



Talking Ethics



Web 2.0: The Blurred Line Between Professional and Private

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The term “social media” (also known as Web 2.0) describes Internet-based technologies that allow users to interact and collaborate with others online. These applications include Facebook, Twitter, YouTube, etc. With this interactivity, social media is viewed as the interface of new technology and social communication to create (or co-create) new knowledge.¹ Social media is a wonderful tool for the dissemination of health information, as well as for engaging professionals to connect, communicate, and share resources in various platforms. CDHA recognizes that online communities are important and invaluable components of our overall communications strategy to connect, share with and learn from each other. We make every attempt to facilitate online interactions between CDHA, our members as well as the public via online platforms, such as, [Facebook](#), [Twitter](#), and [Communities of Practice](#).

With the rapid growth of social media use, it is evident that it's here to stay. Social media vehicles will continue to be integrated into both our personal and our professional lives. However, when we combine the use of technology with our social connections, the line between “private” and “public” is blurred.² The increased use of social media introduces a range of ethical considerations for dental hygiene practitioners.

There are many occasions when ethical distress may arise as a result of social media. Does your colleague vent about his or her workplace frustrations via Twitter? Are you unsure how much identifying information to provide when inquiring about a case on a listserv? Has a client invited you as a “Friend” on Facebook?

Social media networks are firmly in the public domain. The reach is wide and far, and often permanent. The information can be viewed by anyone, despite any privacy settings offered by the various social media sites. The critical consideration for dental hygienists who use social media is the privacy and confidentiality of the clients for whom they care. Confidentiality is a core principle in [CDHA's Code of Ethics](#).

The “Principles” depict the broad ideals to which dental hygienists aspire and which guide their practice. The “Responsibilities” outlined on the following pages are more precise and provide direction for behaviours in ethical situations.

Confidentiality is the duty to hold secret any information acquired in the professional relationship. Dental hygienists respect a client's privacy and hold in confidence information disclosed to them except in certain narrowly defined exceptions.³

Dental hygienists have a responsibility to demonstrate respect for the privacy of clients. In addition to this ethical consideration, dental hygienists also are to abide by federal, provincial, and territorial laws regarding the protection of personal health information. Difficulties arise when trying to find a balance between the differing concepts: social media encourages open interactions and immediate sharing of personal information, whereas privacy regulations are aimed at protecting client rights through firm and explicit standards regarding the use of such client information.⁴



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Talking Ethics



Grey Markets: Do You Need to Be Concerned?

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Dental supplies are regulated products under the Food and Drugs Act and Medical Devices Regulations. When a company wishes to sell products from a specific manufacturer, and the manufacturer will not authorize them to sell those products, the company will often obtain the products through other means and sell them anyway. The marketplace for such unauthorized products is commonly referred to as the “grey market.”

Generally, almost any dental product that is sold in quantity (toothbrushes, fluorides, sealants, polishing pastes, composites, cements, etc.) may be sold on the grey market. Small equipment, like ultrasonic scalers that have not been certified by CSA or other equivalent standards, may also be found on the grey market. The sale of products on the grey market may involve lesser violations such as improper shipping, storage, and handling or more serious offenses including alterations to products and packaging and, in some cases, outright counterfeiting. Unregulated products (non-dental) that are nothing more than “grey”; that is, obtained from a source that is not in the manufacturer’s distribution chain, do not pose a risk to consumers and are not necessarily illegal, although their existence may compromise the manufacturer’s trademark.

According to CDHA’s biennial Job Market and Employment Survey, most dental hygienists report having an influence on the products that are purchased by the office where they are employed. However, they may not be the person who decides from where the products are purchased. As a result, dental hygienists are advised to check for the following:

1. Are the medical devices licensed by Health Canada?
2. Are they licensed in their packaging?
3. Do the drugs have a Drug Identification Number (DIN)?

4. Did the company where it was purchased have a valid Establishment License?
5. Did the product that was actually received in the practice meet with these requirements?
6. Products display license information on packaging. Defaced products and packaging, repackaged products, missing or defaced labelling, missing or defaced lot numbers and expiry dates, and labelling not in English and French are indications that the products may not be licensed for sale in Canada, and may in fact be counterfeit.
7. Does the equipment in the practice comply with CSA or equivalent standards for their province?

Legitimate manufacturers are now moving to the next step. Next generation products are now being developed for specific markets, so they cannot be brought back into North America without the package and/or the product or both being counterfeited.

In addition, the Dental Industry Association of Canada (DIAC) is currently lobbying Health Canada to become more aggressive in monitoring products that are being illegally imported and sold in Canada, particularly since the Protecting Canadians from Unsafe Drugs Act (Vanessa’s Law)—a law that would amend the Food and Drugs Act—is set to impose substantially greater penalties.

In the meantime, DIAC and CDHA suggest that dental hygienists take a proactive approach in their practice when receiving new products. Scrutinize the packaging carefully, raise questions about the source of products at staff meetings, and advocate for an office policy requiring that materials and equipment be purchased from known vendors.

Talking Ethics



Ethical Advertising and Fee Discounts

by Ann Wright, RDH, MBA • awright@cdha.ca

As the number of dental hygienists practising independently grows across Canada, dental hygienists may believe that they must offer “something special” to attract clients. Unfortunately, some dental hygienists inadvertently undertake inappropriate advertising activities, which are in conflict with the principles outlined in the [Dental Hygienists’ Code of Ethics](http://www.cdha.ca/codeofethics) (<http://www.cdha.ca/codeofethics>) and may result in an investigation from dental hygiene regulatory bodies.

The College of Dental Hygienists of Ontario (CDHO) is very clear about advertising activity. Its *Guideline on Advertising* states the following:

Advertising is defined as any form of communication to current or potential clients in which a registrant is promoting her/his dental hygiene practice/business. This includes, but is not limited to, information posted on websites, pamphlets, promotional signs, flyers, newspaper articles or advertisements and the use of social media sites such as Facebook and Twitter.¹

The College of Dental Hygienists of British Columbia (CDHBC) declares the following regarding advertising:

Any marketing undertaken or authorized by a registrant to promote professional services for dental hygiene care must not be false, inaccurate, misleading, unverifiable, or contrary to the public interest. A registrant must avoid claims that establish unreasonable expectations for results of treatment or that imply a level of care not achievable by other registrants or another health profession.²

In relation to fees charged, the College of Registered Dental Hygienists of Alberta (CRDHA) *Rules Respecting Advertising* state:

A dental hygienist shall ensure that any fees published or advertised are not, in any respect, false, inaccurate, misleading, unverifiable, contrary to the public interest or harmful to the integrity of the profession of dental hygiene.

Furthermore, a dental hygienist shall ensure that any fees published or advertised:

- are precise as to the services offered for each fee quoted;
- do not refer to minimum or sliding fees;
- state whether other amounts, such as disbursements and taxes, will be charged in addition to the fee; and
- are strictly adhered to in every applicable case.³

The CDHO is also very specific on the protocol for charging fees and applying discounts:

For clients whose treatment is paid for in whole or in part by a third party, do not charge them a different fee than clients who pay for the treatment themselves. Offering a discount may be acceptable if the discount is applied to all qualifying clients (not just those who do not have insurance) and the required co-payment is not compromised. Individual reductions for persons in need are permitted as long as one is not systematically charging insured clients more.¹

DESCRIBE THE ISSUE

A dental hygienist sees that many of his clients are in desperate need of oral care. They do not qualify for social assistance programs, nor do they have private dental insurance benefits. There is certainly no extra money at the end of the month to pay for dental care. Therefore, the dental hygienist would like to offer this group discounted dental hygiene services at 50% of his regular fees. He is even considering offering free treatment for their children.

GATHER INFORMATION

The dental hygienist estimates that this group of clients, who need dental hygiene services but cannot afford to pay his usual fees, represents approximately 10% of his client base.

He believes that he could offer this group oral care services at 50% of his regular fees and still earn enough through his other clients to meet his monthly expenses.

He wants to keep the details of this discount as confidential as possible.

CLARIFY THE CHALLENGE

The dental hygienist knows that, ethically, he should not charge different fees for the same population in his practice.

He understands that if he decides to provide dental hygiene care at a 50% discount, he must provide this for all clients.

He knows that he can't earn a living by charging 50% of his fees for all clients, but he wants to provide oral health care for his low-income clients and he is conflicted because he is aware that they just cannot afford his fees.

WHAT ARE THE ETHICAL IMPLICATIONS?

- Responsibilities for Beneficence: The dental hygienist should always place the needs of his clients first.
- Responsibilities for Integrity: The dental hygienist must be consistent in his actions, while considering the needs of those who are more vulnerable. This responsibility also states that dental hygienists must communicate the nature and costs of professional services fairly and accurately, adhering to guidelines and/or regulations.
- Responsibilities for Confidentiality: The dental hygienist has a duty to protect the confidentiality of his clients, including identifying groups with different abilities to pay for services.

The options facing this dental hygienist are somewhat complicated. He believes that, in order to practice beneficence, he should put the needs of his clients first. However, he may not be acting with integrity by segregating his practice into those who can afford to pay his customary fees and those who cannot. He also has a duty to communicate the costs of the services he provides truthfully. Finally, while he believes that he can identify this specific client base, he is not in a position to know if his assumptions are correct.

OPTIONS FOR ACTIONS

1. Charge the disadvantaged client group 50% less than the others and hope his other patients don't find out.
2. Charge all clients the same rate.
3. Set aside one day/month for community service. Advertise discounted fees for that day only for all kids under 12.
4. Select a few clients per month for pro bono work.

In general, discounts are allowed by the colleges and, if applied properly, are not contrary to the ethical practice of dental hygiene. Discounts cannot discriminate, however, between insured and non-insured clients. This means that dental hygienists cannot charge a client with dental insurance benefits more than a client without benefits. Dental hygienists must also collect the co-payment. The co-payment is the difference between the dental hygiene fee and the amount the insurance company will pay. It is unethical to waive this amount. Finally, discounts must be applied equally to all client groups. It is perfectly ethical to provide a discount for seniors, as long as all seniors receive the discount.

In our case study, the dental hygienist could choose options 3 or 4, in order to ensure that his disadvantaged clients receive the oral health care that they need. Alternatively, he could continue to charge all of his clients the same rate for services provided. Offering the disadvantaged clients a discount would be fraudulent, however, because it would discriminate between insured and non-insured clients.

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NEXT ISSUE'S ETHICAL CHALLENGE!

A member called and asked about discounts and freebies. The office she works in routinely offers free whitening treatments, draws for gift baskets, and discount movie passes for referrals. She is wondering what she should do? She understands that this practice is unethical, but since she is not an owner, she worries about keeping her job if she speaks up. She asks whether she should report her concerns and/or if she could face a college reprimand? What are your thoughts?

Replies to "ask the ethicist" directed to marketing@cdha.ca will be published in the next issue of *OH Canada!*

Talking Ethics



Professional Development and Ongoing Inquiry: Everyone Wins

by Kathleen Feres Patry, RDH • kfp@rogers.com

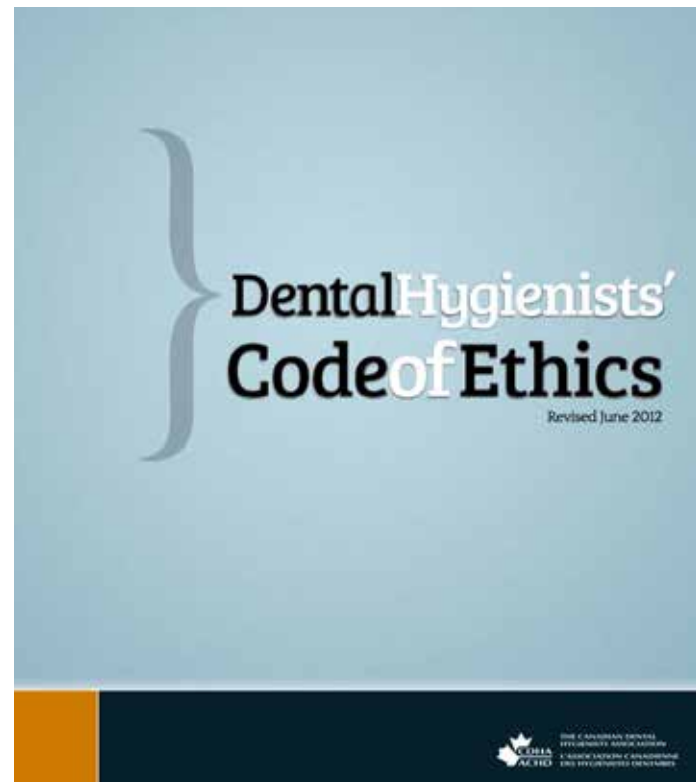
Regulated health care professionals use new information to meet the standards of the profession, support practice decisions, and fuel the search for excellence in client care. This issue of *Oh Canada!* provides the dental hygienist with a subject worthy of investigation: use of laser technology within the scope of dental hygiene practice in Canada.

The search for excellence in client care includes investigation of new treatment options and modalities. Ongoing inquiry allows the dental hygienist to gather and review evidence from relevant and credible resources and synthesize it for the client, enabling him or her to make an informed decision and provide informed consent.

Ethically speaking, the *CDHA Code of Ethics* (2012) articulates the knowledge, skill, professional attitude, and judgment expected of dental hygienists in Canada within the context of provincial laws and guidelines. Autonomy is the ethical principle that pertains to communicating information openly and truthfully to assist clients to make informed choices and to participate actively in achieving and maintaining optimal oral health (p 6).

Helping clients to participate in their care requires that they have current information about treatment modalities and options, which makes ongoing inquiry an important standard of practice for Canadian dental hygienists.

Canada's regulatory authorities have standards of practice that focus on advancing our profession and care to the public. In addition to knowledge and skill, dental hygienists exhibit a professional attitude and professional judgment by being critical thinkers who, according to the *Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists* (2010), are well informed, fair minded in evaluation, and diligent in seeking relevant information. In addition, dental hygienists are obligated to support conclusions based upon a variety of resources with sound rationales, critique literature findings to determine their value, and apply evidence-based decision-making approaches to the analysis of information and current practices.



Legally speaking, the dental hygienist is ultimately responsible to work within the published scope of practice, hold professional liability insurance, and maintain the standards of the profession regardless of the techniques used. It is therefore incumbent upon each dental hygienist to obtain the knowledge and skill to deliver optimal evidence-based care to the public.

According to the College of Dental Hygienists of Ontario (2010), it is not the instrument you use in your practice, but what you do with it, what procedure is performed, and whether or not you are competent in providing treatment using that particular instrument that matters.

As Robert Farinaccia, Manager of Practice Advice at the College of Dental Hygienists of Ontario, explains, "In Ontario a laser is not controlled under our health legislation. It is what you do with it that becomes important.

FEATURE

So a dental hygienist can use a laser within scope in Ontario as long as they do not enter into a procedure (act) that is not authorized to them. For example, they could not use the laser for gingival recontouring. They can use it for dental hygiene procedures such as debridement, and sanitizing pockets. As with any intervention, they must ensure that the treatment is evidence based and must ensure their competency before performing the intervention. Competency in using the laser because of its wide capabilities should be gained through participation in a formal course/training that has a hands-on component."

While this is the recommendation for Ontario dental hygienists, it is your responsibility as a regulated health professional to determine what regulatory requirements apply to this and other new technologies in your province of registration.

Practically speaking, your membership in the Canadian Dental Hygienists Association (CDHA) offers an abundance of support for your professional development. Of great benefit to ongoing inquiry and investigation are the online resources and access to information about online, formal higher education and informal, self-directed education.

A benefit I deem of great value is easy access to the Cochrane and Wiley Online Libraries. While there are costs associated with obtaining copies of full articles, abstracts and *Plain Language Summaries* are available at no charge.

Colleague and online research lecturer Sarah Rolheiser recommends accessing the Cochrane Library via the CDHA website (www.cdha.ca). She offers this information to the readers of *Oh Canada!*: "Scroll under 'The Profession,' select 'Research,' select 'Cochrane Corner' from the menu on the left of the screen, then select 'Cochrane Library,' located second link from the bottom of the page." This will take you to the library.

Your inquiry begins as simply as that, but your greatest value to the client comes when you synthesize the information and communicate it openly, truthfully, and sensitively in recognition of the client's needs, values, and capacity to understand (CDHA, 2012, p6).

Your inquiry can serve your professional development needs as well. Will you consider documenting your ongoing inquiry, continuing education, and critical self-reflection?

Will you choose a goal to identify and investigate new professional trends by accessing current, relevant, and credible sources of information? Will you use the information when you collaborate interprofessionally to educate other health care professionals or to defend or justify your treatment decisions?

Professionally speaking, applying new treatment modalities is not about staying within or stepping out of your comfort zone. Wouldn't you agree that it is about maintaining the professional standard of delivering optimal evidence-based care to clients who then have the information necessary to make an informed decision and provide you with informed consent?

Everyone wins when we engage in ongoing inquiry and professional development: the client and society, our colleagues, our profession, and ourselves. At least that's the way I see it.

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Talking Ethics



Interprofessional Collaboration and the *Circle of Care*; Ethically and legally speaking

by Kathleen Feres Patry RDH • kfp@rogers.com

The public expects their health care professionals to collaborate and put their interests first. For more than fifty years, Canadian dental hygienists have provided ethical care to their clients within a cooperative team-oriented framework. With the evolution of the profession and recognition by provincial governments to legislate self-regulation, dental hygienists are obligated to accept more responsibilities on behalf of the public.

The *Circle of Care* is an interactive model of interprofessional collaborative care that encourages a team-oriented approach that weighs heavily on the experience and expertise that each member brings to a specific situation through shared decision-making and problem solving (Cavoukian, 2009). It involves a variety of stakeholders in addition to the traditional dental and medical teams. A client's *Circle of Care* may include pharmacies, long-term care or residence organizations, community-care access centers (health, wellness & support networks) and ambulance services (Cavoukian, 2009). The document defines the way private health information is shared between the health care professionals who qualify to receive the information.

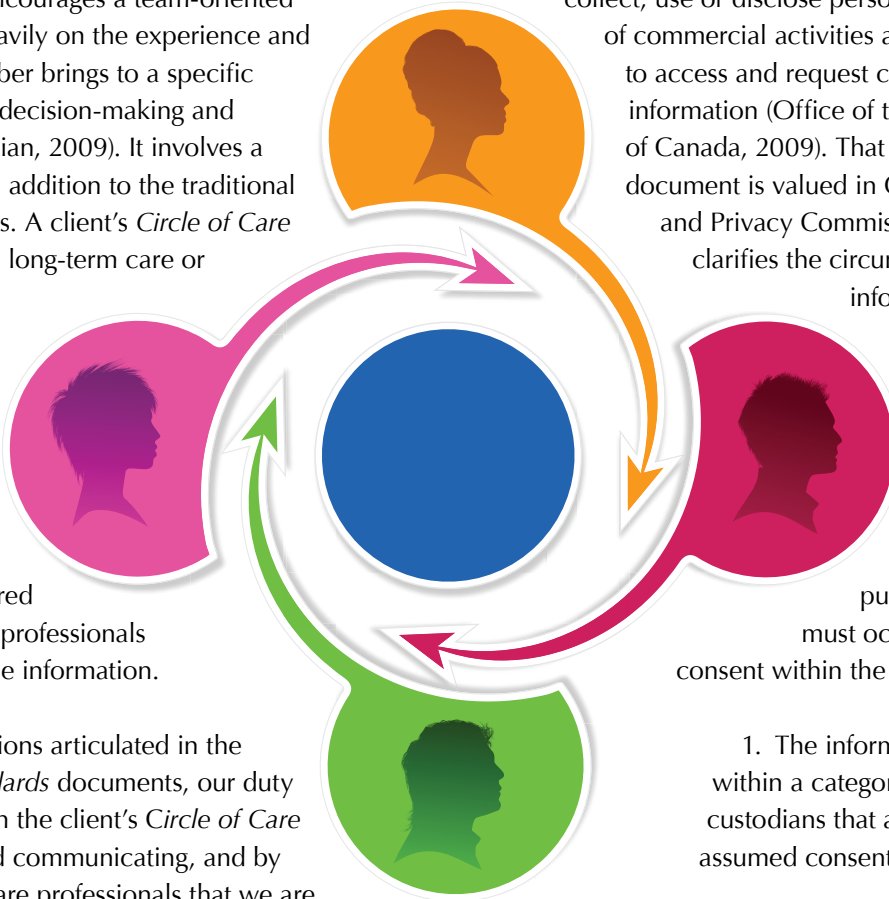
In addition to the obligations articulated in the *Code of Ethics* and *Standards* documents, our duty is to play an active role in the client's *Circle of Care* by treating, referring, and communicating, and by educating other health care professionals that we are preventive oral health specialists and an integral part of the client's *Circle of Care* (CDHO, 2011).

Ethically speaking, the CDHA principle of Confidentiality articulates the knowledge, skill, professional attitude and judgment expected from dental hygienists in Canada **within the context of Provincial laws and guidelines**. Confidentiality is the

duty to hold secret any information acquired in the professional relationship. Additionally, dental hygienists are required to demonstrate respect for the privacy of clients and hold in confidence information disclosed to them except in narrowly defined exceptions (CDHA, 2012).

Legally speaking, the federal legislation titled Personal Information Protection and Electronic Documents Act (*PIPEDA*) sets out ground rules for how private sector organizations may collect, use or disclose personal information in the course of commercial activities and gives individuals the right to access and request correction of the collected information (Office of the Privacy Commissioner of Canada, 2009). That is why the *Circle of Care* document is valued in Ontario; the Information and Privacy Commissioner Ontario, Canada clarifies the circumstances in which a health information custodian (custodian) may assume an individual's implied consent to collect, use, or disclose personal health information for the purpose of providing health care in specific circumstances. Simply put, these six circumstances must occur before assuming implied consent within the context of the *Circle of Care*:

1. The information custodian must fall within a category of health information custodians that are entitled to rely on assumed consent.
2. The health information must have been received from the individual or substitute decision-maker or other health information custodian.
3. The health information custodian must have received the information for the purpose of providing or assisting in the provision of health care to the individual. *Continued*



Talking Ethics cont'd

4. The purpose of the collection, use or disclosure of personal health information must be for provision of health care or assisting in health care of the individual.
5. The health information must be disclosed to another health information custodian,
6. The authorized recipient of the health information must not be aware that the individual has expressly withheld or withdrawn consent for the collection or disclosure of the health information (Cavoukian, 2009).

Additional caveats are that the health information must not be obtained through deception or coercion; it can be given by the individual client or his/her substitute decision-maker (Cavoukian, 2009).

Professionally speaking, what does a dental hygienist do next? What recommendations are there to advance the *Circle of Care* within our praxis? Lisa Taylor (2011) recommends that teaching institutions should make every effort to include interprofessional learning experiences aimed at socializing dental hygienists and other health professionals toward the healthcare delivery model that is being supported and encouraged by government (p 51).

The regulatory authorities have standards of practice that focus on advancing our profession and require that we improve the knowledge of our allied health care professionals. Dental hygienists have the responsibility to educate other health care professions about the dental hygiene scope of practice, areas of

knowledge and how they can work together to ensure the health of the client comes first. Will you contact a client's pharmacist instead of the medical doctor for health information within the *Circle of Care*? Will you choose to incorporate this as a goal in your professional development plan?

In your role as administrator, change agent, clinician, educator, health advocate and researcher, what professional steps, small or large, will you take to increase the awareness of our profession within the context of the *Circle of Care*?

I'd love to hear from you and will be glad to present your ideas and suggestions in the next edition of Oh Canada!.

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CDHA PARTNERS' CIRCLE

The CDHA Partners' Circle comprises dental industry firms dedicated to the advancement of the dental hygiene profession. Members of the CDHA Partners' Circle recognize the important role dental hygienists play in the overall oral health team. We are extremely proud to announce the members of the CDHA Partners' Circle for 2013.



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Talking Ethics



That's What Friends Are For?

by Victoria Leck, RDH, BHA • vleck@cdha.ca

One of your close friends is having difficulty completing her continuing competency requirements for her regulatory college. The deadline to submit proof of completion of professional development activities is looming. Your friend knows that you have successfully completed an online course that she is currently enrolled in but does not have the time to complete on her own. She asks you to sign into the exam under her ID and complete the exam for her. She promises to learn all of the material once her life circumstances change.

Ethical challenges appear in our personal and professional lives. They undoubtedly create tension between our allegiance to a friend and our professional responsibilities. Let's examine this scenario through the lens of the CDHA Code of Ethics.

PRINCIPLE: BENEFICENCE

"Beneficence involves caring about and acting to promote the good of another".¹ There is a danger in not reading beyond this point in the code. You might think that helping your friend is actually upholding the principle of beneficence, as you are doing a favour because you care about her. It is important to read the rest of the definition, however, which says, "Dental hygienists use their knowledge and skills to assist clients to achieve and maintain optimal oral health and overall wellbeing, and to promote fair and reasonable access to quality oral health services as an integral part of the healthcare system".¹ Beneficence refers to assisting clients. By taking the exam for your friend, you are enabling her to practice, contrary to the rules and regulations of our profession, not to mention allowing her to practice without the necessary skills and expertise required to provide optimal client care.

PRINCIPLE: INTEGRITY

By voicing her request, your friend has actually asked you to neglect your responsibility under this principle. Responsibility 6 under the principle of Integrity states that "Dental hygienists promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable".¹ Both you and your friend would be violating this principle.

PRINCIPLE: ACCOUNTABILITY

This principle clearly outlines the fact that, as professionals, dental hygienists are responsible for knowing the regulations under which they practice. Ignorance is not a defence. This principle also states under responsibility 6, that "dental hygienists inform their employers and/or appropriate regulatory authority of unethical practice by a colleague".¹ In fact, if you agree to take the examination for your friend, you will be equally guilty of unethical practice. A much better approach would be to discuss the Code of Ethics with your friend and determine how you might assist her in resolving her current situation.

Perhaps instead of agreeing to complete the examination on behalf of your friend, you might suggest working through "Appendix B: Guidelines for ethical decision making." This step-by-step process can assist you in coming to a satisfactory resolution. For example, you and she could set up a series of study sessions so that you can help her complete the course material. You could offer to work some shifts in her place or to take care of her children on a couple of Saturdays to free up some study time if that would be helpful. Regardless of the type of assistance you offer, by refusing to take the exam in her place, you will demonstrate ethical courage and can feel confident that you have upheld the principles in your professional code of ethics.

It is important to ensure that you are adhering to all five principles: Beneficence, Autonomy, Integrity, Accountability, and Confidentiality. Review the Code of Ethics on a regular basis and work through the ethical dilemmas or develop some of your own. Your decision not to take the examination on your friend's behalf may strain your relationship with her and will certainly take a little extra effort. Ultimately, however, you will be satisfied with the decisions that you have made. We all need somebody to lean on at different times in our life, so be a supportive colleague without regrets.

Reference

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Talking Ethics



Talking Ethics: Show Versus Tell

by Cindy Isaak-Ploegman, RDH, BA, MEd • cindy.isaak-ploegman@ad.umanitoba.ca

An article in a recent golfing magazine discussed how the game of golf teaches players life skills: cheating does not pay, how to follow the rules, self discipline, and managing life's hardships, triple-bogeys in this instance. (Miller, 2012). I am sure the same claim could be made for a variety of other sports. It makes me wonder, however, if teaching ethical behavior is that simple? Merely through participation, do learners absorb all these other values? This raises the question of how professionals learn ethical behaviour.

Is ethical behaviour taught to students through formal instruction or absorbed from instructors that role model professional behaviour. In a study of dental hygienists, 63% responded that their ethical principles were influenced by role models as opposed to formal ethical instruction. (Gaston, Brown, & Waring, 1990). Examples may be role modelling the virtues of lifelong learning as individuals or as a study group by keeping up with literature, (Daaleman, Kinghorn, Newton, & Meador, 2011), or avoiding prejudicial comments that lead to stereotyping. (Kopelman, 1999). It is sobering to realize that as dental hygienists in private practice, research or education we are all role modelling how to engage in ethical dental hygiene practice to others, students and colleagues alike.

Professionals look to good role models, but they also wish to be unique, to create their own niche in their profession, and to make individual decisions in complex situations rather than blindly follow another's example. For this reason, there is value in isolating ethical content and allowing students to discuss hypothetical scenarios, since it provides students with opportunities to vocalize their own values and beliefs and to discover that peers may not share the same opinions. (Jenson, 2005). It also provides instructors with the opportunity to highlight the CDHA Code of Ethics that guides decision making by licencing bodies when managing complaints from the public and other professionals. It prepares students for board exam content related to ethics, even though the result may not be an ethical graduate. (Jenson, 2005). Unfortunately, teaching professionals to avoid certain behaviours does not serve to inspire them to be what they ought to be. (Kopelman, 1999). From this perspective it seems role modelling is a more powerful vehicle since the implication is that a student's role model is someone the student wishes to emulate.

Historically, role modelling was a formal mode of dental education in apprenticeships. In the early 1900s young men, aged 10–12 years, sons of English country gentlemen, were apprenticed for a fee, for 5–7 years. (Bishop, Gibbons, & Gelbier, 2002). Social control was exercised over the apprentice's personal life since he was mandated to exclude behaviours inconsistent with Christian values such as fornication, card playing, drinking ale excessively, attending playhouses (Bishop, Gibbons, & Gelbier, 2002), lying, conniving, tale bearing and quarrelling. He was to maintain integrity, be frugal, industrious, and was given instructions on dealing with the opposite sex in courtship and marriage. (Barnard, 1740). These moral requirements extended throughout the professional's lifetime. (Bishop, Gibbons, & Gelbier, 2002). To modern professionals, these rules of conduct paint a controlling environment that would seem an intrusive mode of moral education. Today, serving students as a mentor has increased in popularity in dental education. It is advocated and encouraged as being beneficial for both mentors and mentees, and is a forum to address students' concerns and to provide advice. (Stenfors-Hayes, Lindgren, & Tranaeus, 2011).

Dental Hygienists'
Code of Ethics

Revised June 2012



The following quotation encapsulates the philosophy of role modelling,

“Each of us has the duty to take a personal interest in a student or several young budding dentists and become a one-on-one mentor and role model to each, so that the right way of life in the profession is indelibly imprinted in these fertile minds and hands of the future. Do not just tell them the way to success, show them!”

(Maitland, 2006, p. 309).

This quotation suggests that the “right way of life in the profession” is clear to all alumni and graduates alike, but we know from clinical practice that ethical choices of behaviour may not be clearly obvious. One suggestion to address this challenge, is to use popular mass media to relay ethical content. (Spike, 2008). The argument is that due to the unique method of exploring the ethical dilemma from all angles via the characters portrayed on television shows such as *Scrubs*, students are provided with a more thorough exposure to the repercussions of ethical choices made during treatment, or when communicating with their clients or third party sponsors. (Spike, 2008). The exhortation to medical students seems to be to watch more TV to become more ethically aware. (Spike, 2008).

We know that the formation of ethical professionals is the result of a process that develops over time. (Daaleman, Kinghorn, Newton, & Meador, 2011). Finding someone, whether it be a fictitious TV character or a real life mentor, to inspire us to be better professionals is as rewarding as a hole in one.

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Talking Ethics



CDHA Releases Revised Code of Ethics

by Judy Lux, MSW, RSW • jlux@cdha.ca

CDHA's Dental Hygienists' Code of Ethics, revised June 2012 is the cornerstone of dental hygienists' commitment to ethics. It sets down ethical principles and responsibilities for the dental hygiene profession. It also helps define accepted behaviours, promotes high standards of practice, provides a benchmark for members to use in self evaluation, and establishes a framework for professional behaviour and responsibilities. All CDHA members are required to understand and comply with the code and follow its guidelines in their practice.



Although the primary users of the Code of Ethics are CDHA members who are employed in a variety of practice settings, some dental hygiene regulatory authorities and provincial associations adopt the CDHA Code of Ethics as their provincial Code of Ethics. Dental hygienists are accountable to other codes of ethics/ethical guidelines including those of their provincial regulatory authority and of their work place.

The Code of Ethics has been updated to meet the needs of a changing environment and the important leadership role that dental hygienists play in their daily interactions with health professionals, clients, communities, governments and stakeholders. The newly revised document, which builds on improvements already made in previous versions, is part of an ongoing effort to ensure that dental hygienists in all settings conduct themselves in an ethical manner.

CDHA extends a heartfelt thank you to the following volunteer committee members who provided expertise, advice and guidance in the development of this document: Paula Benbow DipDH; Dr. Sandra Cobban DipDH, MDE, PhD; Mandy Hayre DipDH, BDSc, PID, MEd; Pauline Imai DipDH, BDSc, MSc; Nancy Johnston DipDH; Carol Kline DipDH, BSc, MA; Laura MacDonald DipDH, BScD(DH), MEd; Nancy Neish BA, DipDH, MEd; Laura Perri, DipDH; Harriet Rosenbaum, DipDH and Ann Wright, MBA.

The committee worked collaboratively with CDHA's consultants the Health Human Resources Group (Christine Da Prat, Dr. Mary Ellen Jeans, and Marg Risk), under the direction of Judy Lux, CDHA's manager health policy and advocacy.

Review of the Code of Ethics, Final Report describes the process for revising the Code of Ethics. It documents the approach and methods, literature review, key informant interviews, consultation with key stakeholders and CDHA members, and conclusion and recommendations. The purpose of codes of ethics was remarkably similar across all health professions. They included the following themes: guidance for members in ethical conduct in the practice of the profession; relationships with clients, peers, other health professional colleagues and the public; assurance to the public of a high standard of ethical conduct by members of the profession. Thank you to all of the CDHA members and stakeholders who provided input during the draft document consultation. Your input allowed this document to reflect numerous practice settings. The consultation results indicate well over 90% endorsed the document and did not have substantial changes. Only 24% had further comments, many of which were very positive, such as "easy to understand", and "concise".

CDHA has developed a knowledge translation (KT) plan to help members implement the Code of Ethics. To ensure that CDHA members fully understand the key aspects of the Code of Ethics, a section of this magazine, over the coming issues, will be devoted to educating dental hygienists in the implementation of the new Code of Ethics, using scenarios and case studies. This KT approach ensures that dental hygienists receive relevant content through real life examples and interactive exercises. It shows dental hygienists how to live the principles and responsibilities articulated in the Code of Ethics. It will also help dental hygienists understand and internalize the Code of Ethics. The series of articles will allow us to delve into topics such as workplace tension and conflict that arise in interprofessional collaboration, and to provide support for dealing with these situations. The articles will also elaborate on Appendix B, Guidelines for Ethical Decision Making. Please take a look at the first in the series of articles written by Beth Ryerse, RDH on page 27 of this issue. A session offered at the 2013 Educators' Workshop will also assist educators to teach students the revised Code of Ethics.

Talking Ethics



Honesty: Everyone's So Untrue

by Cindy Isaak-Ploegman, RDH, BA, MEd • cindy.isaak-ploegman@ad.umanitoba.ca

I once made a conscious thought to keep track of how many times I lied in one day. I included those times when I stretched the truth, and told what is commonly called “white lies”. The number was staggering.

The truth (pardon the pun) is that if we are honest with ourselves, we all lie and do so quite regularly. To reply “I’m fine” when someone asks “How are you?” just to avoid conversation, or fabricating details of an event are both misleading. However, we have a double standard: we expect others to be truthful to us. For example, there is an expectation that clients inform us if they are Hepatitis B or HIV carriers even if it means they may potentially be treated differently if only psychologically.¹

Lying, it seems, is justified if it is in the right context and not too severe. For instance, exaggerating stories of how our weekend went is considered acceptable, but false advertising is not. Forms of lying that cause professional colleges and/or courts of law to consider punitive measures include fraud, cheating, slander and libel, deliberately excluding information, or misrepresenting information.

Fraud is defined as making a deliberately deceptive claim to insurance companies for procedures never rendered in order to receive payment.² Other possibilities are claiming another code covered by an insurance company, breaking a global fee down to individual parts for more monies, mischaracterization of services, claiming unnecessary services, waiving co-payments from clients, and claiming unapproved services.² For dental hygienists, fraudulent documentation to register for licensure will result in censure by their licensing body³ as this constitutes lying about their qualifications to recertify.

Slander is spreading lies that cast doubt about a colleague’s reputation, health, chastity or participation in criminal activities and libel is publishing these lies.⁴ To avoid slanderous accusations against colleagues or other professionals, we should steer away from inappropriate comments about others and expressions of negativity and superiority.⁴ This helps prevent crossing the line to unprofessional conversation based on lies.

Code of Ethics 2012 Available

Check back next issue for a full report on the new Code of Ethics produced by CDHA. In the meantime, download the 2012 Code of Ethics

Cheating is misleading in that it implies students have acquired knowledge or clinical experience they in truth do not have, with the result of substandard care⁵. This is significant when research of dental hygiene students in American dental hygiene programs revealed that 86.5% admitted to cheating a minimum of one time in clinic or the classroom in their university career⁵ and 11.3% admitted to cheating in their dental hygiene program.⁶ Infractions included cheating on tests, allowing others to copy, altering grades, forging faculty signatures, violating infection control standards, falsifying vital signs, and copying previous charting as current findings.⁵ The statistics for Canada are similar with 51.7% dental hygiene students reporting unethical behavior by fellow students in clinic (cheating, breaching infection control, prejudice, breaching confidentiality, or fraud).⁷ The concern is if the problem of lying is rampant, will students stop lying after graduation?

Lying may also occur indirectly by not including information when presenting treatment options to clients or not informing them of concerns that arise during treatment, such as when an instrument tip accidentally breaks during periodontal debridement and is now embedded subgingivally.

Adequate informed consent to oral healthcare includes a proper standard of disclosure. This includes informing clients of material risks involved in the treatment, the client’s ability to understand the proposed treatment, and the implications to withholding or providing consent to perform

the healthcare procedures.⁸ Clients need not be made aware of mere possibilities unless they have grave consequences, as in paralysis or death.⁹ Excluding any of this information is deception.

The context of using placebos in healthcare research is also argued to be deceptive and may erode the integrity of the client-professional trust relationship, since transparency is required in offering choices in clinical services.¹⁰

Honesty it seems is still the best policy¹ when dental hygienists relate to governing bodies, relationships with colleagues, and client-provider relationships. We need to be self aware enough to scrutinize how truthful we are and make the appropriate changes.●

"The foundation of morality is to have done, once and for all, with lying." -Thomas Henry Huxley

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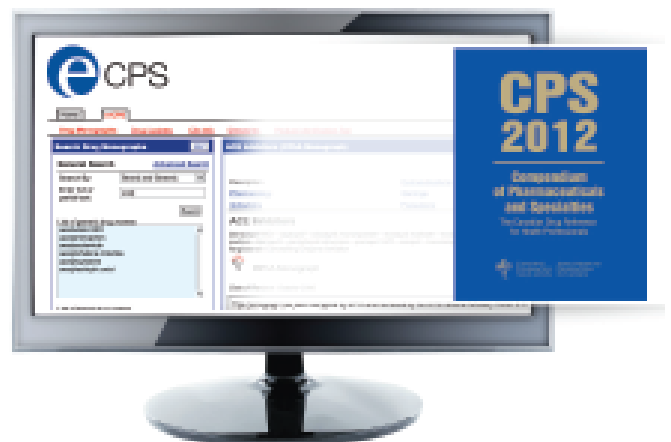
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Talking Ethics



CDHA Code of Ethics Review

by Judy Lux • jlux@cdha.ca

In 2002, CDHA developed a *Code of Ethics* that serves as a foundation for ethical practice in dental hygiene. This document sets down the ethical principles and ethical practice standards of the dental hygiene profession. Clients, colleagues, and the public expect dental hygienists to be guided by, and to be accountable under, the principles articulated in this *Code*. Although the primary users of the *Code of Ethics* are CDHA members who are employed in a variety of practice settings, some dental hygiene regulatory authorities and provincial associations adopt the CDHA *Code of Ethics* as their provincial *Code of Ethics*. Dental hygienists are accountable to other codes of ethics/ethical guidelines including those of their provincial regulatory authority and their work place.

CDHA revises its *Code of Ethics* periodically to ensure that it reflects changing societal values and conditions and the needs of dental hygienists in their practice settings. Since it has been ten years since the last *Code of Ethics* was written, CDHA struck a steering committee to assist with the revision of the *Code of Ethics*. The steering committee members are dental hygienists from across Canada, including: Paula Benbow (Ontario), Mandy Hayre (British Columbia), Pauline Imai (British Columbia), Nancy Johnston (Ontario), Carol Kline (British Columbia), Laura MacDonald (Manitoba), Nancy Neish (Nova Scotia), Laura Perri (Ontario), Harriett Rosenbaum (Manitoba), and Sandra Cobban (Alberta). These individuals were chosen to represent various dental hygiene practice settings, including: public health, university and college programs, independent practice, long term care, private dental practice and experience as board members of provincial dental hygiene associations and regulatory authorities and experience with dental industry. Their mission is to provide expertise, advice and guidance in the development of an updated and revised Code of Ethics for CDHA. CDHA hired the Health HR Group (Christine Da Prat, Mary Ellen Jeans, and Marg Risk) to conduct background research, collect information from key informant interviews, facilitate an in person meeting with the steering committee members that took place on February

1 and 2, 2012, and to consult with CDHA members and stakeholders to validate the revised Code of Ethics.

Member consultation was carried out in April and May with valuable feedback from hundreds of members. Your participation in the consultation process was important, and we appreciate that so many members took the opportunity to ensure that the revised *Code of Ethics* reflects the experiences in current practice settings. Watch our website, future issues of our e-newsletter and the July issue of this magazine for official launch of the new *Code of Ethics*.

