being shared between a team in general practice and an orthodontist, close communication needs to be maintained. Both parties will generally be held accountable if active caries is not detected or allowed to progress unnoticed by the clinicians concerned, or if areas of demineralisation or caries are allowed to develop unaddressed around orthodontic brackets and bands.

Looking good
This is another feature of adolescence which is a reflection partly of developing self-awareness and self-respect and partly a reaction to peer values and peer pressure. But as health professionals it is a period of teenage development that can be made to work in our favour and applied in the long-term interests of the patient. It can provide the ideal opportunity and motivation to embed oral health and oral hygiene into the patient’s understanding of their own responsibility for their health and well-being. These are important discussions and they need to be carefully recorded.

Trauma
Adolescents and teenagers are mostly still at school and a significant proportion of them may well be at the most physically active phase in their life, very often participating in team sports. Clinicians should establish what these activities involve and identify whether or not it would be advisable to recommend the use of a mouthguard. Different activities involve different levels of contact risk and require different levels of protection – this in turn affects the optimal design of the appliance.

These patients are also in a period of growth and development, and often the mixed dentition is still present. This may complicate the provision of mouth protection and add to the difficulty of ensuring that the appliance remains well-fitting and suitable for its purpose and use.

If mouth protection is recommended but not acted upon, the records should be sufficient to demonstrate the initial advice given to the patient and parent(s) and any follow up questioning and/or reminders. If cost is given as a reason for not following your recommendation, a note of this should be made in the records.

Parent power
The relationship that teenagers and adolescents have with their parents can, on occasions, present the clinician with additional problems, whilst on other occasions it can form part of the solution. As dental health professionals we can sometimes find ourselves caught in the crossfire between parents and their adolescent offspring, and by taking sides in these skirmishes we can lose the trust and confidence of the other party very quickly. It is important to keep in mind the fact that the child is the patient, even though the parent is a key player in the equation.

Clinicians have different views on whether or not parents should be present in the treatment room when children of this age are being treated. Much depends on what is going during the visit in question, and what needs to be discussed, and it will often be a balance between different considerations. Wherever possible, involve the teenage patient in this decision; if they express a clear preference one way or the other, do your best to respect that.

Several studies which have looked at the attitudes of teenagers to primary healthcare providers, have highlighted their concerns about confidentiality and the potential for embarrassment and a reluctance to talk about some issues in front of their parents. Obviously this varies from one teenager to another but clinicians should be sensitive to these factors.

The legal complexities relating to consent and the contract for the provision of dental services (see pages 2–3), may require a greater degree of parental involvement on some occasions than others.

Kissing with confidence
The moment when adolescents discover their sexuality, provides dental health professionals with a valuable lever for influencing attitudes and behaviour. Suddenly there is a reason for the patient to take oral hygiene and oral health more seriously. There can be few teenagers and adolescents who have not harboured a secret paranoia about the freshness of their breath at one time or another. Studies suggest that a high proportion of teenage and adolescent patients do value this kind of information even if they do not actively seek it out in their consultations with health professionals, perhaps because they would find it embarrassing to do so.
**Chaperone**

Male clinicians in particular should take care not to treat adolescent or teenagers without a third person being present in the room at all times. Allegations of impropriety by males against unchaperoned teenage female patients arise surprisingly often, ranging from allegations of inappropriate remarks to inappropriate touching. Even the most innocent of comments or actions have the potential to be misinterpreted and because of this, there should be no breaks in the chaperone arrangements, however brief.

Regardless of gender, another basic reason for ensuring that there is a second person available to support the operator is the importance of being able to respond effectively to a medical emergency in the surgery.

**Time**

Teenagers have a very casual relationship with time and time-related commitments. Their own timekeeping is considered entirely optional - a fact which becomes more curious when one considers that they are digital natives who have never known life without computers, are permanently ‘connected’ and rarely separated from electronic devices that continually remind them of the time, down to the nearest fraction of a second. Despite this they still expect everything and everybody else to be available and at their disposal 24/7. Immediacy is a non-negotiable feature of the ‘now’ generation. This curious paradox can create problems when teenage patients turn up late for appointments and have to be turned away or rescheduled. Keep full and detailed records of all these occasions, and also appointments that are missed entirely or cancelled (especially if at short notice). Remember that patients in their teens are more likely to email or text you from a mobile device if they can’t make an appointment – if you are waiting for a letter or phone call you may be waiting for a long time.

**Non-compliance**

Poor attendance is only one manifestation of non-compliance and non-cooperation with any treatment recommended for them. Many teenagers and adolescents aren’t the best at following advice and instructions from adults, and health professionals may struggle for their voice to be heard in a way which is not seen as, yet another disappointing adult telling them what to do. This is part of the challenge of providing healthcare for teenagers, but unless they are listening in the first place, it is hardly surprising if they don’t remember the advice you gave them. For this reason you should keep meticulous records of all the advice and recommendations you give, and of any non-compliance. If the parent(s) or other adult is present when the advice is given, a note should also be made of this fact.

**Other considerations**

- **Aphthous ulceration and other soft tissue disorders**
  
  The hormonal changes of teenage and adolescent years will, in susceptible individuals, result in aphthous ulceration, papillary enlargement and other changes which can occasionally be quite painful and debilitating. The presence, location, size and appearance of these lesions needs to be recorded and monitored and a healthy suspicion maintained of any lesion which fails to resolve in the usual way, or which recurs in the same location. Very occasionally these lesions are not as innocent as they might first seem.

- **Oral piercing**
  
  The clinician will encounter tongue and lip studs with increasing frequency when treating adolescent patients. The oral health risks of these forms of adornment still need to be explained, even though you had no involvement in their placement. The records should confirm that this discussion took place. Similarly, the surrounding tissues need to be carefully and regularly inspected as part of the soft tissue assessment – your duty of care is not suspended or negated just because the patient made a unilateral decision to have themselves pierced by a third party.

- **Eating disorders**
  
  Hygienists and therapists are ideally placed to identify the signs of bulimia, anorexia and other eating disorders that are sometimes encountered in this group of patients. Any tooth tissue loss from these sources needs to be meticulously recorded (see pages 4–5) and discussed with the patient initially and (where necessary/ appropriate) the parents, before the patient is referred back to the dentist.

- **Pregnancy**
  
  Teenage and ‘under age’ pregnancies, even amongst early teens, are no longer rare occurrences in modern society. The dental team may be made aware of the patient’s pregnancy, and able to discuss the oral health significance openly, or occasionally the information may be disclosed in confidence by the patient with a request not to discuss it with the parent(s) – or sometimes, the reverse which can be much more difficult to manage. Each situation needs to be considered carefully on its own merits but as a general principle the best interests and wishes of the patient are paramount.

- **Abuse and neglect**
  
  Dental professionals should remain aware of the potential for neglect, abuse and non-accidental injury and should note any potentially relevant findings in the clinical records, in an objective, factual way. There are well-established protocols for the steps that should be taken where you have grounds for concern that abuse may be taking place.

**Summary**

It is important to remember that we have a duty of care to each and every patient, and irrespective of their age, they have a right to expect that we will place their interests above our own, and also respect their views and take them into account. There are many dento-legal pitfalls for oral health professionals as our patients make the transition from childhood to adulthood and we disregard the views of teenagers and adolescents at our peril. It is easy to forget that in a few short years, many members of this group will be the parents of your next generation of patients.

A further complication is the fact that in litigation terms the patient gets two possible bites at the cherry – one through their parents pursuing compensation on their behalf at the time (although the courts are generally required to oversee any such settlements to ensure that the interests of the minor are fully protected), and another through the patient pursuing an action on their own behalf after reaching the age of majority, if the matter has not already been concluded. Several examples of this have been seen where young adult patients have sued their former dentists, alleging that their Tmj/occlusal problems and headaches had been caused by the inappropriate treatment of their malocclusion when a teenager. One patient even claimed (unsuccessfully) that this was the reason why they had failed to achieve their university degree, and in Australia one teenager’s determined parents were never able to come to terms with the harsh reality that their teenage child was not destined to become a supermodel and no amount of intervention by dental health professionals could change that fact.

The recently-coined term ‘Helicopter Parent’ refers to the baby boomer parents of today’s teenagers who have demonstrated a particular tendency to hover over their offspring and swoop like a personal SWAT team to put right anything that goes wrong in their lives of their children. Something else for the dental team to be on the lookout for when treating teenagers and adolescents.

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