CDHO

COLLEGE OF DENTAL
HYGIENISTS OF ONTARIO

Registrants' Handbook

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PREFACE

The *CDHO Registrants' Handbook* is intended to be a practical resource for dental hygienists practising in the province of Ontario. Because the *Handbook* is a resource and not a textbook, it is dynamic in nature. Therefore, the *Handbook* is presented in a format that will allow changes and/or additions from time to time. The professional practice team at the College is dedicated to ensuring that the content of the *Handbook* remains current and relevant.

Within the *Handbook*, the CDHO registrant will find descriptions of scenarios not unlike those occurrences they may encounter in everyday practice. By working through the situations at their own pace, the reader can consider the possible courses of action and determine the desired outcome in a neutral setting. Registrants are encouraged to read and discuss the *Handbook* with their peers.

INTRODUCTION

This book deals with the professional obligations of a registered dental hygienist. For example, Chapter 1 deals with general principles of professionalism illustrating the three fundamental components of being a professional practitioner: competence, honesty and fairness. Chapter 4 deals with how dental hygienists balance confidentiality requirements with their duty to disclose information to others. Chapter 5 deals with how dental hygienists can obtain consent from clients. Chapter 7 deals with identifying and responding appropriately to conflicts of interest.

Each chapter begins with a "Need to Know" section that summarizes the key concepts of the topic. In addition, scenarios illustrate issues discussed in each chapter. The reader is asked to identify the principles that apply to the dilemma described in the scenario. Quizzes at the end of each chapter further emphasize the principles illustrated in the chapter. The answers set out after each quiz may also be used for further discussion. Resources for each chapter are found in Appendix 2.

The most common abbreviations in this book are as follows:

"CDHO" means the College of Dental Hygienists of Ontario.

"RHPA" means *Regulated Health Professions Act, 1991.*

Please keep in mind that this book does not provide legal advice. The application of the concepts described here will vary depending on the particular circumstances. Dental hygienists are encouraged to obtain their own legal advice whenever appropriate.

CHAPTER 1 — INTRODUCTION TO PROFESSIONALISM

NEED TO KNOW

1. Professionalism means being competent, honest and fair.
2. Professionalism forms the basis of the *Code of Ethics* and the formal legal definition of professional misconduct.
3. The challenge for dental hygienists is to balance competing interests appropriately.

WHAT IS PROFESSIONALISM?

Professionalism refers to the values of a profession that puts ethical and high-quality services before the self-interest of the registrant. **All codes of professionalism can be summarized in one phrase: "be competent, honest and fair".** Competence refers to providing high quality services each and every day. Alistair Cooke said "A professional is a man (sic) who can do his best at a time when he doesn't particularly feel like it." Honesty requires, of course, being truthful both in your statements and your omissions. Fairness refers to appropriately balancing competing interests.

Most professions have developed a sophisticated sense of how their registrants should act in recurring situations because ethical dilemmas tend to follow patterns. However, because each situation tends to have new twists, it is difficult to express a firm rule that applies to every circumstance. For that reason, while most professions have developed written codes of professionalism, true professionalism does not come from obeying rules. True professionalism is a mind-set that is guided by your training, experience and professional contacts (i.e., your socialization in the profession).

Nevertheless, written indicators of professionalism are important as a guide for practitioners and to provoke reflection.

THE *CODE OF ETHICS* VS. THE PROFESSIONAL MISCONDUCT REGULATION

Like most professions, dental hygienists have both a written *Code of Ethics* and a professional misconduct regulation under the *Dental Hygiene Act*. Why would the profession have both documents? Essentially, while covering many of the same topics, they have different perspectives.

The Code of Ethics sets out the ideals that dental hygienists should strive to achieve, focussing on the values needed to reach excellence. It uses words such as "commit", and "advance" to describe the goals of an ethical dental hygienist. The *Code of Ethics* sets out principles, or goals, that a "professional" dental hygienist will strive to achieve. It addresses three separate groups whose sometimes competing interests have to be balanced by dental hygienists: to the public, including clients, to herself or himself and to the profession.

The professional misconduct regulation, by contrast, sets out the minimum legal requirements that a dental hygienist must practise. Failure to meet this bare minimum can result in disciplinary proceedings by the College and legal liability for professional negligence. It uses words such as "shall" and "must" to describe a registered dental hygienist's responsibilities. Thus, the *Code of Ethics* and the regulation defining professional misconduct have different goals.

These different goals can be illustrated by looking at one of the principles found in the *Code of Ethics:* "Dental hygienists use their knowledge and skills to assist clients to achieve and maintain optimal oral health and to promote fair and reasonable access to quality care". This language does illustrate a commitment to actively focus on the welfare of the client over, say, the personal preferences of the dental hygienist. Even the use of the word "client" rather than "patient" (as is often used in the *Regulated Health Professions Act*) indicates the nature of the relationship is focused on the wellness model as opposed to a treatment model.

However, from the legal perspective of professional misconduct, the concept of "to promote fair and reasonable access" is a somewhat vague basis for a discipline hearing. Normally, the disciplinary function kicks in only when a dental hygienist's poor attitude moves from being impolite to being abusive. This aspect is captured in the following professional misconduct regulation:

7. Abusing a client verbally, physically, psychologically or emotionally. O. Reg. 382/08

Thus, it is possible to be impolite, which is unethical, and not engage in professional misconduct. The point at which rudeness transforms from simply unethical behaviour to professional misconduct, and thus will be subject to disciplinary sanction, is a fine line. However, ethical dental hygienists avoid ever having to test the limit by being professional at all times.

ASPECTS OF PROFESSIONALISM

There are three fundamental aspects defining a professional practitioner: (a) competence, (b) honesty, and (c) fairness.

Scenario 1-1 "Stretching the Limits of Competence"

You have worked in a restorative office for 18 years. The dentist has retired and the office has closed. After a long search, you have been hired by a dentist working in orthodontics. You have not done any orthodontics since school. You have been trained by another dental hygienist in the office. Your probationary period is coming to a close and your employing dentist has indicated that you will be getting your own case load now. You get the sense that the dentist is getting tired of "holding your hand" and is concerned that you are taking up too much of the other dental hygienist's time. On the first day by yourself you see a client on a follow-up visit who complains that the appliance is causing constant pain. Your assessment does not reveal any obvious tissue injury but you wonder about the possibility of internal trauma. What should you do?

(a) Competence

Competence is the basis of a number of separate principles within the *Code of Ethics.* For example, the *Code of Ethics* promotes continuing quality improvement.

Incompetence is also a distinct basis for discipline under the *Regulated Health Professions Act*. Subsection 52 (1) of the *Health Professions Procedural Code* (which is an appendix to that Act) states as follows:

> 52 (1) A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted.
> [*N.B. Many statutes use the word "patient" where dental hygienists would use "client".*]

Competence can be seen as having three components:

- appropriate **knowledge, skills and judgment**;
- an attitude towards the client's welfare and towards applying knowledge, skill and judgment; and
- a process of continuously **upgrading** knowledge, skills and judgment.

Knowledge, Skills and Judgment

All dental hygienists need to demonstrate appropriate **knowledge, skills and judgment** in order to be registered. The word "judgment" includes the concepts of problem solving and critical thinking. They need to successfully complete an approved educational program in dental hygiene and pass an examination that involves the application of knowledge and critical thinking. Thus, the foundation for competence is present in all dental hygienists. The question is whether that foundation is maintained and grows or whether it dissipates. The answer to that question depends on the other two components of competence: attitude and upgrading.

Attitude

Key to competence is **attitude**. The disciplinary definition of incompetence above identifies disregard of the welfare of the client as an attitude that affects competence. Knowing what needs to be done but declining to do so because of time pressures, personal problems or sheer laziness is disciplinable. The College's *Code of Ethics* identifies five key attitudes as being the foundation of ethical conduct:

- Beneficence
- Autonomy
- Respect for Privacy and Confidentiality
- Accountability
- Professionalism

It is rare for someone to be disciplined by a health college for a simple mistake. Slip-ups are almost always dealt with through other means (e.g., informal resolution). However, an ingrained unprofessional attitude that causes or aggravates errors can often be dealt with only through discipline.

Upgrading

The process of continuing quality improvement maintains and enhances competence. Traditionally, this was simply an ethical precept with no guidance or accountability. However, one of the innovative features of the *Regulated Health Professions Act* requires all health professionals to participate in a quality assurance program. Typically, these programs involve a process of professional self-reflection and self-learning as well as peer review. The College has developed a program to assist registrants with this component of competence. The Quality Assurance Committee of the College monitors and guides registrants in this exercise. A professional dental hygienist will welcome this initiative even if it is somewhat structured.

Scenario 1-2 "Sterilization Backlog"

You work in a large and very busy office. A dental assistant, Julia, who you consider a friend, is responsible for sterilizing the instruments. When you noticed a failed 'spore test' report lying on the counter you asked Julia about what the dentist had said about it. Julia looked embarrassed and said it was a blip and, please, not to mention it to the dentist (who has been a little hard on Julia). Since then you have noticed small signs of Julia's

disorganization in the sterilization area (e.g., the supply of sterilized instruments always seems to be low, the colour strip hasn't always changed, and the sterilizer often appears overloaded). You have tried to help out a bit but little seems to be changing. You have hesitated speaking with Julia because you are not her supervisor and you personally prefer to avoid confrontation. Today, at a staff meeting on Julia's day off, the dentist asks everyone for feedback for a performance review for Julia and says "Well she seems to be doing OK on the sterilization of instruments because we never seem to run out." What do you do?

(b) Honesty

Honesty can often be difficult. It can also be easy to rationalize away. In Scenario 1-2 "Sterilization Backlog", you could easily justify saying nothing on the following basis:

- You don't know for sure what has happened, you just have bits of information;
- There is no mandatory reporting requirement in this case (see the discussion in Chapter 2);
- You are not saying anything that is untrue;
- It is unfair to tell the dentist anything before mentioning it to Julia;
- It is defamatory to make those allegations and you could be sued; and
- No harm has occurred yet.

Besides, you might get into trouble for having not told the dentist about the failed spore test previously. However, saying nothing is not completely honest either. You are misleading the dentist by being silent, are preventing the office from taking appropriate steps to ensure appropriate infection control measures are in place and are failing to look after the best interests of your clients.

If you are concerned about the fairness of reporting inconclusive information, you could consider the following options:

- Making clear in your conversation with the dentist the inconclusive nature of the information you observed;
- Saying that you need to check some things out first before making a report to the dentist;
- Keeping silent for the moment, but determining to speak with Julia, conducting further investigation and then making a report to the dentist in a less open forum.

As this scenario illustrates, there is often more than one ethical and honest approach to dealing with difficult issues.

Billing issues are another common test of honesty. This includes inaccurately describing the service billed for or inappropriately describing the service so that it is covered by insurance. It is no justification to "stretch" things for the benefit of the client, even a client who is with limited funds. Professionalism never includes dishonesty. Billing issues will be discussed in more detail in Chapter 10 (Working for Others and for Yourself).

Scenario 1-3 "Rationing of Services"

You have a follow up dental hygiene visit with a client on social assistance. She tells you that yesterday the dentist said that a tooth with an infected, painful root has to come out. Welfare only covers an extraction and not a root canal. This will result in the client having three missing molars on this, the most dentate side of her mouth. You learn that the root canal option was not discussed. The client says to you, "I really hate to lose this tooth, now I won't be able to chew on either side of my mouth." You know from past conversations with the dentist that she, and the endodontist she refers clients to, have been burned quite a few times by clients who promise to pay over time. What do you do?

(c) Fairness

One of the most challenging aspects of being a professional is balancing competing interests particularly in the area of managed resources. Challenges in this area can occur in numerous contexts, from a direct pay client who has limited funds, to insurance limitations, to the social assistance client situation described in Scenario 1-3, "Rationing of Services". The issue is complicated by the fact that often the dental hygienist works for another practitioner who bears the heaviest financial consequences for these decisions. How can the dental hygienist put the client first and maintain professional standards in the context of externally managed resources?

The starting point in balancing competing interests is to understand your role. You have a fundamental obligation to the individual client. Even if others hire you, you cannot place their interests above that of the client. You must ensure that clients make fully informed decisions in respect of their care. You also have an obligation to advocate on behalf of the client. Your role is to maintain professional standards (here, permitting the client to make an informed treatment decision) even if it is unlikely that the person would choose another option. However, it is not your role to pay for the service or, with some exceptions, to provide services without prospect of payment. In Scenario 1-3, your role would be to advocate for the client's right to make a fully informed choice of treatment, but not to control the final decision that is made.

In a managed care environment where an insurer or other third party needs to approve the service before it will be paid for, it is important for dental hygienists to communicate thoroughly and clearly, particularly with the client. In Scenario 1-3, the dental hygienist knows that one option has not been explained and that the client might be interested in the option. The possible courses of action for the dental hygienist to address this situation include the following:

- Advising the dentist of the client's comment;
- Advising the client that there may be a way to save the tooth but that it would be very expensive;
- Researching whether there are any community or private services that might be available and advising the client of them;
- Clarifying with the dentist when the office might consider a payment-over-time arrangement and advocating for such an arrangement in certain cases; or
- Advising the client that there may be some offices that would provide root canal treatment with a payment-over-time option.

In considering which option to select, the dental hygienist should consider the client, the community (e.g., what resources are available) and the employer (e.g., some options may not be attractive to some dentists). The dental hygienist will also want to ensure that s/he is transparent in her or his dealings with the dentist as well as with the client.

Scenario 1-3 relates to a scenario where the dentist, not the dental hygienist, is actually providing the treatment. In that situation the dental hygienist would be providing information related to treatment and not participating in the procedure itself.

Where the dental hygienist is providing a service (even if in the employ of a dentist), s/he has an even higher obligation to manage the limitation of resources issues with the client. A distinction must be made between the time period *before* a treatment program starts and *after* a treatment program is in progress. Before the treatment program has started, the dental hygienist generally has no professional obligation to accept the client and initiate the treatment program (except in an emergency or some similar circumstance). If it is obvious that there are insufficient resources to complete the treatment program and that no benefit would be achieved by commencing it, the dental hygienist should not initiate treatment without some assurance that alternative resources are available.

Once the treatment has commenced, however, the dental hygienist has an obligation not to terminate it abruptly. Where the services are necessary, the dental hygienist must not discontinue them unless,

- the client requests the discontinuation;
- alternative services are arranged; or
- the client is given a reasonable opportunity to arrange alternative services.[1]

The length of "a reasonable opportunity" depends on the nature and frequency of treatment and the availability of services in the community. However, usually 10 to 30 days' notice would be appropriate. Even where the treatment is not necessary, the dental hygienist should make every effort to either arrange alternative services or give appropriate notice to the client.

Despite the absence of resources, the dental hygienist must ensure that standards of practice are met. A direction by a third-party payer that they will not pay for a reassessment or the making of records does not excuse the dental hygienist from performing those tasks. If certain appropriate treatment options are not funded, the dental hygienist must advise the client of the options available and permit the client to choose the desired option. For example, if a client has coverage for scaling only once every nine months and the client's condition requires scaling every four to six months, the dental hygienist must discuss the situation with the client. The client should know the recommended frequency of the treatment, the likely consequences of coming only every nine months, and make a choice as to whether to pay for more frequent visits. Simply treating to coverage, without discussion, regardless of the client's condition is not acceptable.

The dental hygienist must always beware of crossing the thin line between a third party restricting resources and a third party interfering with clinical decisions. This does not happen as often with private insurance which permits clients to pay for additional treatment on their own. However, it might occur for some government or

[1] *Professional Misconduct Regulation*, Ontario Regulation O. Reg. 382/08, paragraph 11.

community-funded programs. If there is a real attempt to interfere with clinical decisions, the dental hygienist can perhaps resolve the issue by educating the third party about the dental hygienist's professional role. If educational measures do not work, then the dental hygienist must professionally explain the options to the client. Of course, all of this must be done without making critical or demeaning comments about a third party to the client.

CONCLUSION

Professionalism requires a fundamental sense of how competence, honesty and fairness are to be balanced in the unique circumstances of a dental hygienist's practice. You are well advised to start with a review of the *Code of Ethics*, which sets out what dental hygienists strive to achieve. You would, of course, review the definition of professional misconduct as well, because it describes in legal language what you must do. When analyzing these two documents you will see certain themes emerge. "Professional" dental hygienists are competent, have appropriate knowledge, skills and judgment, possess an attitude focused on the client's welfare and commit to a process of continuous upgrading. "Professional" dental hygienists are scrupulously honest even when it might not be in their immediate interest to be so. Finally, "professional" dental hygienists are fair in the balancing of the competing and, sometimes, contradictory pressures impinging upon them.

The remainder of this book will further illustrate the principles of professionalism applied in specific situations.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 1-1 "Stretching the Limits of Competence", what should you do?**
    a. Get help from a colleague outside of the office.
    b. Get help from either the dentist or the dental hygienist who trained you.
    c. Being a professional means that you have sufficient ability to find the answer on your own. Besides, your employer has suggested that you be independent.
    d. Nothing. You are not entitled to diagnose clients.

2. **In Scenario 1-2 "Sterilization Backlog", to whom are you primarily accountable?**
    a. The clients.
    b. The dentist.
    c. Julia.
    d. Equally to the clients, the dentist and Julia.

3. **Which of the following best describes the differences between a *Code of Ethics* and a professional misconduct regulation:**
    a. Should Not vs. Must Not.
    b. Goals vs. Bare Minimum.
    c. Ideals vs. Law.
    d. All of the above.

4. **A client asks you not to record anything about her HIV positive status because the client's friend works as a dental assistant at your workplace and has access to the records. The dental assistant works primarily with supplies and chair-side assistance to the dentists and is unlikely to have professional contact with your client during your course of treatment. Should you:**
    a. Tell the client that anything s/he says will be recorded because of your duty of honesty.
    b. Tell the client that only relevant information will be recorded. This diagnosis is relevant and needs to be recorded.
    c. Tell the client that this diagnosis is relevant and needs to be recorded, but you will keep it separate from the chart.
    d. Say nothing but record the information.

5. **A client is on social assistance. It will only cover half an hour of dental hygiene services. The client needs at least two hours of dental hygiene services to address only the most pressing preventative needs. The employing dentist tells you to ensure that if you provide more than half an hour of service you must collect the money from the client up front. You should:**
    a. Discuss the treatment options with the client and if he wants more than half an hour of services, advocate with the dentist for alternative financial arrangements.
    b. Quietly refer the client to another office that will accommodate his needs with more financial flexibility.
    c. Provide the services that are needed and tell the dentist you had a professional obligation to do so.
    d. Report the dentist to the Royal College of Dental Surgeons of Ontario because refusing to provide a treatment unless one is paid first is professional misconduct on the dentist's part.

See answers to questions at Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 2 — REQUIREMENTS FOR DENTAL HYGIENISTS UNDER THE *REGULATED HEALTH PROFESSIONS ACT* AND OTHER RELATED STATUTES

NEED TO KNOW

1. The *Regulated Health Professions Act* and other legislation create obligations that dental hygienists need to be aware of.
2. Dental hygienists have a duty to cooperate with the College of Dental Hygienists of Ontario in investigations, inquiries and assessments.
3. Dental hygienists have an obligation to make a mandatory report to the proper authorities in circumstances where they become aware of serious concerns about the welfare of certain vulnerable individuals.

THE STRUCTURE OF THE *REGULATED HEALTH PROFESSIONS ACT*

Law comes from two main sources: case law and statutes. Case law, often called the "common law", is based upon decisions by the courts. For example, the case of *McInerney v. MacDonald* (1992), 93 D.L.R. (4th) 415, is a decision of the Supreme Court of Canada, which indicates that clients se about physicians and their clients, this law almost certainly extends to clients of dental hygienists. In this case, the same right is now set out in statute (PHIPA). generally have a right to look at and obtain a copy of their chart from their health practitioner. Although a ca

A "statute", often called an "act", is made by either the Federal or the Provincial legislature. There are a number of statutes that do not relate directly to the regulation of the profession, but which have implications for the practice of dental hygiene. The *Healing Arts Radiation Protection Act*, for example, affects dental hygienists who expose radiographs. You will find a selection of these statutes listed in Appendix 1.

The province also makes statutes directly affecting the practice of dental hygienists. Sometimes more than one statute is enacted to form a unified set of laws relating to one topic. The following legislation directly relates to how dental hygienists are regulated:

- The ***Regulated Health Professions Act***. This sets out the framework for the regulation of the entire health profession sector, such as the role of the Minister of Health and Long-Term Care.
- The ***Health Professions Procedural Code*** is an appendix, or schedule, to the *Regulated Health Professions Act*. It sets out the common duties and procedures for each of the 26 health colleges, including the College of Dental Hygienists of Ontario. For example, it specifies the responsibilities of the Council and the seven statutory committees of each College.
- The ***Dental Hygiene Act*** is a distinct statute. It deals specifically with issues pertaining to the regulation of dental hygienists.

Many statutes authorize the making of further law through **regulations** or **bylaws** without having to go to the legislature again. **Regulations** can be made under both the *Regulated Health Professions Act* and the *Dental Hygiene Act*. Those under the *Regulated Health Professions Act* are more general in nature, applying to all health professions while regulations under the *Dental Hygiene Act* specifically address the profession of dental hygiene including:

- The registration requirements;
- The examination requirements;
- The definition of professional misconduct;
- Setting out the quality assurance program;
- Specifying notice to the public of certain meetings and hearings; and
- Describing the advertising rules.

The College has also made **bylaws**. In general, they deal with internal administrative matters, such as elections to the College Council, composition of College committees, fees, the content of the register of registrants and the reporting of information by registrants to the College.

In addition to this legislation, the College has created a number of guidelines, policies and standards. Strictly speaking, these are not laws, but tools assisting registrants to comply with their legal and professional obligations.

DUTY OF THE COLLEGE UNDER THE *REGULATED HEALTH PROFESSIONS ACT* AND THE *DENTAL HYGIENE ACT*

Under the *Regulated Health Professions Act* and the *Dental Hygiene Act*, the College has the duty to regulate the dental hygiene profession. The goal of the College is to serve and protect the public interest. While the College does not exist to advance the interests of the dental hygiene profession, which is the role of professional associations such as the Ontario Dental Hygienists' Association, there is no doubt that a well-regulated profession preserves the profession's reputation and stature. Further, the College has a duty to act "fairly" when dealing with its registrants. Legal "fairness" means that before the College takes any action that might interfere with a dental hygienist's rights, such as making a finding of professional misconduct or imposing a fine or suspension, the College must notify the registrant of the concern and hear and consider the registrant's explanation.

The *Regulated Health Professions Act* and the *Dental Hygiene Act* establish the following mandatory regulatory activities:

- **Registration.** The College reviews the application of all those who wish to become registered as dental hygienists. If the College's published entry-to-practice criteria are met, the applicant will almost always be registered. If the College does not accept an applicant's qualifications, reasons for the decision must be given and the applicant must be provided with a right of review before the independent Health Professions Appeal and Review Board.[2]
- **Inquiries, Complaints and Report Committee (ICRC).** ICRC is an investigative body which deals with all matters relating to professional misconduct, including formal complaints and concerns about registrants that come to the attention of the College from other sources.

[2] The Board is appointed by the government and is made up of lay people. Depending on what the applicant requests, the Board will either conduct a paper review or conduct a full hearing (with witnesses) to assess whether the Registration Committee made a reasonable decision. If the Board believes that the Registration Committee made an unreasonable decision, it can make a number of orders including referring the matter back to the Registration Committee for reconsideration or even, in some cases, directing that the Registration Committee register the applicant. The Board also reviews decisions made by the ICRC respecting formal complaints. While the parties are entitled to attend in person at a complaints review, it does not involve fullhearings.

  - **Formal Complaints.** The College must operate a public complaints system. All complaints must be received and considered. The registrant must be notified of the complaint and be given an opportunity to respond in writing. If the complaint does not lead to formal action against the registrant, there is a right of review before the independent Health Professions Appeal and Review Board (HPARB). The Inquiries, Complaints and Reports Committee can refer allegations to the Discipline Committee for a hearing. The College has published a detailed description of the complaints process on its website.
  - **Investigations.** In addition to public complaints, the College has a duty to investigate concerns about registrants that arise from other sources such as other committees of the College or from mandatory reports (discussed below). If the concerns are serious and are supported by evidence, the ICRC can refer specified allegations to discipline.
- **Incapacity.** If there is a concern that a registrant has an illness that is likely to interfere with her or his professional judgment (e.g., certain chronic and severe mental illnesses, substance abuse) then the College can inquire into the matter. Should medical evidence substantiate a concern, the College will attempt to negotiate a treatment and monitoring plan with the registrant. If no agreement can be reached, a formal hearing, in private, is held before the Fitness to Practise Committee. The Committee can order, among other things, ongoing treatment and monitoring. A decision of the Fitness to Practise Committee can be appealed to the courts.
- **Discipline.** The Discipline Committee holds a formal discipline hearing. Any finding of misconduct or incompetence and any penalty ordered may be appealed to the courts.
- **Quality Assurance.** The College is required to establish and operate a quality assurance program for its registrants. Its goal is to encourage and assist registrants in being the best dental hygienists they can be. The program is non-punitive and participation is mandatory. Dental hygienists participate in the quality assurance program by keeping current quality assurance records that journal their practices, their learning goals and their continuing competency activities for each year. Every year at registration renewal, dental hygienists are required to report their compliance with the program to the College. The College provides registrants with information about the quality assurance program in the following documents: Policies and Procedures Manual; Overview of the Quality Assurance Program; Requirements of the Quality Assurance Program and Guidelines for Continuing Competency.
- **Patient Relations Program.** Another non-punitive program, Patient Relations, tries to provide resources, education, guidelines and tools for both dental hygienists and members of the public to support constructive, collaborative and non-exploitative interactions. Most of these resources are available on the College's website. While preventing sexual abuse of clients is a mandatory component of the Patient Relations Program, it is far from being its exclusive focus. The Patient Relations Program also exists to:
  - help the public achieve greater understanding of the range and quality of the professional services offered by registrants of the College;
  - help the public be fully informed of their rights in dealing with members of the profession and the College, including that they will be treated in an ethical, competent, sensitive and respectful manner;
  - help the public have a greater knowledge of the role of the regulatory College and how to participate in College processes and/or programs.

OVERVIEW OF THE OBLIGATIONS OF DENTAL HYGIENISTS UNDER THE *REGULATED HEALTH PROFESSIONS ACT*

Scenario 2-1 "Cooperation with the College"

A letter arrives from the College informing you of a complaint by a client who says you were rude to her. In fact, it was the other way around and you can barely contain your frustration at having to deal with yet another problem. You are already working 60-hour weeks. Another source of stress for you is that your mother can barely cope in her home and you, her only child in the city, are trying to persuade her to go to a retirement home. Six weeks go by and you receive a reminder letter from the College. On a visit to your family physician for a recurring cough, she diagnoses you with exhaustion and tells you to stop all work-related activity for a month. What do you do?

Set out below are the essential aspects of the regulatory system as set out in the *Regulated Health Professions Act*, which includes the *Health Professions Procedural Code*. These are the fundamental aspects of self-regulation that should be understood and applied by every dental hygienist.

(a) Controlled Acts

No one, including dental hygienists, is permitted to perform a controlled act without legal authority. Controlled acts are procedures that contain an inherent risk to them, such as scaling and root planing or restorative or orthodontic procedures. The issue of the legal authority to perform controlled acts is discussed in Chapter 3.

(b) Use of Title

To practise dental hygiene in the province of Ontario, a person must be registered with the CDHO. Only registrants of the CDHO can legally use the title "dental hygienist", or a variation or abbreviation thereof in this province.

The following are prescribed as classes of certificates of registration:

1. General.
2. Specialty. Only a registrant who holds a specialty certificate shall use the title "restorative dental hygienist", a variation or abbreviation or an equivalent in another language.
3. Non-practising. A dental hygienist cannot practise dental hygiene while holding a Non-Practising Class registration.

All dental hygienists registered with the College of Dental Hygienists of Ontario can use the title RDH which identifies them as a Registered Dental Hygienist. As noted above, the College has one recognized specialty category of registration. Registrants who hold a specialty certificate of registration can use the title RRDH. This title identifies them as Registered Restorative Dental Hygienists and reflects their expanded scope of practice.

Graduates of dental hygiene programs who are not yet registered in Ontario may not use title or an abbreviation of title within the province. An appropriate way to acknowledge their education would be to use the term "diploma dental hygiene" following their name. For example, Mary Smith, dip. D.H. acknowledges that Mary Smith holds a diploma in dental hygiene and would be acceptable for use on a business card or resume.

Dental hygienists are not permitted to use the title "doctor" or an abbreviation or variation of that title in the course of providing or offering to provide health care to individuals in Ontario. Even dental hygienists who have a doctoral degree cannot use that title in that context. Dental hygienists with a doctoral degree can use the title socially or in non-clinical contexts where they would not be taken to be offering to provide health care.

In addition, the professional misconduct regulation prohibits the inappropriate use of a term, title or designation in respect of a dental hygienist's practice. An inappropriate use would likely include:

- Using a false or misleading term such as "Medical Hygienist" when the person is not a physician; or
- Implying specialization or certification such as "Paediatric Dental Hygienist", since there is only one recognized specialty in dental hygiene, "restorative".

It is generally acceptable, however, to indicate that your practice is restricted to a particular area, such as children.

(c) Duty to Cooperate

All dental hygienists have an obligation to cooperate with the College in an investigation, inquiry or assessment conducted under the *Regulated Health Professions Act*. This duty can take many forms including:

- Responding to College communications in a timely manner;
- Providing access for College investigators or assessors to one's facilities and records;
- Not withholding, concealing or destroying documents or things relevant to an investigation or assessment;
- Attending for cautions directed by the ICRC or reprimands ordered by the Discipline Committee;
- Complying with a summons issued by a committee or an investigator appointed by the College;
- Providing required information to the College, including changes of information contained in the public register of the College (e.g., business address and telephone number);
- Fulfilling an undertaking or promise to the College;
- Practising within the restrictions placed on your certificate of registration.

Failing to cooperate with the College is, in itself, professional misconduct even if the behaviour initially being investigated is blameless. Cooperation with the College is part of the accountability expected of registered dental hygienists.

Dental hygienists cannot permit their obligations to their employer to interfere with their duty to cooperate with the College. For example, a dental hygienist cannot let an employer direct her or him to withhold the dental hygiene record from the College simply because it is mixed in with the employer's record. This issue is discussed more thoroughly in Chapter 10.

Dental hygienists also have a duty to cooperate with investigators appointed by other Colleges, such as the Royal College of Dental Surgeons of Ontario. Paragraph 50 of the professional misconduct regulation states:

> Failing to co-operate with an investigator of the College or another regulatory body, upon production by the investigator of his or her appointment under section 75 of the *Health*

Professions Procedural Code or to provide access to and copies of all records, documents, and things that may be reasonably required for the purposes of the investigation.

(d) Participating in the Quality Assurance Program

Dental hygienists are required to participate in the quality assurance program. This includes completing and returning, when requested, their Quality Assurance Records. It also requires cooperating with any peer review or practice review directed by the Quality Assurance Committee or any remediation that might flow from a review.

(e) Avoiding Sexual and Other Abuse

A major theme of the *Regulated Health Professions Act* is the eradication of sexual abuse of clients by registered health practitioners. Any sexual behaviour in the presence of a client, including making a coarse or sexually disrespectful comment, constitutes sexual abuse. See Chapter 8 for a detailed discussion of boundary issues. Also, as discussed below, there is an obligation to report sexual abuse by other registered health practitioners.

(f) Incapacity

A dental hygienist must not treat a client while impaired by any substance or illness. This means avoiding situations that can lead to trouble, such as booking client visits after a Christmas party luncheon where you might consume alcohol or skipping a dose of a necessary psychiatric medication. Special provisions exist to deal with situations where the illness itself so impairs judgment that one does not know one is incapacitated. Typically, this occurs with addiction to alcohol or drugs or with some severe and chronic mental illnesses that are not successfully managed with treatment. If those sorts of conditions are confirmed upon a full inquiry, which can include an independent medical or other examination, the College will usually require the dental hygienist to go through a course of treatment and monitoring to ensure client safety.

(g) Other

There are numerous other legal obligations set out in the legislation, particularly in the professional misconduct regulation. They include: competence (Chapter 1), honesty (Chapter 1), appropriate assignment of tasks and supervision (Chapter 3), respecting client confidentiality and privacy (Chapter 4), obtaining informed client consent (Chapter 5), recordkeeping (Chapter 6), appropriately managing conflicts of interest (Chapter 7), maintaining proper boundaries (Chapter 8), effective communication (Chapter 9) and mandatory reporting.

MANDATORY REPORTING

Scenario 2-2 "Sexual Abuse"

You have been working with your client, Maria, for some time and you and she have developed a good rapport. On one visit, Maria seems quite subdued. After your attempts at small talk don't work, you ask her what is wrong. Maria bursts into tears. After regaining her composure, she tells you that her family physician conducted an improper breast examination. She describes what occurred and it certainly sounds like an unusual breast examining technique to you. You know the identity of the physician from her file. What are your legal obligations?

A special duty under the *Regulated Health Professions Act*, and indeed other statutes, is to make mandatory reports to the proper authority when certain events occur. Significant consequences can occur when a mandatory report is not made. In some cases, you can be prosecuted and fined up to $25,000 in Provincial Offences Court. Generally, it is professional misconduct to fail to make a mandatory report. You can be sued for any harm that results. Some years ago, a physician was successfully sued for more than half a million dollars for failing to report a client who was unsafe to drive who then harmed someone in a motor vehicle accident.

A mandatory report is not a breach of confidentiality, even where your client does not want you to make the report. Your duty of confidentiality is subject to other requirements of law (see Chapter 4 for more details).

If it appears that one of these situations exists, you should obtain specific legal advice. Many of these mandatory reporting requirements have special or unusual features. For example:

- A report of sexual abuse under the *Regulated Health Professions Act* cannot include the identity of the client unless the client gives written consent to including his or her name.
- A report of sexual abuse under the *Regulated Health Professions Act* must be made within 30 days unless there are reasonable grounds to believe that additional abuse may occur, in which case the report must be made immediately.
- The definition of a child in need of protection under the *Child, Youth and Family Services Act, 2017* is quite lengthy and complex. For example, one part of the definition states: "The child requires treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide the treatment or access to the treatment, or, where the child is incapable of consenting to the treatment under the *Health Care Consent Act, 1996* and the parent is a substitute decision-maker for the child, the parent refuses or is unavailable or unable to consent to the treatment on the child's behalf." Obviously, there can be some debate as to the precise meaning of that definition. If in doubt, however, get advice.
- The duty to warn created by case law is not defined very clearly and permits some variation in interpretation.

Table of Common Mandatory Reporting Requirements by Dental Hygienists

#	Legislation / Legal Authority	What Must Be Reported	Trigger for Report	Authority Report Is Made to
1.	*Regulated Health Professions Act*	Sexual relations, touching, behaviour or remarks of a sexual nature between a registered health practitioner and a client where you know the name of the alleged abuser	Reasonable grounds obtained either: 1. in the course of practising your profession or 2. if you operate a health facility	Registrar of the College to which the alleged abuser belongs

2.	*Regulated Health Professions Act*	Professional misconduct, incompetence or incapacity of a registered health practitioner	1. You are terminating employment 2. You are revoking, suspending or imposing restrictions on privileges 3. You are dissolving a partnership or association or 4. You intended to terminate or revoke and the person quits first	Registrar of the College to which the health practitioner belongs
3.	*Child, Youth and Family Services Act, 2017*	That a child (under 16) is in need of protection as defined in the *Child, Youth and Family Services Act, 2017* (e.g., suffering abuse or neglect)	Reasonable grounds to suspect	Children's Aid Society (report must be personal, cannot delegate)
4.	*Long-Term Care Homes Act, 2007*	That a nursing home resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect	Reasonable grounds to suspect	Director of Nursing Homes
5.	Case law "duty to warn"[3]	That an identifiable person or group is at substantial risk of serious harm or death from another person	Reasonable grounds	To an appropriate authority and, possibly, the intended victim

Many of these mandatory reporting criteria refer to "reasonable grounds to believe". That phrase has two components:

1. "Reasonable grounds" refers to objective information, not personal belief. If the facts are present, a report must be made even though you might not believe the facts to be true. You do not have to make a detailed evaluation of whether the person providing the information is credible.
2. "Reasonable grounds" describe the type of information needed for a report to be made. Mere rumour or gossip does not constitute reasonable grounds (e.g., a dental assistant telling you over coffee that everyone knows Dr. Green sleeps with his clients). However, you do not need hard evidence or clear proof either. For example, information from someone who did not personally observe the event is fine so long as it contains some specifics.

[3] This case law duty to warn has been recognized in s. 40 of the *Personal Health Information Protection Act, 2004*.

Scenario 2-3 "Neglect of a Child's Oral Health"

You work in public health. On a school visit you see Laura, a child you also saw last year. Last year you reported to the parent(s) that Laura should be seen by a dentist to diagnose a suspected cavity. The parents have not followed up on this recommendation and the child is now presenting with an apparent abscess. What do you do?

For a report under the *Child, Youth and Family Services Act, 2017*, you only need reasonable grounds to "suspect", not to "believe". This means that the degree of information suggesting that a child is in need of protection can be quite low.

Probably one of the more frequent mandatory reports that dental hygienists will have to consider making is where they are treating a child. There may be bruising or lesions that appear inconsistent with usual childhood activities. It may be that the manner of interaction between the child and their parent or guardian raises concerns, particularly if it adds to comments made by the child. Alternatively, a dental hygienist may be able to detect signs of oral sexual activity during inspection of a child's mouth. Where these signs raise a reasonable suspicion that the child is in need of protection, a report must be made to the local children's aid society.

The duty of making a mandatory report lies with each practitioner who has the reasonable grounds (or, in the case of child abuse, reasonable suspicion). Thus, a dental hygienist cannot simply advise her or his employer and expect the employer to make the report. Nor can the dental hygienist let an employer dissuade the dental hygienist from making a report where grounds exist (even if the employer disagrees).

Turning now to another type of mandatory report, a dental hygienist who has office administration duties or works in public health or is a teacher may have to terminate an employee. A dental hygienist working with or for others may end an association with another registered health practitioner for professional misconduct, incompetence or incapacity. You would have to make a mandatory report to the Registrar of the relevant College, for example, if you quit your job simply because you could no longer tolerate a practitioner's drinking or repetitive rudeness to clients.

A report should either be made in writing or be confirmed in writing and should include:

- A **summary of the** concern. Be clear about your concern. Do not make the reader guess about why you are concerned, particularly if the matter is technical or clinical.
- Provide **details**. This will assist the recipient to respond appropriately. It may also reduce your subsequent involvement in answering obvious questions. It is usually acceptable to attach pertinent documents.
- Include a **list of witnesses** the authority may wish to contact. Remember, for reports of sexual abuse under the *Regulated Health Professions Act*, the identity of the client cannot be included unless s/he consents in writing to it being disclosed.
- If the subject of your report has provided any **response or explanation**, fairness would suggest that you mention it. This demonstrates your good faith in making the report. In addition, including the response helps everyone understand the complete situation right away. You are not taking sides by making a report, but rather, are providing important information to an authority that needs it.

- Outline any **action** that has been taken to date on the allegation. It is important for the authority to know, for example, that the person has been fired (and thus may be searching for a new job with someone who does not know of the underlying concern).
- Once the mandatory report is made, **the authority will first consider** if there is enough information to conduct a formal investigation. If there is any doubt, you will probably be contacted again. If a formal investigation is initiated, the investigator will focus on locating and interviewing firsthand witnesses of the actual events and obtaining documents that might bear on the allegations. Most authorities try not to reveal the name of the person making the mandatory report unless it is necessary to do so. However, it sometimes is necessary to disclose the reporter's name in order to properly investigate or prosecute the matter.

Should you conduct your own investigation if a mandatory report is going to be or has been made? Some worry that this could interfere with or even jeopardize the official investigation. There is no clear answer to this question, but you should consider the following factors:

- In every case, try not to disturb the evidence. Make sure that documents are not altered by your inquiries. Try to ensure that you do not affect a witness' recollection by asking leading questions or by interviewing a witness in the presence of another witness or person who may, by their mere presence, influence the answers (or be influenced by what the first witness said).
- Only make your own inquiries if you have an important reason for doing so. This might include ensuring that you have sufficient facts in order to make a report, to ascertain whether anyone is at immediate risk, or for necessary internal disciplinary action.
- If it is reasonably possible, wait until the authorities have completed their inquiries.

If you make a mandatory report you have some legal protection from retaliation. For example, you cannot be successfully sued for making a mandatory report unless you acted in bad faith. Making a false report in order to get someone into trouble would be an illustration of bad faith. Some statutes provide additional protection as well. The *Regulated Health Professions Act,* for example, protects reporters from retaliation in their employment or their contract to provide services.[4]

Even where the criteria for making a mandatory report is not present, courts tend to offer similar protections for voluntary reports made to an appropriate authority in good faith. For instance, if you learned at a social event about a health practitioner having sexual relations with a client, a report is not mandatory (see table above). However, you might feel compelled to report the matter in order to protect the public and you could expect legal protection for reporting in good faith.

CONCLUSION

For reasons of public protection, the *Regulated Health Professions Act* and other laws specify obligations that registered dental hygienists must follow. For example, to protect vulnerable individuals, dental hygienists sometimes have to report when the individual has or might be exploited. For those who are unaware of their professional responsibilities, failure to comply could result in legal consequences. Dental hygienists need to learn and understand how these laws apply to their professional practice. In an effort to guide dental hygienists,

[4] Section 92.1 of the *Health Professions Procedural Code*.

the following chapters examine the complexities of legal issues in more detail and their application to dental hygiene practice.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 2-1 "Cooperation with the College" above, what should you do?**
    a. Follow doctor's orders and do not respond to the complaint.
    b. Call or write the College explaining the situation and requesting an extension.
    c. Write a brief response because you must cooperate with the College.
    d. Call the client, apologize, explain your condition and ask her to withdraw the complaint.

2. **In Scenario 2-2 "Sexual Abuse", what do you do?**
    a. Report the physician to the Registrar of the College of Physicians and Surgeons of Ontario with all the details including the client file.
    b. If you get the client's written consent, report the physician to the Registrar of the College of Physicians and Surgeons of Ontario.
    c. Report the physician to the Registrar of the College of Physicians and Surgeons of Ontario without the client's identity unless you have the client's written consent.
    d. Report the physician to the Registrar of the College of Dental Hygienists of Ontario.

3. **In Scenario 2-3 "Neglect of a Child's Oral Health", should you:**
    a. Repeat your recommendation in stronger language.
    b. Ask the child's teacher to follow up to ensure that the child receives treatment.
    c. Follow up directly with the child's parents.
    d. Report the matter to the local children's aid society as this is neglect.

4. **You have reasonable grounds to suspect that a 19-year-old mentally challenged potential client desperately needs dental hygiene care (the oral condition is quite bad). The person is clearly incapable of consenting. You have discussed the situation with the parents. The parents won't act because of their fragile financial circumstances and tell you to "drop" the matter. Should you:**
    a. Report the matter to the Public Guardian and Trustee's office (who looks after the affairs of incapable persons) under the common law (case law) duty of care.
    b. Report the matter to the Children's Aid Society under the *Child, Youth and Family Services Act, 2017*.
    c. Contact the family physician to try to talk some sense into the parents since you have implied consent to discuss the case with the client's health care team.
    d. Search for another substitute decision maker.

5. You have a private practice serving nursing home clients. You have reasonable grounds to believe that a resident of a nursing home is being physically abused by a health-care aide. The resident is mentally capable but fearfully denies any suggestion that someone might be hurting her. You understand that you must make a mandatory report under the *Long-Term Care Homes Act*, 2007. Should you advise the resident that you are making the report?

    a. Yes, the *Long-Term Care Homes Act, 2007* requires it.
    b. No, the *Long-Term Care Homes Act, 2007* prohibits it.
    c. No, it might interfere with the investigation.
    d. While not required to do so, it is a good idea.

See answers to questions at Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 3 — SCOPE OF PRACTICE, CONTROLLED ACTS, DELEGATION AND ORDERS

NEED TO KNOW

1. Controlled acts cannot be performed without proper legal authority.
2. Dental hygienists who act outside of their scope of practice can be prosecuted for performing dangerous acts, even if they are not controlled acts.
3. Other statutes, employers and the standards of practice of the profession may impose additional limitations on a dental hygienist's ability to provide certain services.

SCOPE OF PRACTICE AND THE HARM CLAUSE

Scenario 3-1 "Stomatologist Using Topical Anaesthetic"

A client's wife, Michelle, tells you about an experience suffered by her late husband, Jorge. Jorge had a serious heart condition. He saw what Michelle calls a "stomatologist" from their country of origin for preventive oral hygiene care. During the procedure the stomatologist used a topical anaesthetic gel to ease discomfort that you know to be highly concentrated for professional use only. You cannot tell precisely what procedure was being performed: it appears not to have involved scaling, but rather an aggressive form of flossing. The stomatologist sent some of the topical anaesthetic home with Jorge for use for the gum pain. Within six hours Jorge had a heart attack and died. Did the "stomatologist" do anything illegal? Does it matter whether the "stomatologist" is a registered dental hygienist or not?

Each profession under the *Regulated Health Professions Act* has a scope of practice statement that describes in broad terms what that profession does. For dental hygienists, the statement is set out in the *Dental Hygiene Act* and reads as follows:

> The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services.

There is no exclusivity to this statement. People who are not registered dental hygienists can provide these services unless they contravene a provision of the *Regulated Health Professions Act* or the *Dental Hygiene Act*. The primary purpose of the scope of practice statement is to educate dental hygienists and the public as to the focus of the dental hygiene profession. For example, while the College can regulate certain aspects of a dental hygienist's private life, such as dishonesty or exploitation, the College's interest lies mainly in actions performed within the scope of practice. The College uses the scope of practice statement, for example, to define parameters for developing standards of practice.

Dental hygienists should be aware that when they are acting outside of their scope of practice, they are not practising dental hygiene. They are practising something else and should not call it dental hygiene. For instance, a dental hygienist who offers weight reduction counselling is not practising dental hygiene.

The most significant legal implication of the scope of practice statement is its impact on the "Harm Clause" (Section 30 of the *Regulated Health Professions Act)* prohibiting any individual from engaging in high-risk treatment practices:

> Treatment, etc., where risk of harm
>
> 30. (1) No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

Breach of this provision is an offence. In the "Stomatologist Using Topical Anaesthetic" example in Scenario 3-1, there obviously was a reasonably foreseeable risk of serious physical harm because of Jorge's heart condition. If the stomatologist was not a registered dental hygienist (or dentist), s/he could likely be prosecuted under the "Harm Clause". If the stomatologist were a registered dental hygienist, s/he could not be prosecuted under the harm clause because the treatment was within the scope of practice. However, as noted below, the stomatologist might still be prosecuted under some other provisions.

RESTRICTIONS ON A DENTAL HYGIENIST'S ABILITY TO PRACTISE

In addition to the "Harm Clause", there are a number of other restrictions on a dental hygienist's ability to perform certain kinds of assessments or provide certain kinds of treatment:

- Dental hygienists cannot perform **controlled acts** without legal authority.
- Other **statutes** may restrict a dental hygienist's ability to do certain things.
- The dental hygienist's **employer or facility** may impose certain reasonable restrictions, not inconsistent with the legislation, on the procedures that a dental hygienist may perform.
- The College requires that dental hygienists maintain generally accepted **standards of practice**. Some standards of practice limit what dental hygienists can do in certain circumstances.

A dental hygienist must ensure that no restrictions apply before initiating dental hygiene interventions.

CONTROLLED ACTS

Scenario 3-2 "Chipped Tooth"

A dental hygienist's client arrives to her 4:00 p.m. recare appointment with her seven-year-old son. She asks the dental hygienist to look at his primary tooth that has a very small incisal chip from a recent fall. His mother asks the dental hygienist to smooth it out so it won't look so bad in his school photo. The dental hygienist takes a handpiece and smooths the edges of the chip. Has the dental hygienist broken the law?

Controlled acts are health care actions which are considered potentially harmful if performed by unqualified persons. The controlled act system is intended to permit all practitioners to provide a broad range of services, and to permit professions to develop without unnecessary barriers. Previously, each profession had a rigid scope of practice that no one else could perform. The *Regulated Health Professions Act* replaced that system with a list of the most harmful procedures and leaving as much of health care as possible in the "public domain".

There are fourteen controlled acts set out in the *Regulated Health Professions Act* (See table below). All dental hygienists should be aware of them as no person may perform a controlled act unless they have legal authority to do so.

Dental hygienists have been authorized to perform three controlled acts:

1. Scaling teeth and root planing including curetting surrounding tissue.
2. Orthodontic and restorative procedures.
3. Prescribing, dispensing, or selling a drug designated in the regulations.

For a dental hygienist to perform any other controlled act, s/he must either obtain the authority from someone else (e.g., receive a delegation from, say, a physician) or one of the established exceptions must apply.

If a procedure is not a controlled act, it is said to be in the public domain, meaning that anyone can do it. However, it would be subject to the "Harm Clause" and other applicable restrictions described in this chapter.

The Fourteen Controlled Acts Under the *Regulated Health Professions Act*

(1)	**Communicating** to the individual or his or her personal representative a **diagnosis** identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
(2)	Performing a procedure on tissue **below the dermis**, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
(3)	Setting or casting a **fracture** of a bone or a **dislocation** of a joint.
(4)	Moving the **joints of the spine** beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
(5)	Administering a **substance by injection or inhalation**.
(6)	Putting an **instrument, hand or finger**, i. beyond the external ear canal, ii. beyond the point in the nasal passages where they normally narrow, iii. beyond the larynx, iv. beyond the opening of the urethra, v. beyond the *labia majora*, vi. beyond the anal verge, or vii. into an artificial opening into the body.
(7)	Applying or ordering the application of a **form of energy** prescribed by the regulations under this Act.
(8)	Prescribing, dispensing, selling or compounding a **drug** as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
(9)	Prescribing or dispensing, for **vision or eye problems**, subnormal vision devices, contact lenses or eyeglasses other than simple magnifiers.

(10)	Prescribing a **hearing aid** for a hearing-impaired person.
(11)	Fitting or dispensing a **dental prosthesis**, orthodontic or periodontal **appliance** or a **device** used inside the mouth to protect teeth from abnormal functioning.
(12)	Managing **labour** or conducting the **delivery of a baby**.
(13)	**Allergy challenge testing** of a kind in which a positive result of the test is a significant allergic response.
(14)	**Treating, by means of psychotherapy technique**, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

The first controlled act, **communicating a diagnosis**, does not stop dental hygienists from formulating a diagnosis but prevents them from communicating it to clients in certain circumstances. Nor does it prevent a dental hygienist from communicating the results of an assessment, so long as this does not amount to communicating a formal diagnosis.

The scope of practice statement for dental hygienists makes it clear that they can assess and treat clients. Indeed, given their obligation to obtain an informed consent from clients, dental hygienists must be able to assess and clearly tell their clients about assessment results so long as they do not communicate a formal diagnosis. Communicating a formal diagnosis has the following characteristics:

- It is a communication to a client or a client's representative.
- It is a formal, medical label of a disease, disorder or dysfunction. Describing or giving proper names to symptoms such as temporomandibular joint pain is not a diagnosis. Similarly, using the terms gingivitis and/or periodontitis is not stating a diagnosis as these terms simply indicate the presence of inflammation in and around the gingival and periodontal tissues. These diagnostic labels tend to be orthodox, traditional western medicine.
- The medical label is a conclusion. A list of possible conditions under consideration is not usually considered a diagnosis.
- The medical label is not one that has been previously given to the client. Repeating a diagnosis previously given to a client is permitted. Even expanding upon the nature and implications of a previously given diagnosis is permissible.
- There must be a reasonable expectation that the client will be relying upon the communication to make health decisions.

Telling a client that tooth 3-5 is non-vital and that s/he should see an endodontist is communicating a diagnosis. Conversely, telling a client that your assessment indicates a number of symptoms suggesting that there is something going on around tooth 3-5 and advising them to see a dentist to rule out a serious condition like a non-vital tooth is not communicating a diagnosis. Advising a client that s/he appears to have a "cavity" is conveying a symptom rather than a diagnosis, but the College would expect such a statement to always be combined with a strong recommendation that the client see a dentist.

Test results are not usually the same as a diagnosis. For example, telling a client a radiograph shows a dark patch on tooth 3-5 is not communicating a diagnosis. Invariably, questions are asked about the meaning of the result, which a dental hygienist often cannot answer without giving a diagnosis. It is prudent, therefore, to be cautious about releasing a test result to a client who is not already aware of his or her condition. In addition, some laboratory tests are almost diagnostic in themselves (e.g., oral pathology or cytology) and should not be communicated to clients who have not previously been advised of their diagnosis.

The second controlled act, performing a **procedure below the surface of the skin or in or below the surfaces of teeth** would include most restorative procedures. However, the CDHO does not believe that it includes most teeth whitening procedures which do not really enter tooth surfaces. However, administering a glucometer test appears to involve the pricking of the skin and thus, constitutes a controlled act. In any event, a dental hygienist administering a glucose test in an unlicensed facility would likely be contrary to the *Laboratory and Specimen Collection Centre Licensing Act* (discussed below).

The fifth controlled act, administrating a substance by **injection or inhalation** would include administering nitrous oxide and oxygen. In accordance with the *Regulated Health Professions Act 1991*, (RHPA) dental hygienists are not authorized to administer nitrous oxide and oxygen by inhalation, or monitor clients receiving nitrous oxide and oxygen for conscious sedation.

Dental hygienists may perform dental hygiene interventions on clients receiving nitrous oxide and oxygen if the following conditions are present:

- Informed consent is obtained before the client is sedated.
- Nitrous oxide and oxygen has been administered and is being monitored by an appropriately trained dentist who is a member of the RCDSO or an appropriately trained registered nurse or respiratory therapist under the order of an appropriately trained dentist.
- If a registered nurse or respiratory therapist is administering or monitoring the nitrous oxide and oxygen delivery, the appropriately trained dentist must be present in the office suite and immediately available for emergency.
- Clients must be monitored by the appropriate professional mentioned above by direct and continuous clinical observation for level of conscious sedation and assessment of vital signs.
- The healthcare professional that is monitoring the client must be present in the treatment room/ operatory at all times and the dental hygienist is never left alone with the client while the client is receiving nitrous oxide and oxygen.

The sixth controlled act relates to **entering openings into the body**. An attempt has been made to give anatomical precision to the provision. However, it would be very rare for a dental hygienist to enter any of the described body openings.

The seventh controlled act, applying a **prescribed form of energy,** refers to electricity, electromagnetic energy, sound waves and light. It does not refer to radiographs that are dealt with under the *Healing Arts Radiations Protection Act* (which will be discussed below).

The eighth controlled act, **prescribing, dispensing, selling or compounding a drug** covers many over the counter or publicly available substances.

Prescribing is a privilege available to dental hygienists who have demonstrated the appropriate skill, knowledge and judgment by successfully passing the Drugs in Dental Hygiene Practice Examination (DDHPE). A dental hygienist must follow the principles outlined in the document titled Recommending, Prescribing, Dispensing, Selling and Using Drugs in Practice when issuing a prescription to ensure that a client is given a safe and effective drug regimen.

Dental hygienists are authorized to perform the controlled act of prescribing, dispensing, or selling a drug, but only those drugs that are designated in regulations (i.e., chlorhexidine and its salts when used as a topical oral preparation and/or fluoride and its salts). Dental hygienists are not authorized to compound.

Dental hygienists must ask themselves three questions before acting in this area:

1. Is it a drug?;
2. Is a prescription required?; and
3. Am I authorized to prescribe, dispense, or sell?

The word "drug" is given a very broad meaning under the *Drug and Pharmacies Regulation Act*.[5] It is not restricted to prescription drugs but is defined as follows:

> "drug" means any substance or preparation containing any substance,
>
> (a) manufactured, sold or represented for use in,
> (i) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical or mental state or the symptoms thereof, in humans, animals or fowl, or
> (ii) restoring, correcting or modifying functions in humans, animals or fowl,
> (b) referred to in Schedule C, D, E, F, G or N,
> (c) listed in a publication named by the regulations, or
> (d) named in the regulations, but does not include,
> (e) any substance or preparation referred to in clause (a), (b) or (c) manufactured, offered for sale or sold as, or as part of, a food, drink or cosmetic,
> (f) any proprietary medicine as defined from time to time by the regulations made under the *Food and Drugs Act* (Canada) that does not contain any substance or preparation containing any substance referred to in Schedule C, D, E, F, G or N,
> (g) a substance or preparation named in Schedule A or B.

A general guide is that if the substance has a *drug identification number* (DIN), it is a drug; but that test is not infallible.

Even if the substance is a drug, there is a difference between recommending and prescribing it. Recommending is advising a client about a drug, such as over-the-counter pain relief, that they can obtain on their own and explaining how it might be of assistance to them. Prescribing means authorizing the dispensing of a drug, usually with specific doses and frequency, to a client who would not normally be able to obtain it on his or her own.

[5] *Drug and Pharmacies Regulation Act*: Section 117.

Applying a topical anaesthetic to assist in performing a procedure is not prescribing. In fact, pharmacists are expressly permitted to sell drugs to dental hygienists that they need for administration in the course of their practice.[6]

The eleventh controlled act relates to fitting or dispensing a **dental prosthesis**, orthodontic or periodontal **appliance** or a **device** used inside the mouth to protect teeth from abnormal functioning. It is to enable the performance of this controlled act that dental hygienists are authorized to perform orthodontic procedures where there has been an 'order' by a dentist.

The use of a high-speed handpiece is not, in and of itself, a controlled act. It depends on what you do with it. Removal of bonding material does not involve a procedure in the surface of a tooth and is not a controlled act.

In addition to the fourteen controlled acts, section 32 of the *Regulated Health Professions Act* also prohibits the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device unless the technical aspects are supervised by a dentist or a dental technologist (or by a denturist for the denturist's own clients).

EXCEPTIONS TO THE CONTROLLED ACTS

There are a number of exceptions to the rules that permit people to perform controlled acts in certain circumstances:

- Any controlled act can be performed during an **emergency**. This would include applying a defibrillator where someone appears to be having a heart attack, using an EpiPen in an allergic response, or administering oxygen during an emergency.
- Assisting a person with his or her "**routine activities of living**" may involve administering a substance by injection or inhalation or performing an internal act.[7] For example, a dental hygienist on a home visit could assist a client with their regular insulin injection.
- Treating a member of your **own household** can properly involve communicating a diagnosis, administering a substance by injection or inhalation or performing an internal act.
- **Students** training for a profession that has controlled acts can do them under the supervision of a registrant. For example, dental hygiene students can scale teeth or perform restorative or orthodontic procedures in the course of their studies under the supervision of a dental hygiene instructor. However, students could not moonlight and perform controlled acts for, say, a summer or part-time job. As another example, dental hygiene students cannot practise the controlled acts under the supervision of a dentist, whether this occurs in a dental office or a dental hygiene school.

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[6] *Drug and Pharmacies Regulation Act*, ss. 118(3) which reads as follows:

> Nothing in this Part prevents any person from selling, to a member of the College of Chiropodists of Ontario, the College of Dental Hygienists of Ontario, the College of Midwives of Ontario or the College of Optometrists of Ontario, a drug that the member may use in the course of engaging in the practice of his or her profession.

[7] i.e., Putting an instrument, hand or finger,

i. beyond the external ear canal,
ii. beyond the point in the nasal passages where they normally narrow,
iii. beyond the larynx,
iv. beyond the opening of the urethra,
v. beyond the *labia majora*,
vi. beyond the anal verge, or
vii. into an artificial opening into the body.

- Spiritual or **religious healing** can involve the performance of a controlled act if it is a tenet of the religion.
- **Aboriginal healers** can provide traditional healing services.

DELEGATION, ORDERS AND ASSIGNMENT

Accepting Delegation

Dental hygienists can perform controlled acts delegated by registrants of the professions authorized to perform those controlled acts. For example, a physician may authorize a dental hygienist to dispense a drug such as an antibiotic. The healthcare professional considering providing a delegation must check with their regulatory college for the conditions under which they may delegate. For instance, the delegation can be made specifically for a client whose treatment has been discussed with the physician. Conversely, a medical directive (sometimes called a standing order) is a form of authorization that is not restricted to a specific client and usually sets criteria as to when it can be relied upon.

Providing Delegation

In Dental Hygiene, delegation of the controlled act of scaling and root planing, including the curetting of surrounding tissue, is only to be used for the purpose of assisting graduates from a Dental Hygiene program to practise clinical skills for CDHO clinical evaluation. Educators who are registrants of the CDHO and who meet the following criteria are permitted to delegate.

- The delegation takes place within the clinical facilities as part of a clinical competency evaluation preparatory course within a dental hygiene school accredited by the Commission on Dental Accreditation of Canada (CDAC).
- The delegator is either a full or part time member of the faculty in which the delegation occurs, or in another accredited dental hygiene program and is currently teaching and evaluating student clinical experience.
- The delegation is part of a structured program acceptable to the CDHO.
- The delegation is to facilitate applicants who require clinical practice prior to the clinical competency evaluation.
- The applicant has completed all other requirements for registration with the CDHO.
- The delegator personally reviews the client's medical history and the treatment plan developed by the applicant.
- The delegator supervises the treatment in a manner consistent with all of the circumstances, evaluates the outcomes and provides feedback to the applicant.
- Record keeping is in line with the CDHO Records Regulation.

Delegators are responsible to ensure that none of the specified contraindications are present before or during the procedure and that the delegation complies with accepted standards of practice.

There is significant confusion about the differences between delegation, orders and assignments (see table). In delegation, the person delegating the procedure is accountable for the decision to delegate. Furthermore, both the person delegating and the person receiving the delegation are responsible for its performance. Accordingly, it is reasonable for the delegating practitioner to set certain criteria for the performance of the controlled act and to monitor its performance. That is the major distinction between a delegation and an order. If an 'order' is

given, the ordering practitioner is not generally responsible for its actual performance. The major exception is where the person giving the 'order' is the employer of the person receiving the 'order', but that is because of the principles of employment law, not because of the *Regulated Health Professions Act*.

A dental hygienist does not need a delegation to perform the controlled acts authorized to the profession. However, dental hygienists who provide orthodontic and restorative procedures do require an 'order' to perform these controlled acts. An 'order' can specify certain reasonable pre-conditions for its performance (e.g., that there has been no significant change to the client's medical condition since a specific 'order' was issued). An 'order' can be specific (for one client) or for a group of clients. An 'order' can be in writing or it can be verbal. Some Colleges have standards of practice for their registrants who give 'orders' (e.g., the College of Physician and Surgeons of Ontario state that a physician should be familiar with the procedures s/he orders).

In every circumstance prior to initiating the controlled act, dental hygienists must refer to the Contraindications Regulation and consult with a medical/dental professional if appropriate.

An assignment is a direction by a health practitioner to another person to perform a public domain procedure (e.g., applying fluoride). Health practitioners operating an office or facility may set some rules or criteria for the performance of public domain procedures in his or her capacity as a manager or an employer. Managers can set these rules or criteria even though the assignees could perform the procedure without restriction outside of the office or facility. However, these directions must be reasonable and consistent with the legislation; a manager or employer cannot impose a restriction that is contrary to the professional standards of the employee. For example, a dentist cannot require that before a dental hygienist performs certain preventive procedures on a client with a cardiac condition that s/he need not administer antibiotic. See Chapter 10 for more detail.

Table: Comparing Delegation, 'Order' and Assignment

Term	Acts it Applies to	Authorizer Co-Accountable for Performance?	Example
Delegation	Controlled acts	Yes	Physician delegates the dispensing of antibiotic to a client with a cardiac condition
'Order'	1. Controlled acts where recipient authorized to perform only with an 'order' 2. Public domain acts where other legislation or facility rules require an 'order'	No, unless person giving 'order' is employer of person performing	1. Restorative or orthodontic procedure, scaling and root planing 2. In hospital, physician orders physiotherapy
Assignment	Public domain acts that are part of the authorizer's practice	Yes, as the act is a part of the authorizer's practice	Dental hygienist asks assistant to help a new client fill out a medical history

OTHER STATUTES

Acts other than the *Regulated Health Professions Act* can also restrict the practice of a dental hygienist.

For example, the *Healing Arts Radiation Protection Act* sets out detailed rules as to who can prescribe and who can expose x-rays. It also establishes rules about the equipment that can be used, their operation, safety measures that must be followed and the inspection of the equipment. These rules are independent of the *Regulated Health Professions Act*, which does not deal with ionizing radiation.

The *Patient Restraint Minimization Act* applies to both public and private hospitals. It prevents the use of any sort of restraint on the freedom of a client unless:

- It enhances freedom;
- It prevents harm; or
- Immediate action is necessary.

Many forms of restraint would not be controlled acts. The Act might be expanded in future to include long-term care facilities. In any event, the principles of that Act can be applied by dental hygienists working in long term care facilities even if the statute is not directly applicable there.

The *Criminal Code* of Canada has a number of provisions that would apply to dental hygienists engaging in dangerous or dishonest activities. For example, criminal negligence would apply to some dangerous actions or omissions. Federal drug legislation such as the *Controlled Drugs and Substances Act* also applies to dental hygienists.

EMPLOYER OR FACILITY RESTRICTIONS

Employment contracts may contain some restrictions in the practice of a dental hygienist. For example, an office may confine itself to paediatric or geriatric care. Similarly, an employer may choose to refer certain types of cases (e.g., orthodontics) out of the office even though you might wish to treat them. Even if the dental hygienist is authorized to perform the acts, the contract might apply unless it would involve a breach of professional standards, is unreasonable or is inconsistent with the legislation. See Chapter 10 for a more detailed discussion of this issue.

Similarly, facilities have the right to impose limitations on what a visiting practitioner does. A nursing home could, for example, require an authorization from a Director of Nursing before a client may receive preventive oral health care on the premises. As long as a dental hygienist is associated with the facility or wishes to use their premises, appropriate restrictions should be honoured unless there are concerns about a breach of professional standards or legislation.

However, it should be noted that legislation covering long-term care facilities does not require physicians to give orders for dental hygiene care. In such cases, limitations are imposed by facility policy, not statute. Failure to comply with a valid contractual term or facility rule can constitute grounds for termination without notice or compensation.

STANDARDS OF PRACTICE

Being legally authorized to perform a procedure does not mean that it is always within the accepted standard of the profession to do it. If the standard of practice dictates that a certain step should not be taken in a particular circumstance, then disregarding the standard can result in disciplinary action and civil liability to pay for any resulting damages.

Standards of practice refer to the shared understanding of what is proper within a profession. These standards need not be in writing. However, general principles are usually written down. You may want to consult College publications, respected textbooks and periodical literature for current information about standards of practice.

The College has published a substantial standard of practice document that applies to all contexts. These standards are intended to guide the professional judgment and actions of dental hygienists and inspire self-reflection and continuous professional development. They reflect the CDHO mission to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario. The Dental Hygiene Standards of Practice contain practice parameters and standards which should be considered by all registrants in the care of their clients and in the practice of the profession. College publications are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Changes to standards of practice are part of the normal growth of a profession. The *Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists* (January 2010) have been accepted by the regulatory authorities of all 10 provinces. This is a significant accomplishment and a huge step toward a consistent approach for dental hygiene education and practice across Canada.

The new standards are more reflective of how dental hygienists are practising now, and also establish the importance of inter-professional collaboration and evidence-based practice in all practice settings.

The CDHO was a key participant in the development of the national competencies and standards and used these to develop new CDHO *Standards of Practice*.

In addition, the College has published specific standards of practice, guidelines and best practice documents that relate to particular matters such as dental waste management, educators, delegation and self-initiation. These are available from the College website under the Standards and Resources tab. If in doubt about your actions in any situation despite any published standards or discussion with your colleagues, ask yourself: Would the vast majority of right-thinking registrants of the profession think that this action was appropriate? If the answer is no, then do not do it.

CONCLUSION

The system of controlled acts is fundamental to the health regulatory system and the ideals of public protection in Ontario. It applies to everyone, even lay persons, because all are forbidden to perform controlled acts without being authorized to do so. Every dental hygienist must be aware of the complex issues involving the interpretation of controlled acts in relation to dental hygiene. This understanding is critical because dental

hygienists want to be able to provide the full range of professional services that their clients need and deserve in a legally appropriate manner.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 3-1 "Stomatologist Using Topical Anaesthetic", assuming that the stomatologist is not a registered dental hygienist, the stomatologist has probably broken the following law:**
    a. The Harm Clause under the Regulated Health Professions Act.
    b. The criminal negligence portion of the *Criminal Code* of Canada.
    c. Dispensing and selling a drug, which is a controlled act under the *Regulated Health Professions Act*.
    d. All of the above.

2. **Assume in Scenario 3-1 "Stomatologist Using Topical Anaesthetic", that the stomatologist said: "I don't accept the diagnosis of dentists" and did a full assessment. Following the assessment, the stomatologist said to Jorge: "You have some 'plaque' that can be managed by preventive means". Jorge then agreed to the aggressive flossing treatment. Did the stomatologist perform the first controlled act relating to diagnosis?**
    a. Yes, the client relied on the communication for making treatment decisions.
    b. Yes, the stomatologist identified plaque as the diagnosis.
    c. No, because plaque is not a disease or disorder.
    d. No, because the stomatologist did not identify a specific cause of the condition, but simply recommended treatment.

3. **In Scenario 3-2 "Chipped Tooth", did you just break the law?**
    a. Yes, it involved a procedure in the surface of the tooth.
    b. No, it was an emergency.
    c. Yes, it involved putting an instrument into an opening into the body.
    d. No, it was a primary tooth and so no permanent harm could be done.

4. **An elderly client is having severe chest pain. She cannot stop shaking long enough to put a nitro glycerine pill under her tongue. Can you help her take the pill?**
    a. Yes this is an emergency.
    b. Yes, this is a routine activity of daily living.
    c. Yes, you are not dispensing a drug, just administering it.
    d. No, this is dispensing a drug.

5. A dental hygienist could inject insulin into a client where:
    a. The dental hygienist creates a religion where that is a tenet in faith healing.
    b. The dental hygienist is aboriginal.
    c. The client receives regular injections every day but requires assistance.
    d. The client's dentist gives an 'order' for it.

6. A dental hygiene student would like to practise scaling on some of her former co-workers at the dental office she used to work in as a dental assistant. Her former employer has agreed to allow her to practise her clinical skills as long as she is not billing for her services. Under what circumstances is this allowed?
    a. The student can practise her clinical skills with client consent.
    b. The student can practise her clinical skills with an order from the dentist.
    c. The student cannot practise her clinical skills in this scenario.
    d. The student can only practise her clinical skills once she has graduated from the program.

See answers to questions at Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 4 — CONFIDENTIALITY AND PRIVACY OBLIGATIONS

NEED TO KNOW

1. All client information is confidential.
2. Disclosure of client information is normally made only with client consent.
3. There are some legal provisions and obligations that permit or require dental hygienists to disclose client information without consent.

DUTY OF CONFIDENTIALITY

Scenario 4-1 "Curling Team"

Inspired by the movie, Men with Brooms, you are organizing a women's curling team to compete against your husband's team. You recall a former client of yours who spoke about enjoying curling when she was a youth up north. You look up her telephone number in the closed records file drawer. You are about to give her a call when you hesitate because you recall the staff at a hospital getting into trouble for looking up former Prime Minister, Brian Mulroney's file. Is this the same thing?

One of the highest obligations required of dental hygienists is to maintain the confidentiality of client information. Without confidentiality, clients will not be forthcoming and trust their health care providers with the very private and personal information that is necessary for their care. As a result, revealing confidential information about a client is viewed as unethical, professional misconduct and could result in a lawsuit for damages. The difficulty is not so much with the general concept of confidentiality, but rather applying the duty in difficult circumstances. What information is confidential? When is there consent to disclose? When is it legally possible or required to disclose confidential information without consent?

The definition of professional misconduct that requires confidentiality is worded as follows:

> 24. Giving information about a client to a person without the consent of the client or his or her authorized representative except as required or permitted by law.
> O.Reg 382/08

In addition, the *Personal Health Information Protection Act, 2004* requires that all personal health information about a client be kept confidential unless one of the exceptions listed in that Act apply.

The starting point for considering the duty of confidentiality is that **all information provided by the client is confidential**. This includes non-medical information such as addresses and telephone numbers and social information provided during informal conversations with the client during treatment (e.g., a client may reveal information during a visit about an impending divorce). Even the fact that the person is your client is confidential information.

The notion that certain client information is confidential and that other client information is not, will lead to difficulties. Confidential information could inadvertently be disclosed because a dental hygienist may think that it was not considered confidential by the client. Therefore, all client information obtained through a

professional relationship is considered confidential and authority to disclose it must be acquired from somewhere, if only by implied consent.

This confidentiality obligation places a duty on dental hygienists to be **clear about their role**. For example, when speaking with a client at a social function, a dental hygienist must be aware that the client might be considering the conversation as being covered by the duty of confidentiality even though it is not a professional encounter. Even in that context, the dental hygienist should be sure that the client consents or that there is some other legal authority before disclosing such information.

The case of *Shulman v. College of Physicians and Surgeons of Ontario* (1980), 29 O.R. (2d) 40 (Div.Ct.), illustrates the breadth of the duty of confidentiality. Dr. Shulman wrote for a Toronto newspaper. He received an anonymous brown paper envelope containing a client file revealing a blood transfusion error in a hospital that had resulted in the death of a client. Dr. Shulman wrote about the incident identifying the hospital and the client. Even though Dr. Shulman had no involvement in the care of the client and even though the client was now deceased, Dr. Shulman was disciplined for breach of confidentiality.

The duty of confidentiality **applies to client information in any form**. Disclosing client information verbally is no different from doing so in writing or electronically. Consent or other authority is always needed for disclosure.

In addition to the misconduct definition under the *Dental Hygiene Act*, the primary duty of privacy comes from the *Personal Health Information Protection Act, 2004*. That statute attempts to provide a comprehensive set of rules about maintaining privacy of personal health information. As discussed below, it requires that all health information custodians (e.g., a dental hygienist) appoint a privacy officer (called a "contact person"), have a written information practices document, follow appropriate consent procedures and have appropriate measures to safeguard personal health information.

An implication that flows from this duty of confidentiality is that dental hygienists should **only request client information that they reasonably need** to perform their job. While dental hygienists should not be fearful in collecting needed information and, even if in doubt, ask the questions that might be needed to meet professional standards, the gratuitous collecting of information is to be discouraged.

PRIVACY AND ACCESS LEGISLATION

Privacy is a broader concept than confidentiality. Confidentiality focuses on the practitioner's duty to keep client information secret. Privacy deals not only with confidentiality, but also with the client's right to control all aspects of their personal information.

Privacy and access legislation has been a feature of the public sector for decades. However, in the last few years, such legislation is expanding into the private sector. For example, the federal government enacted the *Personal Information Protection and Electronic Documents Act* in 2000. It applies to all commercial activities since January 1, 2004. On November 1, 2004, the Ontario government enacted the *Personal Health Information Protection Act, 2004* which applies to the collection, use and disclosure of personal health information. The Ontario statute has been designated as substantially similar to the federal one. This means health information custodians need only comply with the Ontario statute in respect of personal health

information collected, used or disclosed in Ontario. Therefore, dental hygienists must comply with both statutes, one for personal health information and one for other personal information (e.g., financial information). In any event, the two statutes are very similar in approach.

The federal *Personal Information Protection and Electronic Documents Act* is somewhat general in its approach. It requires practitioners to develop a *Privacy and Access Code* describing how the practitioner collects, uses and discloses personal information. The *Privacy and Access Code* must adhere to ten principles set out in the Act. There is flexibility in how to achieve the intent of the ten principles. However, failing to reasonably achieve them will leave the practitioner open to investigation and sanction by the federal Information and Privacy Commissioner. Ontario's *Personal Health Information Protection Act, 2004* follows the same ten principles. However, the Ontario statute provides more detailed rules on how the ten principles should be applied to the handling of personal health information.

The *Personal Health Information Protection Act, 2004* has clarified a number of ambiguities that existed under the federal Act. For example, the *Personal Health Information Protection Act, 2004* specifies that the duties of the "contact person" (privacy officer) include the following:

- facilitate compliance with the Act by the custodian (i.e., dental hygienist or organization, such as a dental office);
- educate the agents of the custodian;
- respond to public inquiries about the custodian's information practices;
- oversee access and correction requests by clients;
- handle privacy complaints; and
- make available to the public the custodian's written information practices.

Table: The Ten Principles for Privacy of Personal Information

Principle No. 1 – Accountability • e.g., appointment of a designated information officer is required.
Principle No. 2 – Identify purposes for collecting information • Any use, other than for assessment and treatment of the client, needs to be recorded (e.g., promotional mailings, sale of information, looking up phone number for curling club recruitment).
Principle No. 3 – Consent • Consent will be required for most collection, use or disclosure of information. • The exceptions to consent are listed in the Act and should also be referenced in the organization's privacy policy.
Principle No. 4 – Limit collection to what is necessary for identified purposes, by fair and lawful means • You have to consider what information is necessary for proper service and what information is going too far (e.g., financial information).

Principle No. 5 – Limit use, disclosure and retention of information to original purpose unless further consent obtained or law requires information to be destroyed after purpose fulfilled • The College retention guidelines might be a good place to start in setting out your organization's retention rules. • Use of file for obtaining family history of other clients in the same family may need consent of the first family member.
Principle No. 6 – Accuracy • Probably an existing standard of practice.
Principle No. 7 – Safeguards • Health information is relatively sensitive, so higher level of safeguards is needed. • e.g., files must be in secure area when not in use. • e.g., special safeguards are required when transmitting client information over the Internet. • Clients have the right to be told of any breach of privacy involving their personal health information.
Principle No. 8 – Openness • Need written information policies and procedures. • Need to publish those policies, at least to clients and potential clients.
Principle No. 9 – Individual access to personal information about them • Will have to give access of their files to clients. • Grounds for refusing to provide access to a client is expanded somewhat under the *Personal Health Information Protection Act, 2004*. • Duty to correct erroneous information at the client's request.
Principle No. 10 – Challenging Compliance • Need a process to handle complaints about the information handling practices of the organization. • May be subject to the Information and Privacy Commissioner's investigations of particular cases or general information handling practices.

INFORMATION CUSTODIANS WHO ARE NOT HEALTH CARE PROFESSIONALS

There are times when a dental hygienist may work for an employer who is not a health care professional. Examples of this might be a dental hygienist working in a clinic that is not owned by a health care practitioner, a dental hygienist working at a spa or providing mouthguards for a professional sports team. PHIPA allows for custodians (i.e., a dental hygienist) to authorize an "agent" to maintain the health information records on her/his behalf. In all cases the dental hygienist who assigns an "agent" to manage client records is still responsible for the protection of the personal health information under PHIPA.

There are different circumstances in which a change may take place in the practice of an Information Custodian (e.g. death or retirement). The Information Custodian must have appropriate channels in place to ensure that the transfer of any records does not compromise a client's privacy or access to their records. The following paragraphs are taken from the Office of the Information and Privacy Commissioner of Ontario's guideline titled: *Avoiding Abandoned Health Records: Guidance for Health Information Custodians Changing Practice*.

DEATH OF AN INFORMATION CUSTODIAN

If a custodian dies, the *Personal Health Information Protection Act, 2004* deems the estate trustee of the deceased custodian, or if there is no estate trustee, the person who assumed responsibility for the administration of the deceased custodian's estate, to be the custodian for the records until custody or control passes to another person who is legally authorized to hold them. As a result, the estate trustee or the person who assumes responsibility for the administration of the estate, must comply with the duties and obligations imposed on custodians under PHIPA.

RETIREMENT OF AN INFORMATION CUSTODIAN

If a custodian transfers records of personal health information to a successor in accordance with the requirements of the *Personal Health Information Protection Act, 2004*, the successor becomes the custodian with custody or control of the records of personal health information. For example, where a dental hygienist retires and transfers the records to another dental hygienist, the latter becomes the custodian of the records. This transfer principle would also be applicable if the dental hygienist was to sell his/her practice to another dental hygienist.

If a custodian closes their clinic completely, they may absolve themselves of responsibility for records by transferring them to the Archives of Ontario, or to a prescribed person whose functions include the collection and preservation of records of historical or archival importance. If the archive is not acting as an agent, then this is the only circumstance where a transfer of records may be to a person who is not a custodian as defined under PHIPA.

DUTY TO NOTIFY

The custodian must make reasonable efforts to give proper notice to the individuals to whom the personal health information relates before transferring the records. If it is not possible to give notice beforehand, then notice must be given as soon as possible after the transfer of the record.

CIRCLE OF CARE PROVISION

The term "circle of care" is commonly used in health care to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances described in PHIPA. For example, when a dental hygienist contacts a physician to get medical advice on treating a mutual client who is undergoing chemotherapy, that discussion will fall under the circle of care provision.

1. The health information custodian must fall within a category of health information custodians that are entitled to rely on assumed implied consent.
2. The personal health information to be collected, used or disclosed by the health information custodian must have been received from the individual, his or her substitute decision-maker or another health information custodian.
3. The health information custodian must have received the personal health information that is being collected, used or disclosed for the purpose of providing or assisting in the provision of health care to the individual.

4. The purpose of the collection, use or disclosure of personal health information by the health information custodian must be for the provision of health care or assisting in the provision of health care to the individual.
5. In the context of disclosure, the disclosure of personal health information by the health information custodian must be to another health information custodian.
6. The health information custodian who receives the personal information must not be aware that the individual has expressly withheld or withdrawn his or her consent to the collection, use or disclosure.

All of these six conditions must be satisfied before a dental hygienist may assume that an individual's implied consent to collect, use or disclose personal health information can be reliably discussed within the circle of care.

SAFEGUARDING PRIVACY IN A MOBILE WORKPLACE

When you travel with a client's personal health information, whether it be in paper or electronic format, you are accountable for the safety and security of the document. Personally identifiable health information on your electronic devices pose additional challenges. When you walk out the door with client information on your laptop, USB, PDA or cell phone, the information contained on these devices can disappear as easily as the device on which it is stored. Thousands of mobile devices go missing every year in North America alone.

Identity thieves are looking for opportunities to grab personal identity information and business data. They do this in a number of ways: stealing the hardware, hacking into software, and by shoulder surfing.

- If you keep personally identifiable information on your mobile device, encrypt the data and password protect the device.
- Protect your passwords and encryption keys.
- All electronic devices should at minimum have personal firewall, anti-virus, and anti-spyware programs that are up to date.
- Use lockable briefcase or laptop case that does not bear any visible logos of your practice or business.
- Only conduct confidential work on mobile devices over which you have control. Do not use public computers or networks or work on confidential material in public places.
- Beware of public wireless networks such as "Wi-Fi" or "Hot Spots" in airports, hotels and coffee shops.
- When you travel with personally identifiable health information or collect new information off-site, you are personally responsible for ensuring that privacy is protected.

PRIVACY BREACH

A privacy breach occurs whenever a person has contravened or is about to contravene a provision of the *Personal Health Information Protection Act, 2004* or its regulations including Section 12(1). Section 12(1) of the Act requires health information custodians to take steps that are reasonable in the circumstances to ensure personal health information in their custody or control is protected against theft, loss, and unauthorized use or disclosure and to ensure that records containing personal health information are protected against unauthorized copying, modification or disposal.

A dental hygienist may become aware of a privacy breach in a number of ways. For example, you may witness a breach or it may be brought to your attention by a co-worker or a client. You may also become aware of a

breach when a formal complaint has been received from your client by the Office of the Information and Privacy Commissioner. If the latter is the case, you must co-operate fully with the Privacy Commissioner.

Most instances of breach are unintentional but you should also be aware that intentional breaches can occur. For example, unauthorized access of client files by staff. The College recommends dental hygienists have a "privacy breach protocol" in place in the event of a breach of privacy. You may wish to refer to the guideline "Reporting a Privacy Breach to the IPC: Guidelines for the Health Sector". This is an important resource when developing your protocol.

In the case of a Privacy Breach a dental hygienist should

1. Respond immediately by ensuring that the privacy information protection officer for your practice is notified of the breach.
2. Identify the scope of the breach and take steps to contain it. Retrieve the hard copies of any personal information that has been disclosed or in the case of electronic security breaches, change passwords, identification numbers and/or temporarily shut down the system.
3. Notify the individual affected by the breach, the Information Privacy Commissioner and the regulatory college of what and how the information was breached. And advise them of steps you have taken to address the breach.
4. Investigate how the breach occurred and review the adequacies of existing policies and procedures and make corrections to ensure that the breach is not repeated.

According to the Ontario Regulation 329/04 under the *Personal Health Information Protection Act*, section 6.3, the HIC has an obligation to make a mandatory report of any privacy breaches that may have occurred to the Information and Privacy Commissioner of Ontario (IPC) on or before **March 1 of each year starting in 2019**. HIC must report any personal health information that has been stolen, lost, used and/or disclosed without authority to the IPC.

Reporting a Privacy Breach

For each category, i) stolen, ii) lost, iii) used and/or iv) disclosed without authority, the following information must be reported:

- Total number of incidents
- Of the total in each category, the number of incidents where the occurrence was by:
  - an internal party (such as an employee, affiliated health practitioner or electronic service provider)
  - a stranger
  - the result of a ransomware attack
  - the result of another type of cyberattack
  - an unencrypted portable electronic equipment (such as USB keys or laptops)
  - paper records
- For any unauthorized disclosures you must include the method and means of disclosure for example, misdirected faxes/emails

- Of the total in each category, the number of incidents where:
  - one individual was affected
  - 2 to 10 individuals were affected
  - 11 to 50 individuals were affected
  - 51 to 100 individuals were affected
  - over 100 individuals were affected

Note: Do not count each incident more than once. If an incident falls under more than one of the above categories, choose the category that it best fits. For example, if a dental hygienist accessed and disclosed insurance information to the spouse of a client, this incident would fall under unauthorized use or disclosure, but not both.

DISPOSAL OF RECORDS

Dental hygienists should ensure that all client records are securely kept and must only dispose of records if the conditions below apply.

- Dispose of records in a secure manner only after the expiry of the specific retention period.
- Do not dispose of records that are subject to an access request until the individual has exhausted any recourse regarding the request (e.g., complaint to the Information Privacy Commissioner).
- Ensure that records are destroyed in such a manner that they cannot be reconstructed (e.g., using cross-cut shredding for paper records).
- Secure Destruction of Personal Information.

Further details of the *Personal Health Information Protection Act, 2004* are described below.

CONSENT

Scenario 4-2 "Eating Disorder"

You have treated Beatrice since she was a child and have developed a pretty good rapport. In the last couple of years, since she has become a teenager, she has come without her mother. You have noticed a change in her personality. She has obviously drifted away from her parents and seems to have become subjected to peer pressure. Over the last couple of visits she has appeared to lose weight and wears baggy clothing. On this visit there is discernable erosion of tooth enamel. You confront her about bulimia and, while she does not deny it, she does not quite admit it either. You know her family physician and mentioned to Beatrice that you would like to discuss her symptoms with him. Beatrice becomes angry and tells you "do not contact him to discuss my private business". You are in a dilemma as to whether you should report Beatrice's condition to Beatrice's family physician or mother.

Assuming that all client information is confidential, the real debate is when do other considerations alter this general duty of confidentiality? First and foremost, client consent authorizes the disclosure of client information. Consent can be formal (in writing), verbal or implied. If informed and genuine, each type of consent is equally valid.

Formal consent in writing is appropriate where the disclosure is to a third party, particularly where the information might be used against the client. For example, it is prudent to obtain formal written consent for disclosure to a lawyer for a legal proceeding (say a custody case). Formal consent is often obtained when providing a copy of a chart or a formal report to a third party. However, as will be discussed in more detail in Chapter 5, a signature on a piece of paper does not constitute formal consent. The client must understand what information will be disclosed, to whom it will be disclosed, for what purpose it will be used and the likely consequences that will flow from that disclosure.

Verbal consent is appropriate for most cases where formal consent is not necessary. Again, this involves explaining to the client the nature, purpose and implications of the disclosure and obtaining explicit permission to do so. Verbal consent can be made easier in circumstances where the dental hygienist has a handout or a sign in the office describing common or recurring disclosure issues such as disclosures to students in a teaching facility. It is a simple matter, then, to discuss the information to make sure that the client understands and consents to disclosure. The consent should be documented in the client's file especially when the disclosure may become controversial (e.g., to the mother or the family physician in Scenario 4-2).

Implied consent, while sometimes unavoidable, is the riskiest type. It is difficult to be certain that the consent is fully informed and voluntary when matters are not even discussed with the client. Misunderstandings are easy, particularly in cases where you believe that the client consented and the client does not agree.

However, in many circumstances, implied consent is routine. There is implied consent to discuss a client's condition directly with the client. Another example exists in a dental office where a team is involved in caring for the client; it can often be inferred that the client consents to sharing information within the team. The *Personal Health Information Protection Act, 2004* permits a dental hygienist to rely upon implied consent for the disclosure of personal health information to other practitioners on the health care team. For example, where a specialist office to whom a client has been referred asks that an x-ray be sent in advance of the client's appointment, implied consent can usually be relied upon. However, where the client has given specific instructions preventing you from disclosing the information to the other office, there is obviously no implied consent.

Consent may often be implied for practice settings with norms that are widely followed and broadly understood. To give a non-dental hygiene example, it is generally understood that, in the absence of an express direction by the client to the contrary, a person calling a hospital will be told that a client has been admitted there and their room number will be given (which often is some indication of the nature and seriousness of the client's condition). Similarly, there is a broad recognition of the need for normal administrative access to client information. For example, there is usually implied consent for the secretarial staff to have access to information for routine filing or billing purposes. Also, implied consent would generally cover supervisory access to client information for quality control purposes (e.g., a manager's file audit) or as a part of a systematic quality assurance program.

Implied consent may also apply to information that is publicly available. For example, if a client tells you about their children's achievements and you hear the client tell other non-practitioners about it, you can probably imply consent to tell mutual friends about it. However, even where the information is public, care must be taken because of the credibility attached to statements you make as a treating practitioner. For example, if it has been

reported in the local paper that the mayor is having her wisdom teeth removed, it may still be inappropriate for you to say anything about it as one of the treating practitioners, without the mayor's consent.

Great care must be taken when discussing client information with family members of a client. For example, a spouse calling with a question about his or her partner's treatment plan (e.g., why the client must come in for repeated visits for intensive scaling) may not necessarily justify your discussion of the treatment with the spouse. It would be prudent to obtain the client's consent to involve family members in the treatment process before revealing any information.

Another tricky area is discussing client information with parents of teenagers. If the client is capable, then s/he should consent to any discussions with the parents first (e.g., counselling on smoking). Even when a parent accompanies a teenager on a visit, it does not necessarily mean that the teenager is consenting to disclosure of information about her/himself to that parent. Sometimes parents do not accept this restriction. Dental hygienists need to be sensitive to the dynamic between the teenager and the parent and, where appropriate, arrange to speak with the teenager alone. As discussed below, there is no minimum age of consent.

The *Personal Health Information Protection Act, 2004* has also addressed some recurring problem areas in the area of consent. For example, a direction from a client not to record pertinent information is invalid. Also, if a client directs that part of the file not be given to another custodian (e.g., the client's new dentist) and you feel that the other custodian needs the information, then you can advise the receiving custodian that some relevant information has been withheld at the direction of the client.

CLIENTS WITHDRAWING CONSENT

As a general rule, **consent can be withdrawn**. Even where the client has given consent, the dental hygienist must be sensitive to and respect any wishes to withdraw it. This may occur where the client now better appreciates the consequences of the disclosure. An example would be when a parent is using the information to interfere with a teenage client's treatment choices and the teenager now wants disclosure to cease. If the dental hygienist has reason to doubt that a previous consent is still active, s/he should discuss it with the client. A withdrawal of consent does not reverse disclosure that has already occurred but applies to any future disclosure. You do not have to retrieve the records or reports you have already sent out.

For example, assume that a 13-year-old client authorizes you to discuss her smoking habits with her parents by saying "I have nothing to hide from them". A year later she declines a radiograph because she suspects that she may be pregnant. It would be risky for the dental hygienist to rely upon the consent given a year earlier in a different context to justify discussing the pregnancy with the client's parents. A prudent dental hygienist would confirm that the previous, very broad, consent had not been withdrawn.

In some circumstances, courts would view the withdrawal of consent as unfair. For example, if a client makes a complaint to the College about the actions of a dental hygienist, there is implied consent for the dental hygienist to reveal client information in response to the complaint. It would be unfair for the client to make a complaint and then tell the dental hygienist that, in defence to the complaint, all consent to reveal information about the matter to the College is withdrawn.

CLIENTS INCAPABLE OF CONSENT

Where a **client is incapable**, consent can be obtained from a substitute decision maker. A client is incapable of giving consent when s/he does not understand the nature or the purpose of the matters proposed to be disclosed, or does not appreciate the reasonably foreseeable consequences of the disclosure. For example, you may realize in discussing diet with an elderly client with early dementia and late onset diabetes that he is not following his diet and taking a lot of sugar on the side. In those discussions you may conclude that he does not appreciate the risks of his conduct. Therefore, this resident may not be capable of granting or withholding consent in respect of who should know about his dietary history.

The approach to obtaining substitute consent to disclosure of information is very similar to that for obtaining substitute consent for treatment (see Chapter 5 for details about substitute consent for treatment). *Personal Health Information Protection Act, 2004* provides a few special rules for obtaining substituted consent for personal health information. The substituted decision maker for handling of treatment information issues is generally the same as the substituted decision maker for treatment decisions. One minor difference is that a capable person can authorize someone in writing to act as her or his substitute even though s/he is still capable. For treatment purposes the client must be incapable before the substitute can act.

Another difference is that a custodial parent can authorize decisions affecting the personal health information of their child 15 years or younger unless the child disagrees or the child personally consented to the original treatment on his or her own. For treatment purposes the parent cannot make the decision if the child is capable.

A third difference is that a guardian or attorney for property can act as a substitute for personal health information (but not for treatment decisions where the person must be specifically designated as an attorney for personal care decisions, not just property decisions).

DISCLOSURE WITHOUT CONSENT

A dental hygienist may disclose client information without consent when permitted or required to do so by law. The most obvious example of disclosure without consent is when the dental hygienist is required to make a mandatory report. Mandatory reports commonly required of dental hygienists include: sexual abuse by health practitioners; child abuse; elder abuse in nursing homes; termination of employment or an association with a dental hygienist for professional misconduct and the "duty to warn".

The "**duty to warn**" is the most difficult of these mandatory reports because it is not specified in statute; it arises from case law. The duty to warn typically arises where a client has confided to you a threat to harm another person or identifiable group (e.g., "That is the last straw, I am going to blow him away"). If the threat is clear, immediate and it appears that the client has the ability to carry it out, then there is a duty to warn those threatened. Usually reporting the matter to the police is sufficient.

A threat by a client to harm her/himself is even more difficult to assess. Our society places a high value on personal autonomy and self-determination. A client generally has the right to refuse treatment even if the result might be permanent damage or even death. However, a threat of self-harm may reflect a lack of capacity (or appreciation of their actions), may harm others (e.g., a suicide attempt while driving) or may otherwise engage the duty to warn. If there is time, the dental hygienist should consult with legal counsel. Even if a dental

hygienist turns out to be wrong, warning of a risk of harm will generally be supported where it is reasonably based on genuine concern.

The *Personal Health Information Protection Act, 2004* supports the duty to warn. Under section 40, a health information custodian can disclose personal health information where there is a significant risk of serious bodily harm. The provision reads as follows:

Disclosures Related to Risks

> 40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

Note that this provision does not authorize disclosure where the only harm would be emotional in nature. However, other provisions authorizing disclosure might apply (e.g., for children and nursing home residents).

Table: Duty to Warn Considerations

• Is the threat specific?
• Is the threat to a specific individual or identifiable group?
• Is the threat imminent?
• Is the client capable of carrying out the threat (e.g., does the client have the means to carry it out. For example, does the client have a gun if the threat is to shoot someone)?
• Can the threat be appropriately dealt with through direct intervention? Do you have the skill and the confidence of the client to do so?
• Is there another person on the client's health care team who should more appropriately deal with the threat? Do you have actual or implied consent to discuss it with them? If not, is the threat such that this step should be taken without consent?
• Who should the warning be made to? If criminal behaviour is threatened, it may be the police.
• Should you discuss the disclosure with the client before making the warning?
• Is there a colleague you can discuss the situation with on a no-names basis?
• Is it possible to obtain prior legal advice?
N.B.: Most duty to warn decisions, are made through a combination of the above factors and not any single one of them.

See Chapter 2 for further discussion of your mandatory reporting obligations.

Other disclosures of personal health information permitted by the *Personal Health Information Protection Act, 2004* include the following:

- in respect of a deceased individual for the purpose of identifying him or her, notifying family and friends of the death and to permit relatives to make relevant decisions about their own health;
- for audit and accreditation purposes;

- to potential and actual successors of the custodian (e.g., a person "buying the practice") although potential successors must provide a written confidentiality assurance and affected individuals must be notified of any actual transfer of records to a successor;
- to assess capacity under the *Health Care Consent Act* and the *Substitute Decisions Act*;
- to a health regulatory College like the College of Dental Hygienists of Ontario or the Royal College of Dental Surgeons of Ontario;
- in order to cooperate with a statutorily authorized inspection, investigation or similar proceeding;
- in some research situations;
- in some health planning and management purposes;
- to assist in the monitoring of public health funding;
- to a health data institute under various rules and restrictions; and
- if permitted by law.

To expand on the latter ground for disclosure, there may be a duty to disclose information to government **agencies funding the treatment**. For example, the *Workers Safety and Insurance Act* requires practitioners to provide information when requested to support payment for insured services, even if the client does not consent. For private insurance however, the consent of the client is necessary for communication with the insurer. It is prudent to obtain that consent at the beginning of the relationship rather than trying to locate the client after an insurer asks a follow-up question. The fact that the client authorizes you to submit an account to an insurer on her or his behalf does not necessarily authorize disclosure of all information to the insurer. For example, a client might not want the insurer to know about her or his HIV status.

A dental hygienist may be **summonsed as a witness** in court or tribunal proceeding and be compelled to provide written or verbal information about their clients (e.g., in a custody case). However, any court or tribunal order or summons should be read carefully. Normally, the disclosure is only to be made at the hearing itself. It would often be improper to discuss the information with the person summonsing the information prior to the start of your testimony at the hearing.

Where a dental hygienist is permitted or compelled to disclose client information, s/he should first consider discussing the matter with the client. **Prior notice to the client**, as uncomfortable as it may be, may reduce the anger of the client when learning of the disclosure. Your explanation for why disclosure is being made will probably be more sensitive to the client than anyone else's explanation. However, in some circumstances, particularly where third parties are at risk, prior notice to the client may be inappropriate.

CLIENTS' RIGHTS TO ACCESS AND CORRECT THEIR INFORMATION

These rules for access are based on the concept that the **information belongs to the client** not the dental hygienist or the dental office. It may be that the dental hygienist or dental office owns the paper or computer system in which the information is stored, but the content of the information is held in trust for the benefit of the client.

A consequence of the concept that the information belongs to the client is that the **client has the right of access** to review and obtain a copy of the chart. That includes portions of the chart provided by others such as consultation reports and test results. A refusal to provide access can be challenged with the Information and

Privacy Commissioner under the provisions of the *Personal Health Information Protection Act, 2004*. Where the dental hygienist works for an employer, the existing procedures for handling such requests may have to be followed as long as they do not pose a barrier to reasonable access. See Chapter 10 for more details of how a dental hygienist can balance her or his duties to the client and to her or his employer.

Personal Health Information Protection Act, 2004 provides some **grounds for refusing an access request** including the following:

- Generally, health information custodians are responsible for assisting you by providing access to your personal health information. They may only refuse your request in limited situations, including if:
  - Your personal health information is subject to a legal privilege.
  - Access to your personal health information could reasonably be expected to result in a risk of serious harm to your treatment or recovery or serious bodily harm to you or another person.
  - Your personal health information was collected as part of an inspection, investigation or similar procedure and the resulting proceedings, appeals or processes have not yet been concluded.
  - Another law prohibits the disclosure of your personal health information.

Personal Health Information Protection Act, 2004 also provides some additional procedures for handling access requests by custodians (i.e., the dental office or organization for which the dental hygienist works) including the following:

- the custodian must assist the individual in making a meaningful request, if necessary;
- while the custodian can informally provide access, it can also insist upon a formal written request;
- the custodian should, where reasonably practical, explain terms, codes and abbreviations;
- the custodian must notify the individual of his or her right to complain to the Information and Privacy Commissioner if the request for access is refused (along with the reasons for the refusal) and the burden of justifying the refusal is on the custodian;
- the custodian can refuse frivolous, vexatious and bad faith requests for access;
- the custodian must satisfy itself of the identity of the individual before granting her or him access; and
- the custodian can only charge a reasonable cost recovery fee for access and must provide an estimate of the fee in advance.

The *Personal Health Information Protection Act, 2004* provides for a broad right of individuals to **correct errors** in their records. However, the Act provides some grounds for refusing such requests including the following:

- where the request is frivolous, vexatious or made in bad faith;
- the custodian did not create the record and the custodian does not have sufficient knowledge, expertise or authority to make the correction; or
- the information consists of a professional opinion or observation made in good faith.

The *Personal Health Information Protection Act, 2004* also provides some additional procedures for handling correction requests including the following:

- while the custodian can informally make the correction, it can also insist upon a formal written request;

- the correction should not obliterate the original entry; and
- any notice of refusal must advise the individual of his or her right to include a concise statement of disagreement in the record and of his or her right to complain to the Information and Privacy Commissioner about the refusal.

CONCLUSION

Your duty of confidentiality applies to all information you obtain about clients in the course of your professional duties. Ordinarily you will require a client's consent, whether express, verbal or implied, to disclose information about your client to others. In rare cases you will have a legal obligation to disclose client information even without consent (e.g., mandatory reporting obligations). The *Personal Health Information Protection Act, 2004* further reinforces your duty of confidentiality, provides some additional exceptions permitting disclosure without consent, and adds additional privacy obligations upon you.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 4-1 "Curling Team" above, what should you do?**
    a. Call the former client, the information is not confidential.
    b. Don't call the client from any contact information obtained from the file.
    c. Write to the client asking the client to call you about the curling team. A letter is less intrusive than a phone call and the client is in control of whether to talk to you about it or not.
    d. Call the client at their business number recorded on the chart because that is not personal information.

2. **In Scenario 4-2 "Eating Disorder", what should you do?**
    a. Tell the family physician as he is part of the health care team.
    b. Tell the mother because you have implied consent since she attended early visits.
    c. If on your assessment Beatrice is at imminent risk of serious harm, tell either the family physician or the mother or both, whichever seems best.
    d. Tell no one because clients have the right to self-determine their fate.

3. **You are doing an initial interview of a client. Your standard history form contains questions about a client's social and sexual history. What should you do?**
    a. Only ask the questions if they appear to be relevant.
    b. Have the questions removed from the form.
    c. Ask the client if it is OK to get into these areas.
    d. Ask the questions as the answers may become relevant at some point in the client's care and you may be criticized for not taking a complete history.

4. Your client's parent is suing for custody in a Children's Aid Society matter. The client is 15 years old and is capable of instructing you. You are summonsed to bring your chart and testify at a hearing by the client's parent. The lawyer for the client's parent, who issued the summons, leaves a message asking you to call her. What should you do?

    a. Tell your client that you have been summonsed.
    b. Book time off for the court date and organize and copy the file.
    c. Return the call to the lawyer in case it is about administrative matters (e.g., when and where to appear) but advise the lawyer you cannot discuss any client information until you are on the witness stand without the prior written consent of your client.
    d. All of the above.

5. Your client, Roger, asks to see his chart. It contains a number of consultation reports including some that comment on his non-compliance with treatment recommendations. You worry that revealing these consultation reports might damage his (not to mention your own) relationship with those practitioners.

    a. Provide access to the entire chart, it is the client's right.
    b. Provide access to everything except the consultation reports and direct the client to those practitioners for copies of their charts.
    c. Ask the consultants for permission to share the consultation reports with the client.
    d. Set a $250 administrative fee for looking at the chart. You know that your client cannot afford it.

A suggested answer to each question is found in Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 5 — CONSENT TO TREATMENT

NEED TO KNOW

1. Consent for treatment is, except in an emergency, always required.
2. Consent is generally obtained from a client directly and can be verbal, in writing or, in some cases, implied.
3. Where a client is incapable, the dental hygienist must obtain consent from a substitute decision maker.
4. There is no minimum age for consent; it is based on the capacity of the client.

INFORMED CONSENT

Scenario 5-1 "Identify Yourself"

You work at a restorative dental office. A client is prepped in the chair. You walk in, perform the restorative procedures and leave. You realize that the only way in which you introduced yourself to this new client was giving her your first name. What kind of consent is needed in these circumstances?

You should never confuse a signed consent form with obtaining informed consent. A written consent form is simply a piece of paper unless it is read, understood and its implications appreciated. **Obtaining informed consent is a process** that involves the meeting of minds. Furthermore, informed consent rests on the principle that clients should make their own treatment decisions. The role of the practitioner is to provide information and make recommendations that will enable clients to make informed choices. This principle is based on a number of rationales.

The primary rationale is that in our society individuals have control over their bodies. You should not touch, examine, ask questions about or otherwise interfere with another person's body without true consent. Of course, meaningful consent requires that the client knows all the information needed to make an informed choice.

A related rationale is that, as health care practitioners, you must provide high quality services to your client. In part, these include advising them of their options and partnering with them. The "best possible service" means the best possible service available for that particular client, meaning that the individual client's goals, expectations, needs and abilities direct the selection of all preventive and therapeutic interventions.

A third rationale is that health care practitioners owe a fiduciary duty of good faith and loyalty to their clients. Often health care practitioners have a high status in our society and also have specialized knowledge and expertise. Clients do not. In addition, they often approach health care practitioners such as dental hygienists at a time of need. For all of these reasons, clients are vulnerable; this vulnerability places a corresponding duty on the health care practitioner to act only in the client's best interests.

WHY INFORMED CONSENT IS NOT ALWAYS OBTAINED

The concept of informed consent among some health care practitioners is one of those rules honoured more in breach than in compliance. Dental hygienists know that they are supposed to obtain informed consent and generally believe that they do obtain it. But many objective observers might disagree that clients have truly given an informed consent. There are a number of reasons for this discrepancy in perception:

- **Health care practitioners assume a level of sophistication** in their clients that often does not exist. In the above scenario, the dental hygienist might assume that the client is familiar with restorative procedures and the staffing of dental offices and would know that dental hygienists provide some restorative procedures. However, dental hygienists must recognize that they live day in and day out with oral health matters and that many other people never think about the dental office structure.
- **Health care practitioners are rushed.** In today's environment of efficient office management, there is tremendous pressure to "get through" your client visits.
- **Poor communication skills.** Making assumptions or even making a statement is not communication. Communication involves feedback and understanding. See Chapter 9.
- **Ignorance of the requirements of informed consent.** While all dental hygienists know that they need "informed consent", they often do not appreciate all aspects and responsibilities of this duty. Some wrongly assume that it only applies to invasive procedures like surgery and the administration of drugs. Appropriately, these invasive activities are generally the focus of published standards and guidelines. However, it should be remembered that all treatment decisions and many other matters, such as release of information, require informed consent.

ELEMENTS OF INFORMED CONSENT

As discussed in Chapter 4 in the context of confidentiality and privacy, consent can often be quite informal. For example, when a dental hygienist asks a client questions about his or her medical history, a client generally demonstrates consent by answering them. However, whenever a dental hygienist touches a client or administers a treatment, more formal steps should be taken. A client is entitled to know the following before any assessment is conducted or treatment is performed:

- **The nature of the treatment or assessment.** Dental hygienists must be careful not to assume that clients know what will happen next. You should always tell a client in plain language precisely what you are going to do.
- **Who will be providing the treatment?** Unless a client is unconscious, s/he will generally see who is administering a treatment. Some clients, dealing with health care practitioners they have never met before, may feel uncomfortable about telling them to stop a treatment and to ask for someone else to do it. Therefore, clients should be given some information about the health care practitioners who will be treating them beforehand. They should know whether the person is registered or not, and to what profession she or he belongs. In some contexts it is also prudent to communicate the gender of the person providing the treatment, although that is often less of an issue in the dental office. If treatment will be provided at another time, it would also be sensible to tell the client who will be administering the treatment in advance.
- **Reasons for the treatment.** The client should understand the expected benefits of the procedure. The client should understand and appreciate what the goals of the treatment are, the likelihood of

achieving those goals, how long it will take to achieve them and how long the benefits are anticipated to last.

- **Material effects, risks and side-effects of the treatment.** One court has described a material risk in the following way:

  > a risk is thus material when a reasonable person in what the [practitioner] knows or ought to know to be the patient's position would be likely to attach significance to the risk or cluster of risks in determining whether or not to undergo the proposed therapy: *Hopp v. Lepp*, [1980] 2 S.C.R. 192

  Thus, remote risks, which are a mere possibility, usually need not be disclosed unless the consequence is significant (e.g., death, paralysis, stroke).

- **Alternatives to the treatment.** Often, more than one treatment option may be available for a client. Some options influence a client's choice because they may be more intrusive, painful or expensive than others. Although a dental hygienist may prefer a certain option, it is ultimately up to the client to decide on the best course of treatment for them. It is acceptable, however, for a dental hygienist to explain why certain options are not recommended and in a general way, to explain the material effects, risks and side effects of alternative options. It is not acceptable to provide only the options that the treating dental hygienist or her or his dental office is able to offer; all reasonable options should be presented including those that only other dental hygienists or even other dental offices can provide.
- **Consequences of declining the treatment.** Refusing a treatment is an alternative for all clients and they should have an opportunity to consider the advantages and disadvantages of that option as well. This discussion should not create the impression, however, that the practitioner is attempting to coerce or embarrass (e.g., in the case of financial constraints) clients to agree to the treatment.
- **Specific questions or concerns of the individual client.** In addition to the general aspects of informed consent listed above, dental hygienists should be sensitive to any particular concerns that individual clients may have. If the dental hygienist knows that a treatment could offend any religious, ethical or personal belief held by a client then that issue should be discussed. In addition, any specific questions asked by the client need to be answered.

To give informed consent, the client must not only **understand** the information, but must also **appreciate** the reasonably foreseeable consequences of the decision. For example, a client could understand that periodontal disease may have an effect on the stability of their teeth. However, the client may not understand that at some point periodontal disease will make teeth so unstable that they cannot eat certain foods, tooth loss will occur and it will be difficult for clients to maintain proper nutrition.

Consent can be given for a **course of treatment** (e.g., an aggressive periodontal treatment program) or a **plan of treatment** involving an oral health care team (e.g., the dental hygienist, the family dentist and one or two dental specialists). Once given, such consent applies to the entire course or plan of treatment unless there is a significant change in circumstances or consent is withdrawn. Normally it is the responsibility of the person proposing the course of treatment or the plan of treatment to obtain consent. However, if the person proposing the treatment is not able to obtain the consent (e.g., because they do not know all of the material risks and benefits, because they are too busy to take the time to do it etc.) then someone else may have to do it. Even where a member of the health care team has obtained consent for the course of treatment or a plan of treatment, prudent dental hygienists will check with the client before starting their own treatment to ensure that the consent was informed and has not been withdrawn.

For repetitive matters, it is acceptable to give a **written description** of the information the client needs to know. This paper will often save considerable time. However, there should always be some individual discussion with the client after s/he has read the paper to ensure that the information is clearly understood and that its implications are appreciated. Some clients are functionally illiterate and hesitant to disclose this fact. So, simply asking "Did you understand what you read?" is often not sufficient. Obtaining specific feedback is necessary (e.g., "What adjustments to eating and talking after you receive the appliance will have the most impact on you?").

Generic Consent Form

I hereby consent to the following treatment: **[describe treatment as specifically as possible but in words that are understandable to lay people]**. I have been told about the following:

- what the treatment is;
- who will be providing the treatment;
- the reasons why I should have the treatment;
- the alternatives to having the treatment;
- the important effects, risks and side-effects of the treatment and the alternatives to the treatment
  [consider adding "including the following: {insert major risks}"]; and
- what might happen if I do not have the treatment.

I understand the explanation and have no further questions. My consent is voluntary.

Date: _____

_____ (witness' signature)

_____ (signature of client)

_____ (print name of witness)

_____ (print name of client)

IMPLIED CONSENT

Scenario 5-2 "Implied Consent"

You have taken over from another dental hygienist, Sonia, who worked in the office for twenty years. She has not recorded the pocket depths for a couple of years. Your routine is to do your probing near the beginning of your visits. Assuming that the client knows the routine you simply start measuring. The client displays some signs of discomfort but nothing is said. The receptionist later tells you that the client said "She is pretty rough! I wish Sonia was still here, she would never have done that to me." You wonder whether you in fact had implied consent to do the probing.

In the scenario above, genuine consent may not have been obtained because of certain assumptions that the dental hygienist made. The dental hygienist assumed that the client had pocket depth measurements taken in the past and knew the procedure. The dental hygienist also assumed that there had been no refusal by the client to explain the lack of measurements the last couple of years. The dental hygienist also assumed that s/ he did such measurements in the same way as Sonia. While the absence of an express statement from the client is not always necessary for the consent to be valid, the client was upset and a genuine consent was probably not obtained. Indeed, in the scenario above, the client was not even told beforehand what was going to happen.

Consent need not always be obtained in writing from a client. In many circumstances, such as a routine assessment or just for the measuring of pocket depths, a **written consent** is impractical. The value of obtaining a written consent is in proving that consent was obtained should a subsequent challenge arise. If a particularly risky intervention is recommended, or if a client appears unreliable, then a written consent can help a dental hygienist prove that a proper consent was obtained. The consent form should be simple and easy to understand (a generic sample consent form is set out above). You need to carefully fill in the blanks in language that is easy to understand. If desired, you can also add an explicit acknowledgement of understanding for a particular risk or side-effect because it is serious or occurs commonly (e.g., discomfort, bleeding).

In addition to written consent for treatment, written consent is often also obtained in respect of billing issues (e.g., responsibility for and timing of payment of accounts, to authorize communication with the client's insurer) and in respect of confidentiality and privacy issues (e.g., acknowledging having read and understood the office's privacy policy).

Written consent forms are not a complete defence to an allegation of failing to obtain consent. Dental hygienists sometimes confuse a signed consent form with obtaining informed consent. As noted above, a written consent form is simply a piece of paper unless it is read, understood and appreciated. Obtaining **informed consent is a process** that involves the meeting of minds. The client can still claim that the form was not clearly explained before her or his signature was obtained or that s/he did not understand or appreciate what was signed. Therefore, the written consent form should not be obtained in a rushed or routine fashion. It should never be obtained with the client's initial registration with the office, or clinic unless it is already known what assessment and treatment will occur. Should a problem occur, a clear and simple signed consent form, witnessed by the attending dental hygienist or another person, places a heavy onus on the client to explain why s/he signed the form without clarifying anything that was not understood.

If a written consent is not obtained for particularly risky procedures, practitioners should document in the client's chart that an informed consent was given verbally. A note in the chart is also prudent when the client appears to be unreliable. A useful tip is to document the reason why a client decided on one treatment option over another. Such a note is valuable supportive evidence that the dental hygienist actually obtained informed consent.

WITHDRAWAL OF CONSENT

As discussed in Chapter 4, consent can be **withdrawn**. If a client consents to a course of treatment but then communicates to you that there has been a change of mind, you can no longer rely on an earlier consent. This decision must be respected. A written consent can also be verbally withdrawn. However, you might ask the client to confirm the withdrawal of consent in writing so that you have a record of it. When a client withdraws

consent, you should review again the risks and benefits of that decision to ensure that the withdrawal of consent is itself informed.

CONSENT FOR INCAPABLE CLIENTS

Scenario 5-3 "Separated Parents"

A 14-year-old boy is scheduled for a "sealant and cleaning" visit. When discussing what will be done during the visit the boy says that his mother said he should not have the treatment done and he doesn't want it done. You ask if the mother brought him to the visit. He says no, today is Wednesday and he spends Wednesdays with his dad (you learn that the parents have joint custody of the client). You speak to the father who says that if the dentist wants sealants his son should have sealants. The dentist overhears the conversation and tells you to do what was scheduled for the visit. What do you do?

In 1996, the Ontario government introduced the *Health Care Consent Act* (HCCA). It deals primarily with consent for treatment, personal assistance services and other matters involving incapable persons and it applies to treatment and personal assistance services as defined in that Act. Many of the usual activities performed by dental hygienists on a one-time visit are excluded from the definition of treatment and, consequently, from the requirements of the Act. These include:

(a) the assessment or examination of a person to determine the general nature of the person's condition;
(b) the taking of a person's health history;
(c) the communication of the results of an assessment; and
(d) a treatment that in the circumstances poses little or no risk of harm to the person.

Personal assistance services are defined as assistance or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, position or any other routine activity of daily living.

When an activity is excluded in the Act by the definition of "treatment" or "personal assistance services", the dental hygienist must still obtain consent because common law (case law) and the College's professional standards require consent for everything, not just those procedures covered by the *Health Care Consent Act*. Thus many dental hygienists follow the general approach of the *Health Care Consent Act* regardless of whether the Act actually applies to the particular assessment or treatment.

DETERMINATION OF CAPACITY

Clients are assumed to be capable. An assessment of a client's capacity should be made only when there is reason to doubt the client's capacity. However, a hard and fast set of rules does not exist for determining the capacity of a client. When reservations about a client's capacity exist, a dental hygienist should perform an assessment to determine capacity based on the condition of the client and the nature of the proposed service.

For the purposes of a dental hygienist's interactions with a client, a general assessment of the client's entire capacity or incapacity is not required. The assessment should simply determine whether a client is capable of giving informed consent to a proposed treatment or service. A client may be capable of consenting to some

treatments or services that are simple to understand but not for those that require the analysis of complex considerations. Also, a client may be capable during some periods of time but not at others, for example, with some forms of dementia a client may have "good days" and "bad days".

In each case, the dental hygienist must assess whether the client understands and appreciates the reasonably foreseeable consequences of the decision. The assessment of capacity must be based on observations about the client (apparent confusion) rather than on presumptions, generalizations or stereotypes (age, diagnosis, disability, that a client questions your advice).

There is no minimum age for consent. As a general, informal guideline, a dental hygienist may often find that:

- Children under 7 are incapable of consent for almost any treatment;
- Children between the ages of 7 to 12 can very rarely consent to treatment; and
- Youth over 12 need to be carefully assessed as to their capacity on a case-by-case basis.

SUBSTITUTE DECISION MAKERS

When a client is found to be incapable of giving consent, the consent must be obtained from a substitute decision maker unless there is an emergency. The following considerations apply to obtaining consent from a substitute decision maker:

- The substitute must be at least 16 years old (unless the substitute is the parent of client).
- The substitute must be capable herself or himself.
- The substitute must be able and willing to make the decision.
- The substitute must act in accordance with either:
  - the last capable wishes of the client, if any; or
  - in the best interests of the client.
- There is some obligation on a dental hygienist's part to intervene if it is clear that the substitute is not fulfilling his or her obligations. In some cases, explaining the obligations to the substitute is sufficient. In other cases, the dental hygienist would be required to make a report to the Public Guardian and Trustee (e.g., if the substitute is misconducting her/himself).

There is a priority list of substitute decision makers ranked from the highest to the lowest as follows:

- Guardian of the person appointed by the courts;
- Attorney for personal care conferred by a written document when the client was capable;
- Consent and Capacity Board appointed representative;
- Spouse or partner;
- Child or custodial parent;
- Access parent;
- Brother or sister;
- Any other relative;
- Public Guardian and Trustee.

Where a substitute from the first three groups listed above is able and willing to make the decision then s/he must be used. At the family member level, any available substitute on the list can be relied upon so long as there is not a higher ranked substitute who is available and is known to want to make the decision (see discussion below). The Public Guardian and Trustee, a government official, is relied upon as a last resort.

As a practical matter, when dental hygienists are dealing with a family member of an incapable client, they merely have to ascertain the following:

1. whether the family member knows of any formally appointed substitute; and if not,
2. whether the family member knows of another, higher ranked substitute who would object to that family member making the decision.

Where a formally appointed substitute, such as a power of attorney for personal care, or another higher ranked family member, would object to the making of a decision then the dental hygienist cannot rely on the lower level substitute that is present, but must then try to obtain consent from the higher level substitute if they are available and willing.

Dental hygienists will want to keep the incapable client as involved as possible in their treatment and personal service decisions.

Consent if Child Is Incapable

If the child is incapable of consenting to treatment within the meaning of the *Health Care Consent Act, 1996*, a dental hygienist would generally look for consent from the parent accompanying the child. This situation can be complex in situations where parents are separated or divorced. The dental hygienist should inquire whether there is anyone else who would want to be taking part in this decision.

Where parents are not separated, the dental hygienist may rely on consent to treatment of the child from either parent.

Where the parents are living separately and apart and the child resides with one parent with the consent of the other, unless or until a separation agreement between parents or a court order provides otherwise, the parent with whom the child resides has the right to consent to treatment on behalf of the child.

Once the final custody arrangement has been determined by agreement or court order, the parent with custody may consent to treatment on behalf of the child.

In a joint custody arrangement usually either parent can give consent. It is rare for the consent of both parents to be required. However, where this is the case this provision must be observed.

If the person accompanying the child reports having custody or being able to consent to treatment on his/her own in a joint custody arrangement, the dental hygienist may rely on the consent of that person, unless the dental hygienist has reasonable grounds to doubt the word of that person.

Reasonable grounds could be based on the dental hygienist's judgment regarding questionable behaviour of the person or on available information contradicting the person's claim respecting custody.

EMERGENCIES

In an emergency, consent is not needed when the delay in obtaining consent would prolong suffering or put the client at risk of sustaining serious bodily harm. The definition of what constitutes an emergency is set out in the *Health Care Consent Act*. In particular, an emergency includes circumstances where a client "is apparently experiencing severe suffering" or is at risk of "sustaining serious bodily harm". Even where a client is capable, treatment can be administered without consent in emergencies where a language barrier or other communication difficulties make it impossible to obtain informed consent without delay.

One of the rare situations where a dental hygienist will face an emergency is when a client is experiencing severe dental pain and is unable to communicate (e.g., because of a language barrier). In such a case you should work with a dentist or other health care practitioner to try to communicate as best you can with the client. You should also attempt to locate someone who can assist you in communicating with the client (a relative or caregiver can be sufficient depending on their ability to communicate with the client and her/his respect of the client's autonomy to make their own treatment decisions).

CONCLUSION

Dental hygienists should apply the principles underlying the legal and professional requirements for consent. It is important to remember that consent is always required for treatment except for an emergency. Written, verbal and implied consents are all valid but in the latter case dental hygienists should be sensitive to the possibility of misunderstanding. They should also remember that capacity to consent is not age-related but depends on a client's ability to understand the scope of the treatment and appreciate its consequences. In cases where clients are not capable of consent, a substitute decision maker must be found.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 5-1 "Identify Yourself" above, what should the dental hygienist have done?**
    a. Nothing, it was the dentist's job as the proposer of the treatment to obtain consent.
    b. Nothing, the client signed a blanket consent form at the first visit to the office.
    c. Tell the client that you are a Registered Dental Hygienist and wear the CDHO pin.
    d. Explain who you are and what you are going to do and ask the client to give a clear sign of consent if that is OK with her.

2. **In Scenario 5-3 "Separated Parents", is the client capable?**
    a. Probably not since the client is just 14.
    b. You need more information about the client's understanding before you can tell.
    c. Probably not since he is relying on his mother's wishes.
    d. All of the above.

3. In Scenario 5-3 "Separated Parents", assume that in fact the boy is 9, not 14, and after an assessment, is found to be incapable of making the decision. What should you do?
    a. Since there is no urgency in applying sealants, defer the decision until you can meet with both parents and the boy to discuss the matter.
    b. Since the parents have joint custody and don't agree, you go to the Public Guardian and Trustee to resolve the matter.
    c. Tell the parents that they have to reach a consensus or you are doing nothing.
    d. Follow the dentist's direction since the dentist assessed the client, is presumed to have obtained consent and is your employer.

4. A signed written consent from a client
    a. is the best protection you can have for a risky treatment decision.
    b. is better than a verbal consent.
    c. provides some evidence of informed consent.
    d. needs to be witnessed to be effective.

5. A client can withdraw their consent
    a. at any time.
    b. only in the same form in which the consent was originally given (e.g., in writing, verbally).
    c. if it is informed.
    d. through a power of attorney for personal care.

A suggested answer to each question is found in Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 6 — RECORDKEEPING

NEED TO KNOW

1. Keeping appropriate records is important both for client care and for enabling you to be accountable.
2. There are various acceptable ways of keeping records so long as you have access to the necessary information when needed.
3. Records must be kept secure and confidential; they must also be available for professional use and for clients to review and to correct, if necessary.
4. Employers / payers may establish reasonable procedures for access to information by clients as long as these do not result in creating unnecessary barriers.

REASONS FOR RECORDKEEPING

Probably one of the more routine aspects of dental hygiene practice is recordkeeping. Making chart entries is often tedious, taking time away from "important" work such as client contact. Human nature being what it is, the task of recordkeeping is often postponed until the last minute or is completed at the end of the day. The fact that the record may not be urgently needed and that dental hygienists can go for years before an entry becomes significant further conceals the importance of keeping records.

One primary use for a record is to assist dental hygienists in their **day-to-day practice**. Obviously this use of a record is more important for ongoing treatment plans than for one or two visit encounters (e.g., where the client's regular dental office is closed for holidays). In follow-up visits, dental hygienists need to review:

- the client's medical history;
- previously identified concerns;
- past treatment and results/treatment outcomes;
- past advice, counselling, and referrals given to the client; and
- the details of any ongoing treatment plan.

Good recordkeeping will also be useful to the other members of the oral health **care team** such as dentists (and not necessarily the current dentist if the client changes offices), other dental hygienists, dental assistants and support staff (e.g., for scheduling or billing purposes). Often dental hygienists never know that others have reviewed their records. Inappropriate treatment decisions may result from recordkeeping that omits information (e.g., pregnancy, new medical conditions), records it incorrectly or too late.

Records are sometimes needed to **prepare reports.** Clients are entitled at any time to a report of your assessment, treatment and prognosis. Clients may request them for use by others, such as insurers, employers and lawyers. Clients may need the information for legal proceedings, such as a disability claim, a motor vehicle accident benefit, a custody battle, or a discrimination suit on the basis of disability. Failure to provide an adequate report because of poor records may not only embarrass you but will also increase the likelihood of your being asked to testify in court as a witness.

Records are critical in a **dental hygienist's accountability** for services. Clients, employers, payers and the College will rely heavily on your record in assessing the adequacy of your conduct or competence. The axiom "if

it wasn't recorded, it wasn't done" is not far off the truth. Most adjudicators will have serious difficulty rejecting a client's claim that something was not done if the chart has no record of it, regardless of evidence provided by a dental hygienist. Similarly, most adjudicators will generally accept that something did occur if the dental hygienist recorded it, regardless of evidence to the contrary provided by a client.

Accountability is not restricted to disputes with clients. Your record is often the focus of risk management and quality management by employers. In its quality assurance program, the College also relies upon your charts. The quality of your records is generally seen as a good barometer of the quality of your practice.

WHAT SHOULD BE RECORDED?

There is an element of judgment as to what should and should not be recorded in a client's record. The content of a record depends upon: the nature of your practice, who has access to records, and what forms of accountability you are most likely to face. There are few hard and fast rules. For example, a dental hygienist who works in industry (e.g., a supplier of dental office products) primarily acts as a resource and provides a perspective on complex business decisions in which dental hygienist's views are rarely the primary consideration. In such a context, minimal records would be required. For instance, the dental hygienist's contribution to a corporate decision to market one type of oral health product over another would generate few "professionally" required records. In addition, a dental hygienist working in public health would often keep group records for many activities except where specific concerns are identified. However, for private practice, the following types of records are most often expected and maintained.

Equipment Service records are important where the equipment can have health consequences or where the accuracy of measurements taken from the equipment is important. The most obvious examples are x-ray machines and sterilizers. A record of the date of inspection or service and by whom it was done can be crucial if a problem develops later. A reliable reminder system for such inspections or maintenance is also required.

The documentation of maintenance and repair of all **cleaning and sterilization equipment** including, quality monitoring and documentation of the reprocessing procedure including biological indicator tests, chemical indicator tests, and physical parameters.

Further, employers and employees must comply with all applicable federal and provincial legislation (e.g. WHMIS, Occupational Health and Safety, Health Canada).

Sterilization equipment monitoring records including spore-testing results, WHMIS log book and Material Safety Data Sheets are records required to be maintained within the workplace.

Refer to CDHO IPAC Guidelines.

Financial records need to be maintained when billing occurs. Audits of financial payments are a fact of life in both the private and the public sector. Typically, financial records include:

- a client identifier;
- the date, time, nature of service and the units or length of time it took;
- the method of determining the fee if it is not uniform in the practice (e.g., units of time, block fee, fee schedule, based on a prior estimate, etc.);

- the actual fee; and
- the fact and method of payment by the client or third party.

Where the dental hygienist does not personally prepare bills, s/he must consider recording the actual time spent rather than "units" in one's records. This helps reduce confusion that can occur over the interpretation for billing "units".

A daily **appointment log or record** that contains the name of each client who is examined, treated or provided with a service must be kept. Client privacy must be maintained and the log or record must not be displayed for others to see.

A record of **consent** obtained from a client for any risky, invasive or otherwise significant service is valuable. While a signed consent form from a client may be desirable, it is not necessary (see Chapters 4 and 5). What really counts is that there is evidence that the client was given the necessary information and provided consent. Simply recording the fact that consent was obtained after a discussion with a client and that it appeared to the dental hygienist to be genuine and informed is often sufficient. Both a signed consent form and a dental hygienist's note of obtaining consent in the chart are legally recognized ways of demonstrating that actual consent was obtained.

A **client health record** has, perhaps, the most extensive content requirements. The goal of the record is to give a clear idea of what happened during a visit and why. The record should describe: the client's condition, the dental hygienist's assessment and treatment plan, the treatment actually provided, any changes to the treatment plan and any plans for future visits. The College has published a Medical/Dental History Guide which provides a useful checklist of points to cover (or to include in your own forms). In addition, the College's Records Regulation contains a detailed list of what should be recorded, as demonstrated in the following table. Note that a dental hygienist's record also includes documents obtained from others, such as referral slips, specialist reports and radiograph and other laboratory results.

Client Health Record Information

A client health record must include the following:	
(a)	The client's name, address, and date of birth.
(b)	The date of each professional contact with the client, or the clients substitute decision maker, and whether the contact was made in person, telephone or electronically.
(c)	For each intervention, the amount of time the registrant spent providing dental hygiene care.
(d)	The name and address of the client's primary care physician or nurse practitioner, if obtainable.
(e)	The name and address of the client's primary care dentist, if available, if the record is not shared with that dentist.
(f)	The name and address of any referring health professional.
(g)	An appropriate medical/dental history of the client.
(h)	Every written report received by the registrant in respect to examinations, tests, consultations or treatments performed by any other person.

(i)	A copy of every written communication sent by the registrant relative to the client.
(j)	Each examination, clinical finding and assessment relating to the client.
(k)	Any medication taken by the client as a precondition to treatment or examination by the registrant for each intervention, including the name of the medication, the time it was taken, and if the medication was not administered to the client by the client, the name of the person who administered it to the client.
(l)	Any dental hygiene treatment plan.
(m)	Each treatment or procedure performed for each intervention and the identity of the person applying the treatment if the person applying the treatment was not the registrant.
(n)	Any advice given by the registrant including every pre-treatment or post-treatment instruction given by the registrant to the client or the client's substitute decision maker.
(o)	Every controlled act within the meaning of Section 27(2) of the *Regulated Health Professions Act, 1991*, performed by the registrant, including the source of the authority to perform the controlled act.
(p)	Every referral of the client by the registrant to any other person.
(q)	Every procedure that was commenced but not completed, including reasons for non completion.
(r)	A copy of every written consent provided by the client, or the client's decision maker.
(s)	A record of every refusal of a treatment or procedure by the client, or the decision maker.
N.B. A modified list is provided for communal screening and treatment programs.	

Records should contain relevant information even if you are concerned that it might be embarrassing to provide access to the client. For example, if a client smells of tobacco and has significant staining but they claim not to smoke.

RECORDKEEPING STYLES

There are various approaches you might take to recordkeeping. **Handwritten notes** on **blank sheets of paper** are fine and provide maximum flexibility, if not maximum legibility.

Most dental hygienists, however, find that a **pre-printed form** or **template** designed for a dental hygiene or dental office saves time and helps ensure that information is not forgotten. However, diligence is needed with checklist forms so that points are not checked off thoughtlessly, resulting in inaccurate records. Inaccuracies might include ticking off a series of boxes without reading them or omitting to record information because the form does not have a specific space for it.

Computerized records are becoming common. They can work well and are legible. However, for your own protection, it is strongly recommended that you use a program that leaves an audit trail to demonstrate when each change was made and by whom. Again pre-established computerized forms can be helpful but care must be taken not to cut and paste information that does not apply from other files to the current client. Also, special security measures will be required for any computerized system (e.g., user ID, passwords, virus and firewall protection, etc.). Also, if your practice uses a mixture of paper and computerized records there must be a clear protocol as to how to locate specific information.

Charting by exception is rare in the dental hygiene context. However, it is possible so long as there are clear written protocols that specify what is and is not meant by an entry or a lack of entry. You must ensure that you are familiar with the protocol and that you consistently follow it. If it can be established by other records that you, or others on your team, do not consistently follow the protocol, you will have lost much of the benefit of the record.

Charting by reference is also quite acceptable. For example, referring to a standing directive, a written assessment protocol, a recurring consent to treatment information sheet or a known treatment regime can be a handy and quick way of incorporating a lot of information in a very brief entry. However, to be credible, it is important that the reference be accurate and complete. Of course, the referenced document and the period of time for which it was used must be readily available well into the future.

Similarly, the use of **abbreviations** is quite acceptable. You should try to use abbreviations that are recognizable by others who share access to your records. In addition, you should develop a master list of your usual abbreviations (i.e. a key) for reference by others on your team who are not familiar with them and to outside readers of your records (e.g., when you send a copy of your chart to the client or someone else at the client's request).

Dictated records are also acceptable. This approach can be resource intensive as someone needs to transcribe the tape (unless you have voice recognition computer software). In addition, there are a lot of steps in this system of recordkeeping that can lead to errors, misfiling or even record loss. You should review the transcribed records later to ensure that they are accurate and indicate that you have done so by signing off on the transcribed record. If this is not possible you should, at a minimum, do spot checks on transcribed records to ensure that they are generally accurate and that systemic errors are caught.

COMMON OBJECTIONS TO "DEFENSIVE PRACTICE"

Some health professionals minimize the importance of recordkeeping by suggesting that it detracts from the real practice of dental hygiene and that it signifies the usurpation of lawyers over the profession. However, as noted above, recordkeeping is an integral part of a high-quality practice and is not just required for accountability purposes.

Another concern expressed by dental hygienists is the length of time involved in keeping appropriate records. Once you have developed a system that you are comfortable with, you should find that recordkeeping can be done quite efficiently. Your system might include references to other documents, a set of usual abbreviations and possibly using a pre-printed form. Remember, record only what is significant. With experience you will learn what is significant (e.g., areas of periodontal concerns) and what is not significant (e.g., full details of the client's frustration with your recommended home care protocols may not be necessary if you record the fact of the frustration and in a few words explain its nature).

Some health professionals worry that recording everything means that your mistakes will be recorded as well, resulting in easier legal liability. While theoretically possible, the practical reality is that for every one case in which you might regret recording a detailed note, you will have a thousand cases in which you wish you had recorded more.

JOINT RECORDS

Scenario 6-1 "Joint Records"

You work as a restorative dental hygienist in a busy office. You follow a team approach to treatment. Typically, three clients are being treated at one time in separate operatories. Each person writes what they can. Sometimes one member of the team writes notes about what other members of the team do. You may not see the chart before it is taken away and you may not sign the record. Are you at risk for this recordkeeping approach?

Dental hygienists often work in settings where they are expected to use a joint record with others because this makes practical and clinical sense for a team practice. However, the use of a joint record then places some obligation on you to ensure that the recordkeeping practices of the team are consistent with the expectations of the College and the dental hygiene profession. Values and approaches will more likely be shared by a team made up of or lead by registered health practitioners. Even in these situations, dental hygienists should still check recordkeeping practices to ensure their quality and accuracy. Where the employer, office or program is privately operated or is managed by unregistered persons the dental hygienist needs to exercise a higher degree of scrutiny of the recordkeeping practices. A checklist of information practices that a dental hygienist will want to review is found in the following table:

Joint Records Checklist

• Records kept securely.
• Identity of the person providing the treatment must be noted.
• Confidentiality maintained – only those with express or implied consent of the client may access the record (see Chapter 4).
• Reasonable client access to record.
• Appropriate policy for correction of errors.
• Records maintained for a minimum period of 10 years (longer for minors).
• Dental hygienist will have reasonable access to the chart both before and after leaving the job or office.
• Reasonable plan for secure storage of records or for the transfer of records if office or program closes.
• Identify who is the custodian of the records.

Where the office, employer or program does not meet the recordkeeping expectations of the dental hygiene regulatory authority (CDHO), the dental hygienist must either negotiate a change to the practices or must keep separate records. This should not be done secretly (see section on *Keeping Private Records*).

It is important to resolve recordkeeping issues when starting a position. If you are already in a job where you have not resolved these issues, you should do so now. Once a relationship comes to an end or a dispute arises, it is very difficult to then resolve it. In private practice, the records are a crucial component of "goodwill" and their ownership can be contentious. For non-profit operations, the recordkeeping obligations for security and retention can be onerous.

KEEPING PRIVATE RECORDS

Scenario 6-2 "Keeping Private Records"

You work in a dental office. The dentist tells you that your entries are taking up too much room on the form making it difficult to quickly review the relevant information on recall visits. You place the traditional information (e.g., medical history, major findings on assessment, treatment plan) on the approved form. However, there is not an appropriate space to put your detailed counselling and advice you give to clients. Also, sometimes you counsel clients on related matters (e.g., smoking cessation, nutritional counselling, caries management) that are not of much interest to the others on the team. Plus these entries are rough and messy and you would be embarrassed to put them in the central chart. They would be of no use to anyone but you. Can you keep those notations on a separate piece of paper that you keep as long as you are seeing the client and then discard them when the client leaves the practice?

Private records consist of entries that are not included in the official chart of the office or employer for whom you work. Unlike rough notes, which can usually be destroyed after they have been completely transcribed onto the official chart, private records contain additional information that does not appear in the official chart. They are typically kept by a dental hygienist for some time for private use. There are a number of reasons why a dental hygienist might wish to keep a private record:

- The official chart requires a form that does not lend itself to record all of the information the dental hygienist wishes to record.
- The employer or office discourages the extensive recording of information that the dental hygienist wishes to note or that is required by the College.
- The official record is inconvenient to access for various reasons, either because of the procedures or the length of time it takes to retrieve the record or because others are often using it.
- The dental hygienist believes that the office's or employer's information handling policies do not permit compliance with College regulations or other legal requirements (e.g., providing adequate access to clients).
- A dental hygienist's private record tends to be messy and not in a form that is useful or appropriate for others on the health care team to see.
- On rare occasions the dental hygienist may be concerned about the lack of privacy afforded to the official record (e.g., where very private information is revealed that a client does not want the entire team to know; the employer or office is privately owned and does not respect confidentiality).
- You are concerned about changes being made to your records after the fact for billing purposes.
- The dental hygienist is concerned that a copy of or access to the official record will not be given when leaving the job.

However, very serious problems can arise when a dental hygienist maintains private records without the knowledge and authority of the office or employer. These include the following:

- It is difficult for the office's or employer's information policies to apply to a dental hygienist's private record. For example, it might not be kept with the same degree of security as the official record.
- The legal obligations of the office or employer cannot be fulfilled. If a client wishes to exercise his or her right to see the entire file, the office or employer cannot do so because it has no knowledge of a dental

hygienist's private record. Or, if the entire chart is required to be produced in a legal proceeding, the private record will not be included, placing the office or employer in contravention of the law.

- Valuable information may be inaccessible to the rest of the health care team.

Some solutions to these competing considerations include the following:

- Do not keep private records. Record everything that needs to be recorded in the official chart.
- Advise your office or employer that you are keeping private records and negotiate appropriate policies and procedures respecting them such as access by others, security, your ability to remove private records if you leave, etc.
- If you are not an employee, but on contract to the practice where you work, consider whether you are a separate and distinct "health information custodian" within the meaning of the *Personal Health Information Protection Act, 2004* such that you can set up your own recordkeeping system.
- Discuss the reasons for your keeping private records in the first place with your office or employer so that any underlying issues are appropriately addressed.

SECURITY OF RECORDS

It is generally recognized that health records must be securely maintained. The *Personal Health Information Protection Act, 2004* now expressly requires that appropriate security measures be adopted. In addition, that Act designates the Information and Privacy Commissioner of Ontario to monitor compliance. However, there exists no uniform approach or simple set of rules to guide dental hygienists. Much depends on the nature of the practice and the recordkeeping system chosen (e.g., paper or electronic). In some sense, that ambiguity is positive in that dental hygienists have a lot of flexibility in developing a system of safeguards. On the other hand, the lack of guidance in developing security measures leaves little doubt that some organizations (particularly some small private offices) have minimal safeguards. Dental hygienists must ask themselves whether the system in place in their office provides adequate safeguards to allow only authorized persons to have access to records.

A system of safeguards should cover the matters identified in the following table:

Checklist for Securing Personal Information

(a)	Have a written *Privacy and Access Code* for the organization.
(b)	Provide a copy of the *Privacy and Access Code* to staff of the organization upon the hiring or training of new staff.
(c)	Train staff about the confidentiality of personal information. Access is on a need-to-know basis.
(d)	Consider asking staff to sign a confidentiality statement.
(e)	Require that personal information that is not in a secure area be locked or otherwise protected from unauthorized access. Obtain written confidentiality assurances from persons having unaccompanied access to records (e.g., cleaners, maintenance, IT consultant).
(f)	Revise practices for leaving attendance books and day sheets in plain view.
(g)	Ensure that conversations about clients over the telephone or in an open office respect client privacy.
(h)	Develop protocols for the secure e-mail, facsimile, mail or courier transmittal of client information.

(i)	Restrict removal of client information from the office and establish clear rules if it occurs (e.g., to work at home on files).
(j)	Require personal information in paper form to be shredded or otherwise destroyed before its disposition.
(k)	Require the use of password protection, virus protection, spyware protection and firewalls and other recognized security measures for electronic information.
(l)	Require that electronic data be destroyed or securely reformatted before the hardware holding the data is discarded.
(m)	Monitor compliance with the safeguards.

In summary, access to records must be on a need-to-know basis within the organization. Sharing of information should have at least the implied consent of the client and any external disclosure should be on consent or with other legal authority. See Chapter 4 for more information about the duty of confidentiality and the need for consent.

Where there has been a privacy breach, the *Personal Health Information Protection Act, 2004* requires that the affected client(s) be informed. See Chapter 4 for detailed information about privacy breaches.

Where a dental hygienist is not responsible for the information practices of an organization, s/he should advocate for changes to those practices to address safeguard issues. In the long run, a dental hygienist should not contribute client information to an organization that has ongoing, serious security lapses.

CLIENT ACCESS AND CORRECTION RIGHTS

A client has the right to have access to his or her complete chart. This right exists under case law[8] and both the *Personal Health Information Protection Act, 2004* and the federal *Personal Information Protection and Electronic Documents Act*. Exceptions are rare and relate primarily to any serious safety concerns for third persons or, in rare cases, the client. This access applies to the entire chart, including consultation reports and any documents provided by other practitioners.

A client's right of access extends to persons authorized by the client to access the chart, including family members, other practitioners and lawyers. Where a client is incapable, a substitute decision maker would authorize the access. See Chapters 4 and 5 for more details.

Reasonable fees or administrative obligations can be imposed on a client's access rights. Dental hygienists may offer to review the entries with the client first to explain any abbreviations or technical terms. However, fees and administrative obligations should not be barriers to prompt and easy access to records by clients. Unless the entries are particularly sensitive, dental hygienists should consider providing a copy of the chart for free or at cost.

Some of the entries will occasionally be challenged by a client. Dental hygienists need to consider requests for record changes. Where a request relates to a factual entry (e.g., year of birth) and the dental hygienist agrees that the record is inaccurate, then a change should be made. However, for audit trail purposes, the original entry should not be obliterated. Rather you should indicate that the original entry was in error, striking it out with one

[8] *McInerney v. MacDonald* (1992), 93 D.L.R. (4th) 415 (S.C.C.)

line so that it is still legible, and inserting a corrected entry indicating the date and person making the correction. It would be appropriate for you to send the corrected entry to those who have had access to the erroneous one if asked by the client.

If the dental hygienist does not believe that the entry is wrong, then no correction should be made. This is particularly true where the entry contains an evaluative component or an expression of professional opinion. However, if the client continues to dispute the entry after the dental hygienist's explanation, the dental hygienist should permit the client to file a statement of disagreement in the chart. Depending on the nature of the issue, the dental hygienist might also send the statement of disagreement to those who had recent access to the entry.

Where there is a joint record, the custodian of the record should consult with the person making the entry before taking any corrective measures. For example, it would be unfortunate if an office manager decided to change the results of an assessment recorded by a dental hygienist at the request of the client without first discussing the matter with the dental hygienist.

RETENTION OF RECORDS

Records need to be retained for a reasonable period of time, not only for the purposes of ongoing care, but also for accountability purposes. Indeed, it is in a dental hygienist's own interest to have the record available should there be any question about the intervention.

Under the College's Records Regulation, a client record should be kept for at least 10 years since the latter of:

- the client's last visit or the last chart entry; or
- the date at which the client turned 18.

The latter reference is in recognition of the fact that the limitation period for a child suing a dental hygienist does not begin to run until the child turns 18. A record should be maintained of when each client chart was destroyed. At a minimum this record might note the name of the client, any file number, the date of last treatment and the date the file was destroyed.

- Communal screening or treatment records should be kept for a minimum of three years.
- Retention requirements apply to both paper and electronic records, including digital radiographs.
- Under the *Personal Health Information Protection Act, 2004* you should have a written retention policy.

DISPOSAL OF RECORDS

Records must be kept in accordance with the Records Regulation and dental hygienists must ensure that records are disposed of only after the expiry of the specific retention period and that records are not disposed of until it is safe to do so. If a client has filed a complaint to the Information Privacy Commissioner those records should be kept until the individual has completed the process of the investigation.

After the expiry of the specific retention period, records must be completely destroyed to the extent that they cannot be reconstructed.

- Dispose of records in a secure manner only after the expiry of the specific retention period.
- Do not dispose of records that are subject to an access request until the individual has exhausted any recourse regarding the request (e.g. Complaint to the Information Privacy Commissioner).
- Ensure that records are destroyed in such a manner that they cannot be reconstructed. (e.g. Using cross-cut shredding for paper records).

TERMINATING OR TRANSFERRING YOUR PRACTICE

The overriding principle when a dental hygienist leaves a practice is client care. This means that you have to be in a position to ensure that the client can have access to the information in the record and that the client can transfer that information to any subsequent treating practitioner. In addition, given your record retention obligations (see above) and your accountability to the client, the College and others as to the care provided, you must ensure access to your records after you leave.

You can achieve this access in one of two ways:

1. In cases where the dental hygienist is the owner of the records, s/he may take the clients' records with her/him. When the clients' records contain documentation from other practitioners that may have treated the client, the dental hygienist has an obligation to maintain the records and may be required to provide access to the other practitioners. The dental hygienist may consider leaving a copy behind.
2. Where the dental hygienist is not the Health Information Custodian (owner of the records), the departing dental hygienist can take a copy of her/his client records with her/him, provided the Health Information Custodian is in agreement. If the Health Information Custodian is not in agreement, the departing dental hygienist can leave the records behind on the understanding that they will be maintained for the required period of time and that s/he can have access to them if required. It is inappropriate for the dental hygienist to unilaterally remove the original or a copy of the client records if the dental hygienist is not the Health Information Custodian (owner of those records).

In both these situations, clients must be informed of the location of their oral health records.

If you own the practice and retire or sell it, you must deal with your records. While the piece of paper or digital files may belong to you, the information on them belongs to the client. Section 25 of the professional misconduct regulation specifies a dental hygienist's obligations to clients. It reads as follows:

> 25. Failing to make arrangements with a client or his or her authorized representative for the transfer of the client's records in the care of the member,
>
> i. when the member retires from practice,
>
> ii. when the member changes office location and the client or his or her authorized representative requests that the records be transferred, or
>
> iii. when requested to do so by the client or his or her authorized representative.

When records are physically leaving an office, reasonable efforts should be made to ensure that clients know where their charts are and that they have control over who holds them. "Reasonable" depends on the circumstances. A one-time encounter with a client eight years earlier might not require a letter of notification if the chart is transferred to another dental hygienist. A publication in the local newspaper may be sufficient. However, it would be appropriate to send a letter to a client who has received an intensive amount of assistance in recent months, or to one who is still requiring on-going intervention.

Dental hygienists may work in practices that are not owned by a regulated profession. Although *PIPEDA* may apply to the non-custodian employer, the collection, use or disclosure of personal health information by dental hygienists working for these non-custodians in the province of Ontario is governed by *PHIPA*. It is important to note that, even in unforeseen circumstances, dental hygienists are still responsible for ensuring the security of records at all times and for fulfilling their obligations under *PHIPA*.

When a dental hygienist works in a practice owned by a non-regulated person or sells or closes her/his dental hygiene practice, special steps must be taken to ensure that clients records will be safeguarded. For more detailed information, please refer to the document entitled: *Avoiding Abandoned Health Records: Guidance for Health Information Custodians Changing Practice*.

The *Personal Health Information Protection Act, 2004* has rules about the transfer of records to another practitioner (e.g., a prospective purchaser must sign a confidentiality provision before reviewing the records for the purpose of completing the purchase of the practice).

- Identify the health information custodian who will manage the health information records of your former clients.
- Notify clients of a change in practice.
- Ensure that your former clients know who is keeping the records, how long records will be retained for and how to access them.
- Ensure that the health information custodian retains the records in a secure manner.
- If records are to be transferred, this must be done in a secure manner.
- Make arrangements for the safe disposal of records after the expiry of the specific retention period set out by the governing legislation.

CONCLUSION

Good client records are needed to support quality dental hygiene services. As an essential part of a dental hygienist's accountability to clients, employers, payers and the College, records must capture significant information such as the information described in the College's records regulation. There are many charting styles and formats and dental hygienists should be mindful of the opportunities and risks associated with each of them. Dental hygienists should take necessary steps to ensure accuracy, security and appropriate access to their records. **Joint records and private records pose special problems related to access, security and retention and careful consideration must be given to them to ensure that legal and professional requirements are met in all cases.**

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 6-1 "Joint Records" above, is the recordkeeping system adequate?**
    a. No because the records are not kept in accordance with College and professional expectations.
    b. No because people other than you control the record.
    c. Yes because the person served is a client of the dental office, not your client.
    d. Yes because the record is maintained according to the criteria of your employer.

2. **In Scenario 6-1 "Joint Records" above, what should you do?**
    a. Keep your own records separate and apart from the office chart.
    b. Make your entries on the office chart but keep a copy for yourself.
    c. Review the records at the end of the day to ensure that they are adequate.
    d. Explain the situation to the client and obtain his or her consent to follow the office's recordkeeping practices.

3. **In Scenario 6-2 "Keeping Private Records" above, should you keep separate records and then discard them when no longer needed?**
    a. Yes, as no one else needs this additional information.
    b. Yes, so long as you get the permission of your office and you do not discard the information for 10 years.
    c. Yes, as the official chart contains the minimal information expected by the College.
    d. No, private records are too dangerous to keep.

4. **Reasonable security measures for client health records would likely include all except which one of the following:**
    a. Written policies and procedures.
    b. Records will never leave the office.
    c. All staff are told they must follow the need-to-know rule.
    d. Access to records is on a need-to-know basis.

5. **Client records should be retained for:**
    a. 10 years from each visit / entry.
    b. 10 years from the last visit / entry.
    c. 10 years from the last visit / entry or since the client turned 18, whichever is longer.
    d. 5 years for most diagnostic imaging records.

A suggested answer to each question is found in Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 7 — CONFLICTS OF INTEREST

NEED TO KNOW

1. A conflict of interest occurs where you have a personal interest that a reasonable person might think could improperly influence your professional judgment.
2. Some conflicts are best managed by complete avoidance.
3. Most conflicts can be successfully managed by the **DORM** principle — **D**isclosure, giving **O**ptions, providing **R**eassurance and **M**odifying the circumstances.

THE DEFINITION OF "CONFLICT OF INTEREST"

Scenario 7-1 "Gifts to Office Manager"

You work in an orthodontic practice. You act as the informal office manager, at least when it comes to ordering supplies. Your employing dentist is hopeless when it comes to administrative matters and since you have taken over, supplies don't run out. One of the suppliers is really pushing for you to use expensive, gold archwires. Clients who receive them are charged extra. You give it a try and they seem to work well. On a return visit, in December, the supplier pushes for a larger order. He takes you out to lunch to have undisturbed time to discuss the new offerings for the next year. At the same time he gives you a box of chocolates and a fine silk shawl from Holt Renfrew as a "Christmas present". Is there a conflict?

The fiduciary duty of dental hygienists to their clients, reviewed in Chapter 1, includes being loyal, diligent and, in good faith, to act in the best interests of clients. They may also have a duty to others such as their employers, other colleagues, third-party payers and to the general public. Clients, colleagues and others need to be able to trust their dental hygienists. Having a conflict of interest can undermine that trust. A conflict of interest occurs where you have a personal interest that, in the mind of a reasonable person, could improperly influence your professional judgment.

There are four principle elements to this definition:

1. You have a **personal interest**. This interest can include any benefit, gift, advantage or preferential treatment. Examples might be monetary payment, hospitality, a rebate or discount in what you might otherwise pay for something, a loan or other business opportunities. The interest might be direct such as a payment to you, or could be indirect such as a benefit to a family member or an advantage for your employer for which you would obtain recognition. The personal interest could also be of a moral nature regarding a strong religious or moral view on an issue affecting your client.
2. The interest relates to a **professional judgment** you have to make. It can be quite explicit, a specific treatment recommendation for a specific client, or can be implicit; by not objecting you may be deemed to be supportive of an action, program or product. A common factor in all conflicts of interest is that your professional status and capacity as a dental hygienist are in question; private or personal decisions are not the issue. A conflict between family members about who should be invited to a wedding, for instance, would not be relevant to your role as a dental hygienist.
3. The interest could **improperly influence** you. It must be something that could hold sway over you because you want the benefit or because you wish to avoid a loss that accompanies the interest. Thus,

a customary or trivial benefit such as a bottle of home-made wine would not constitute a conflict of interest. On the other hand, paying for an out of country vacation might improperly influence you.

4. The interest must be weighed from the perspective of a **reasonable person**. A conflict of interest is not determined from your own perspective, but from the perspective of a neutral observer. Consequently, the fact that a conflicting interest did not, in fact, influence you is irrelevant because third parties cannot read your mind. The test of what constitutes a conflict of interest is what most people would think reasonable. As a result, a perceived or potential conflict of interest is as significant as a real conflict of interest. In this area of professionalism, appearances count.

The *Code of Ethics* identifies some of the factors that can create a conflict of interest by referring to your duty of beneficence, accountability and professionalism.

Scenario 7-1, "Gifts to Office Manager", illustrates a classic conflict of interest. A personal interest is found in the expensive silk shawl and other gifts and benefits. As office manager, you have to exercise professional judgment in making purchases in the best interest of your employer and clients. You must consider whether the gifts offered by this supplier could reasonably influence your professional judgment in the mind of a reasonable observer. In assessing the situation, you should consider:

- The value of the benefits;
- The frequency of the gifts;
- Who actually obtains the benefit;
- Who the gifts are from;
- Any perceived "motivation" behind the gifts;
- Any policies that exist at your organization;
- Your employer's knowledge of these activities;
- Your client's knowledge, freedom of choice and any additional charges arising from these activities; and
- Any generally accepted practices in the profession.

Assuming that no office policy exists to the contrary, a reasonable approach would be to accept the chocolates as a minor goodwill gesture but make them available to all staff. Accepting a rare lunch without alcohol at a modest establishment, where business is the primary topic of discussion might be justified on the basis of developing a good relationship with the supplier and to enhance the information you need to make good purchasing decisions and avoid distractions at the office. It would be prudent, however, to think carefully about the lunch and, at a minimum, advise your employer that this is happening. If there were frequent lunches, even if any one were insignificant, cumulatively they might become significant. So you would want to ensure that their frequency did not create an appearance of conflict.

An expensive shawl, on the other hand, could reasonably be viewed as influencing your professional judgment and could potentially constitute a conflict of interest. In this case, the concern is that purchasing decisions would not be made on the basis of quality and value alone, but on the basis of appreciation for the gift you had received. Your employer might well have chosen to negotiate a price reduction on the gold archwires rather than have you receive the shawl.

CATEGORIES OF CONFLICTS OF INTEREST

One of the greatest difficulties in dealing with conflicts of interest is that they are often difficult to recognize because they come in many different shapes and forms. Reviewing some of the recurring forms and examples may be the best way to prepare for them. The main categories include:

- Receiving a **benefit from a supplier**. Scenario 7-1, "Gifts to Office Manager", is one illustration. A related conflict is **conferring a benefit** for a referral of business. For example, a dental hygienist in private practice might be tempted to offer a nurse in a long-term care facility $20 for every new client referred. This can promote unnecessary services or, at the very least, result in third party steering of clients to a dental hygienist on the basis of criteria other than a client's best interest.

  Incentives to new clients (e.g., free tooth whitening kit) are also questionable because they may promote unnecessary services or the disruption of continuity of care. Even freebies for existing clients, (e.g., the traditional free toothbrush and floss), are an area of concern and if offered, should be of nominal value. Incentives that are not for the maintenance or promotion of well-being or oral health, are inappropriate (e.g., movie passes, coffee cards).
- **Improperly using one's influence or status**. Dental hygienists, as regulated health professionals, have a special status in our society. Using that influence to endorse a product, especially if it is for money, could constitute a conflict of interest. For example, appearing in an advertisement for an oral health care product would constitute an endorsement. Even passing out samples to clients contains an implicit endorsement of that product and should be handled thoughtfully (e.g., advising clients that the brand is irrelevant; it is the product that matters).
- Allowing one's **personal, moral or philosophical beliefs** to interfere with professional judgment is also a source of concern. Having strong views about the morality of smoking or drinking wine (e.g., where these activities might be against your religion), for example, should not interfere with giving balanced professional advice about the health, particularly oral health, impact of those activities.
- Dispensing a **product for a profit** raises an issue that requires analysis. Clients come to dental hygienists primarily for professional advice and services, and expect to pay for that expertise. However, not all clients would understand that there might be a profit built into the price of a product purchased from a dental hygienist. This explains why selling oral health products to clients at a profit is generally viewed as a conflict of interest. The conflict resides partly in any perceived personal financial motive you may have in recommending the products. In addition, you should be mindful that some clients might feel pressured to buy products from you, fearing that the quality, availability or friendliness of your service might otherwise suffer.
- A similar concern exists when a client is **referred to an apparently arm's length organization** in which the referring dental hygienist **has a personal interest**. Referring a client to a mouth guard clinic where the referring dental hygienist's family is part owner confers an indirect benefit to you. Again, you should be mindful of personal motives in recommending products or services from a family business and about how this activity might be perceived by others. Clients should, at a minimum, be informed of your relationship to the family outlet and they should feel free to shop around without feeling pressured.
- A dental hygienist seeking a client's participation in a **research project** has an inherent conflict of interest. The dental hygienist obtains a benefit from the client's participation while that participation may not be of benefit and, in some circumstances, may be potentially harmful to the client. As explained below, this potential conflict of interest can be managed through proper safeguards.

- **Personal use** of a client's or employer's things is also a potential conflict of interest. Depending on office policy, using an employer's computer to surf the Internet may be viewed, as a misuse of resources intended for professional purposes including your time and diligence to practice matters. More troublesome would be using a client's computer on a home visit. Even if the client purported to consent, the client might have felt pressured because of your influence and stature and might even question the basis of your professional concern for them. In this illustration, the potential boundary crossing is of even greater concern than any subtle influence gifts might have on your professional judgment. (See Chapter 8, Boundary Issues, for more detail.)
- As discussed above, even if not solicited, any **gifts from clients** unless very small, raise the same concerns. If the gift is significant the client may expect special consideration in return. In addition, gifts from clients raise boundary issues.

ADDRESSING CONFLICTS OF INTEREST

It is quite important to recognize that not all conflicts of interest are prohibited. They all require an action of some sort, but complete avoidance is not necessarily the only answer. Sometimes other alternatives are acceptable. Below are examples of conflicts of interests that might occur in dental hygiene practice which need to be managed. Possible strategies for managing them are included in the quiz at the end of the chapter.

Scenario 7-2 "Bartering With the Roofer"

You work in a small town dental office. You need roofing work done. There is only one professional roofer in town. He happens to be your client. During a visit you discuss that you might require his services. He says, "Look let's cut out the tax man and the middle man. I will give you a 10 percent discount on the roofing job if you give me and my family each a free cleaning". What do you do?

This scenario raises a number of issues.

- If you are employed by a dentist, is this fair to him or her?
- Will this interfere with the freedom of choice of the roofer's family members should they choose to go to another office?
- Will this influence the treatment recommendations you might make, perhaps tempting you to give less (or more) than you otherwise would?
- Is this tax evasion? Do you as a professional have a duty to be a good example of honesty in all of your dealings?

This scenario also raises some boundary issues, which are discussed in more detail in Chapter 8.

Scenario 7-3 "Promoting a Product"

You work in sales to dental offices. Your company has developed a two-part fluoride rinse that it wants to aggressively promote. It is supposed to be as effective as a regular, longer fluoride treatment. You check the literature on the product and find that the research is weak. What are your professional obligations? Can you promote the product? Are you in a conflict of interest?

As a registered dental hygienist, promoting oral health related products is a delicate matter. You have a certain stature and respect because of your expertise. Using your position to promote a product when you have a competing interest to your customers (i.e., the dental offices you sell to) and to the ultimate consumer is a conflict of interest. The issue here is identifying and understanding the nature of the competing interests. The company hiring you wishes to make a profit from selling the products that you are asked to promote. The company knows that, as a professional, your opinion about the effectiveness of the product is respected by its customers. They are buying that trust.

The perceived conflict lies between the interests of the company paying you to represent their products and that of other dental hygiene professionals and consumers expecting that your representations of the product will be in their best interests. A reasonable person could question where your interests lie: with the company or the customer and consumer. In most circumstances, however, transparent, honest and evidenced-based promotion of a product could perhaps be perceived as managing the conflict appropriately.

Your customers are not "clients" except in the most commercial sense of the term. They can still reasonably expect, however, that you will be transparent. For example, they expect you to clearly identify your role as a sales agent for your employer. They can also reasonably expect that any oral health effectiveness claims you make will be fair and accurate and not misleading by omission either verbally or in print. You must ensure that your representation of the product is always based on evidence.

The situation would be quite different if, as a dental hygienist, you were to participate in advertisements to the general public endorsing the product. In that context, your duty to the general public would be a competing interest. Dental hygienists may well wish to avoid those sorts of endorsements entirely because they are so open to misunderstanding.

Scenario 7-4 "Selling April"

You are an outgoing, social person. One of the best parts of your job is speaking with clients and despite the natural hurdles to carrying on a conversation during treatment you manage to do so. You also sell April products. Not only does this put a few extra dollars in your pocket, it also permits you to socialize with other women and provide them with great quality products. You would never sell April, a high-end cosmetic company, products at the office. However, you wonder if you could pass out invitations to an April party to clients (there is no pressure on them to attend). You also wonder if a dental hygiene client places an April order, whether it is OK to deliver it to them on their next office visit if the timing happens to coincide.

In this scenario, the primary conflict of interest is that clients might feel pressured to come to an April party or support your April business. You have to recognize that, for at least some of your clients, you are in a position of trust and power. They may feel that if they do not support your side business they might end up being treated differently or that you would think less of them. The fact that the products for sale are not related to your professional practice does not remove this potential conflict.

In addition, you need to be extra careful because your outgoing personality might be misunderstood by some. Some people might interpret it as a form of pressure. Others on the other hand, might feel that you are more than a treating professional, you are trying to become their friend. See Chapter 8 on boundaries.

Another potential conflict is with your employer who might feel that this activity might drive away some clients who prefer to have more social distance from their dental hygienist.

Scenario 7-5 "Sponsored Conference"

You are a respected dental hygiene instructor. You are speaking at a conference on recent research about the ergonomics of dental hygiene. Your presentation is focusing on instrumentation, but you were going to mention office design as well. After agreeing to speak, you receive the conference materials and learn that each session has a corporate sponsor. A manufacturer of special dental chairs is sponsoring your session. Is there a problem?

As in Scenario 7-3, "Promoting a Product", one of the dilemmas here is whether you are using your professional status to implicitly endorse the dental chair manufacturer. In addition you would not want to be in a situation where you felt pressured to slant a presentation in a particular way in order to avoid upsetting the sponsor. To a large extent, the perception of conflict would depend on how the sponsorship was portrayed before, during and after the conference, how much influence the sponsor had or appeared to have over the content of the presentation, and what other safeguards were in place.

In some circumstances, there might be an inference of influence over the content of the presentation if the dental chair manufacturer's logo was on your paper or handouts. Additional information would be required to clarify the situation. Another possible safeguard might be a disclaimer in the written materials that you had no connection with the sponsor. The organizers of the conference could also be approached to ensure that there is no actual or perceived influence of the sponsor over the content of the presentation.

CONFLICTS THAT SHOULD BE AVOIDED ENTIRELY

Some conflicts of interest need to be avoided entirely. In some cases, no amount of safeguards can present a reasonable level of confidence in the appropriate exercise of your professional judgment. For example, accepting a benefit beyond the trivial from a supplier of products that you recommend to your clients should probably be avoided at all times. No amount of disclosure to clients will provide an objective and reasonable level of confidence in your professional judgment if you recommend brand name oral health products from a company that pays for your Caribbean holiday. If in doubt as to whether a conflict of interest should be avoided entirely or not, discuss the issue with experienced and respected colleagues.

There are a number of conflicts of interest that are not salvageable by safeguards. These occur where a registrant, or a related person or related corporation, directly or indirectly,

- confers a benefit for the referral of a client to the registrant,
- accepts a benefit for the referral of a client to another person,
- practices in another regulated or non regulated health care discipline and inappropriately connects the provision of dental hygiene services to the use of the other service provided.

The following circumstances should also be avoided entirely to prevent a serious conflict of interest from arising:

- Conflicts involving more **vulnerable clients** or those less able to protect themselves should be avoided. Certain individual health clients are more likely to be vulnerable than your employer or a business colleague.
- Avoid conflicts that relate directly to client assessments or treatment recommendations (e.g., a referral to a specialist who is related to you). The closer the professional interest is to **your core expertise**, the more likely it is to create a perception of conflicting interests.
- The **larger the benefit**, the better to avoid it entirely. Once you move from the scores of dollars to, perhaps, the hundreds of dollars and certainly to the thousands of dollars, it is increasingly difficult to deny the potential influence this gift may have upon you. It is more likely that a reasonable observer would believe that you might exert not only influence, but pressure on your client in view of this gift.
- Avoid any situation where clients may not be likely to use **disclosure or other safeguards to protect themselves**. For example, disclosing to an elderly client that changing his or her will to include your research program will benefit you is unlikely to assist that client in protecting themselves from your request.

CONFLICTS THAT CAN BE MANAGED BY SAFEGUARDS

Scenario 7-6 "Family Mouthguard Business"

You work in a dental office in the suburbs with lots of athletic child clients. Many of your young clients are involved in hockey and other contact sports where mouthguards are required. Your family operates a custom made mouthguard business that makes high calibre mouthguards with innovative designs. Can you refer your clients to the family business?

Many conflicts of interest can be managed through safeguards that involve openness and transparency in addition to fostering an environment where clients are not pressured to make choices. These safeguards are developed using the DORM principle: (Disclosure, Options, Reassurance & Modifications). It is fair to say that most conflicts of interest can be successfully managed by the DORM principle.

- **Disclosure.** The primary safeguard in managing any conflict of interest is disclosing to your client and any other interested party, such as your employer, the nature of the conflict, including the potential benefit to yourself. While simply disclosing the conflict may not always be sufficient, failing to disclose it will almost always be a breach of your professional obligations. In the family mouthguard business example, you would advise the client that your family owns the store. Upon request, disclosure should also be made to the College as well.
- **Options.** Providing clients with additional options will permit them to make an informed choice and reduces the pressure on them. In the family mouthguard business example, you would provide your client with a list of two or three other outlets for similar products or services. The options might identify which are more generic (and cheaper) and which are customized (and more expensive).
- **Reassurance.** A common concern for clients facing such a choice is that you will be insulted or put out if they do not accept your recommendation. It is important to reassure them that choosing another product or service from the list will not affect their ability to receive professional services from you. The only exception would be where choosing the other supplier could result in inconsistent treatment, a rare occurrence and one that is difficult to envision with the family mouthguard business example given above. An example of possible inconsistent treatment is where you recommend a dental periodontal specialist and the client chooses to go to another family dental practice for treatment.

If there was not good communication between the two offices, duplicative or even inconsistent treatment could occur.

- **Modification.** Occasionally making a small modification in a situation can remove or greatly reduce the potential for conflict. For example, much concern would be alleviated if you were to arrange for your family's family mouthguard business to provide recommended products to your specific clients at no profit.

The College recognizes the value of the **DORM** principle for managing some of the conflicts of interest that dental hygienists may encounter in practice.

CONCLUSION

A conflict of interest occurs when a personal interest arises that could improperly influence a dental hygienist's professional judgment in the mind of a reasonable person. Although some conflicts are best managed by complete avoidance, most conflicts can be successfully managed by the **DORM** principle. If in doubt, discuss the matter with a colleague that you trust or phone the College for advice.

Quiz

For each of the following scenarios discussed earlier in this chapter, express your view as to whether the concern can be addressed through the **DORM** principle. If so, set out the safeguards that might successfully manage the potential conflict.

- Scenario 7-1 "Gifts to Office Manager"
- Scenario 7-2 "Bartering With the Roofer"
- Scenario 7-3 "Promoting a Product"
- Scenario 7-4 "Selling April"
- Scenario 7-5 "Sponsored Conference"

A suggested answer to each question is found in Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 8 — BOUNDARY ISSUES

NEED TO KNOW

1. A boundary crossing occurs where you permit another type of relationship or feelings towards or from a client to interfere with your professional relationship.
2. Boundary issues are insidious and can creep up through good-hearted actions.
3. It is always the responsibility of the dental hygienist to maintain professional boundaries.

THE CONCEPT OF BOUNDARIES

It has been said that a boundary crossing is like a conflict of interest, except that the competing interest is one's feelings rather than money. In order to remain objective with your clients and not confuse them as to your role and intent, it is important to maintain a "professional distance". If you become more than a dental hygienist to a client, that client may be uncertain as to why you are asking certain questions or why you are giving certain advice. Sometimes that confusion can have profound effects on the professional relationship or the well-being of clients and others.

Scenario 8-1 "Hiring a Client"

You volunteer once every two weeks at a community clinic that serves new immigrant women and their children. You have spent some time assisting Felicia and she has shared with you some of the terrible things that have happened in her life and you know she has virtually no money. She asks you if she could clean your house. In fact you are looking for a house cleaning service and would be pleased to pay her generously. Is there a problem?

In this scenario, you are being asked to enter into a dual relationship with the client: to be both her dental hygienist and her employer. Difficulties can arise when a dental hygienist has such a dual relationship. If you hired Felicia to clean your house, the following situations could occur:

- The employer-employee relationship tends to be more directive than the more collaborative dental hygienist-client relationship. The client might feel compelled to follow your treatment recommendations without question in appreciation of her other relationship with you or for fear of losing her job with you.
- If the client failed to meet your house cleaning expectations, you might have to confront her and perhaps even terminate her services. That disciplinary step could easily damage your ability to engage the client in an ongoing dental hygiene treatment program.
- The client would learn much about your private life and this could interfere with the clinical relationship. This knowledge could provoke a wide range of responses, from idealized respect at your respective wealth and success to disdain because of perceived defects in your lifestyle or personal foibles. Either way, the healthy dialogue and give-and-take of the professional relationship could be damaged.
- You could become dependent on Felicia's excellent service and be prone to let it interfere with your professional judgment in her clinical care. For example, you may keep her on as a client despite the fact that she no longer meets the community group's eligibility criteria in order to maintain the house

cleaning relationship. Or, you may give undue weight to her requests for special or even inappropriate assistance.

- Other clients who find out about the house cleaning arrangement might feel that you are treating Felicia as "special". They might ask for similar consideration and be upset if you say no.

A boundary crossing has a threefold risk; one for you as a professional, one for your client and one for any observers of the relationship. It can interfere with your professional judgment because of an emotional or other benefit you gain or because you fear that your inappropriate conduct will be exposed. Conversely, it can compromise a client's ability to question your treatment suggestions or provide an informed and voluntary consent. You can probably identify a number of other complications arising from this scenario.

WHY BOUNDARY CROSSINGS OCCUR

Dental hygienists, like most health practitioners, often choose their career to "help" people. They try to establish a therapeutic relationship of trust and openness on the part of the client. It is only human for a dental hygienist to try to reciprocate by being open as well, without realizing that this may not always be appropriate.

Dental hygienists have a fairly unique risk factor in that during most visits they have a silent captive audience. This circumstance provides an opportunity for the dental hygienist to engage in self disclosure with very little feedback from the client as to how it is being received. This circumstance requires a strong sense of boundaries by dental hygienists.

Another risk factor that is rare for other professions is that dental hygienists can see clients regularly over a very long period of time. In some circumstances, depending on both your personality and that of the client, you can have a fairly detailed overview of a person's life story.

It is also important to keep in mind that a client can initiate a boundary crossing. Indeed, s/he may do so in good faith, not understanding the boundary or the reason why it exists. **It is your responsibility as the dental hygienist to maintain the boundary, as you are the professional in the relationship.** Also, you are generally considered to have the power that comes from knowledge and expertise and the ability to prevent or resolve pain and periodontal disease. Unfortunately, because dental hygienists are often "helpful" by nature, they may find it hard to say no.

Scenario 8-2 "Pregnancy Crisis"

You have treated Alyssa since she was a child. She has a delightful personality that just brings out your nurturing instinct. Alyssa's mother on the other hand is immature and needy and has been through quite a few relationships with men. You have often worried how this would affect Alyssa. Alyssa is now 14 and has declined an x-ray because she may be pregnant. She asks you not to tell her mother because she does not know for sure. She starts to tear up and you just want to give her the biggest hug of her life. What do you do?

Alyssa clearly needs help. However her issues are outside of your area of professional expertise. Obviously Alyssa likes and respects you and you want to help her. There is a therapeutic way and a non-therapeutic way in which you can use this position of influence and the confidential information it has elicited. The difficulty is in

recognizing the difference and, sometimes, resisting your own personality to do what might not be best for the client. See the quiz questions below for further perspectives on this scenario.

Typically, boundary problems present themselves in a dental hygienist's area of weakness or vulnerability. A dental hygienist with a tendency towards rescue fantasies will be able to handle a sexually precocious young client, identifying the need to keep the boundary clear, but may get into trouble with Alyssa's case. S/he may want to become a "big sister or brother" or "parent" in order to help "save" this client. Of course, the infinite human capacity for self-deception exacerbates this cause of boundary invasion.

Boundary Checklist

This checklist will help you assess whether a boundary crossing may be occurring.
• Is this in my client's best interest?
• Whose needs are being served?
• Could this action affect my services to the client?
• Could I tell a colleague about this?
• Could I tell my spouse about this?
• Am I treating the client differently?
• Is this client becoming special to me?

CATEGORIES OF BOUNDARY CROSSINGS

Boundary crossings are subtle and are often motivated by what appears to be the most noble of intentions. They are not, for the most part, products of predatory behaviour. Boundary crossings are insidious, usually beginning with small actions that by themselves are innocuous but which over time become cumulatively significant. There are a number of ways in which a boundary can be crossed. Some of the more common examples include:

- **Self disclosure.** While careful and limited disclosure of details about you can help develop a rapport, it has to be managed with extreme care. Sharing personal details about yourself can confuse your client. The client might assume that you want to have more than a professional relationship. It might suggest that the professional relationship is serving a personal need of yours. Clients might even become concerned that you are so self-absorbed in your own circumstances that you are not being attentive to their treatment (particularly if you interrupt the procedure in order to "finish the story"). Self-disclosure can also result in your own dependency upon the client, which is damaging to the therapeutic relationship.
- **Giving or receiving of gifts.** Gift giving is potentially dangerous to the professional relationship. A small token of appreciation by the client purchased while on a holiday or given at the end of a course of intensive treatment can be acceptable. However, anything beyond that can indicate that the client is developing a personal relationship with you, holds you in excessive regard, or may even expect something in return. Gift giving by a dental hygienist is open to misinterpretation. Even small gifts that have an emotional component, such as a "friendship" card, can raise similar questions even though the financial value is small.

- **Dual relationships.** As discussed above, any dual relationship has the potential to have the other relationship interfere with the professional one. Even selling non-health products to clients can lead to problems (e.g., if the product does not perform as expected or if the client forms the opinion that the price was too high). It is best to avoid dual relationships whenever possible. Where the other relationship pre-dates the professional one (e.g., a pre-existing friend), referral to another practitioner is the preferred option. Where a referral of an existing relationship is not possible (e.g., in a small town, where you are the only dental hygienist in an office), special safeguards are essential.

It is common for co-workers to treat each other in an office. This is often viewed as a "benefit" of the job and saves money. In addition, it may also be viewed as a chance to compare and/or evaluate techniques and provide some professional or collegial feedback. While this practice is accepted in the profession, it does raise boundary concerns and caution should be exercised. For example, will the "intimate" questions in the history form really be asked? The visit should be treated as a formal one, with a full assessment and treatment, maintaining a professional demeanour with no "horsing around", full documentation and the giving of all appropriate advice. In addition where there is any issue that arises (e.g., non-compliance with advice, identification of a possible condition outside of one's expertise), a referral to an external practitioner should be made.

- **Ignoring established conventions.** While being a rebel looks brave and individualistic in the movies, the reality is that established conventions (such as having treatment sessions during scheduled business hours when other staff are present) usually exist for a reason. Ignoring established conventions is a professionally high-risk activity.
- **Rescue fantasies.** Most health care workers like to help people. It is an important part of their self-image. However, there is a point where rescue fantasies of fragile or vulnerable clients can fulfill the needs of the dental hygienist and be harmful to the client. Dental hygienists should be attempting to cultivate the autonomy of clients and not foster their dependence upon the dental hygienist. In addition, dental hygienists should not assume the role of an expert in matters outside of their scope of practice (e.g., trying to provide family counselling).
- **Becoming friends.** Being a personal friend is a form of dual relationship. Clients should not be placed in the position where they feel they must become a friend of the dental hygienist in order to receive ongoing dental hygiene care. It is difficult for all but the most assertive of clients to communicate that they do not want to become friends. While one cannot say that it is always improper to become a friend of a client (especially in a small community or where you see the client outside the office in a church, health club or other organization you both happen to join) it is important that the professional relationship is not used to search for new friends, even if one is new to the community.
- **Romantic relationships.** The most obvious boundary crossing is developing a romantic or sexual relationship with a client. This is discussed in more detail below.
- **Touching.** Touching can be easily misinterpreted. What may be intended as encouraging by the dental hygienist (e.g., hugging a teen when s/he has their braces finally removed) or an innocuous contact (e.g., allowing a tube or instrument to rest on the chest of a client) can sometimes be misinterpreted as an invasion of space or even a sexual gesture by a client. Extreme care must be taken in any touching between dental hygienists and their clients.

SEXUAL ABUSE BOUNDARIES

Most dental hygienists would think that the sexual abuse provisions would never apply to them. However, complacency in this area is dangerous for a number of reasons:

- **Sexual abuse can be "consensual".** The popular notion of a practitioner physically assaulting a client is not what most sexual abuse is about in the health professions. Dental hygienists who "fall in love" with their clients and who believe that their clients return the feeling and "consent" to the personal relationship are engaging in sexual abuse. Indeed, it is no defence even if the client vigorously initiates the relationship. Such "consent" is not valid where there is an imbalance in the relationship. By definition, clients come to a dental hygienist because they have a "problem" (or want to prevent one from developing) and want to access the expertise of the dental hygienist. These and other circumstances (e.g., societal status accorded to health professionals generally) create an imbalance of power between the dental hygienist and the client that requires the maintenance of professional boundaries. The first discipline case of the CDHO involved a consensual sexual relationship with a client, resulting in the revocation of the dental hygienist's certificate of registration (revocation was mandatory under the *Regulated Health Professions Act).*

In 2015, the CDHO submitted a Spousal Exception Regulation to the government which would permit dental hygienists to treat their spouses without it constituting sexual abuse as long as the dental hygienist was not engaged in the practice of the profession when the sexual conduct occurred. The regulation was passed by the Ontario government on **October 8, 2020**.

The definition of a "spouse" for the purposes of this regulation is very narrowly defined in the Health Professions Procedural Code of the *Regulated Health Professions Act, 1991* (RHPA), and includes **only**

(a) a person who is the member's spouse as defined in section 1 of the *Family Law Act* (i.e., a person to whom the member is married), or

(b) a person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years.

The passing of this regulation into law means that dental hygienists are now permitted to treat their spouses but only where the member's spouse actually meets the statutory definition of "spouse" (i.e., is a person to whom the member is married or with whom the member has been living in a conjugal relationship continuously for at least three years) and where the sexual relationship is kept entirely out of the office setting. While treating a spouse, the dental hygienist must follow all of the professional formalities and maintain the professional distance that the dental hygienist would for any other client. Similarly, when the dental hygienist is out of the office (e.g. at home), the professional relationship must not be allowed to intrude on the personal relationship.

Treating a sexual partner who does not meet the definition of a spouse under the RHPA will continue to be considered sexual abuse.

Should a mandatory report, complaint or other information be brought to the attention of the College that a dental hygienist is treating someone with whom the dental hygienist is having a sexual relationship with, and if this person does not meet the definition of spouse under the RHPA, this could lead to a referral to the Discipline Committee. The mandatory penalty for a finding of sexual abuse, even where the client is one's spouse, is revocation of the dental hygienist's certificate of registration for a minimum of five years.

- **The development of the sexual relationship can be insidious.** A common pattern of sexual abuse is that the crossing of professional boundaries begins with small steps, such as disclosure about oneself, and progresses incrementally over time. Typically, the relationship fulfills an unmet personal need of the dental hygienist (e.g., being idealized by another, feeling unappreciated in an existing relationship, recovering from the breakdown of a previous relationship). Afterwards the dental hygienist is often as surprised as anyone as to what has occurred.

The definition of sexual abuse is very broad and includes any of the following conduct with respect to a client:

- any sexual behaviour in the presence of a client, including making a coarse or sexually disrespectful comment, whether consensual or not
- sexual intercourse with a client
- touching of a sexual nature including touching of a client's genitals, anus, breasts or buttocks
- genital to genital, genital to anal, oral to genital, or oral to anal contact
- masturbation of the member by, or in the presence of, the client
- masturbation of the client by the registrant
- encouragement of the client by the registrant to masturbate in the presence of the registrant
- making comments of a sexual nature[9] to a client or in the presence of a client.

An exception is where the touching or behaviour or remarks is clinically appropriate (e.g., taking a sexual history where that may be necessary). This definition of sexual abuse would include telling a dirty joke to a client or posting a sexually provocative calendar. This definition would also include the dental hygienist laughing at a sexual joke told by one client in the presence of another client.

- **You may become involved through the conduct of others.** As is discussed in the mandatory reporting portion of Chapter 2, if you learn about the sexual abuse of another practitioner, you may need to make a mandatory report.

Maintaining clear and firm boundaries with clients is essential to avoid conduct that could be perceived as sexual. Avoid any sexual behaviour and when a client initiates such behaviour by telling a joke or engaging in flirtatious behaviour, politely but firmly put a stop to it. Other protective measures include:

- Avoid misinterpretation, do not make suggestive or seductive comments or gestures.
- Do not take a sexual history except to the extent that it is clinically indicated.
- Do not comment on a client's body or sex life.
- Never date a client.
- Avoid or at least limit self-disclosure.
- Detect and deflect clients who attach themselves to you emotionally.
- Document any intimate talk, touch or exposure even where it is entirely clinical and quite appropriate.

[9] "sexual nature" does not include touching, behaviour, or remarks of clinical nature appropriate to the serviceprovided.

Touching Principles for Dental Hygienists[10]

• Never make assumptions
• Maintain the client's dignity
• Show respect for the client
• Respect the client's space
• Respect cultural diversity
• Obtain the client's consent
• Remember clients can change their minds
• Never place instruments or other materials on a client's person

If you are considering dating a client, you should first terminate the dental hygienist/client relationship. Arrangements should be made for another dental hygienist to treat the client. A one-year cooling-off period is considered the minimum amount of time required before contemplating dating a client. You should then wait an acceptable time before beginning to date the client. If you terminate a professional relationship with a client in order to date them, it would be wise never to treat that client again, even in the event that your intimate relationship with that client does not flourish. Full details of the termination of the clinical relationship must be documented in the client record.

The definition of a client for the purpose of the Sexual Abuse provisions of the Code under the *Regulated Health Professions Act, 1991* (RHPA) has been expanded to extend the person's status as a client to at least one year after the professional relationship has ceased. The College often receives inquiries around the parameters of treating someone with whom the dental hygienist is in an intimate relationship. If you can check off any of the following points below, the individual is considered a client:

- They are a person who received health care services from the registrant and payment is charged or received;
- The registrant made an entry in the person's health record;
- They provided consent to a health care service recommended by the registrant; or
- The registrant prescribed a drug for the person.

MANDATORY REVOCATION

The mandatory penalty for a finding of sexual abuse is revocation of the dental hygienist's Certificate of Registration for a minimum of five years.

Legislative changes have expanded the mandatory revocation provisions of the RHPA and applies to registrants found guilty of the following offences under the Criminal Code of Canada:

- Sexual interference
- Invitation to sexual touching

[10] Taken from the CDHO guideline *Prevention of Sexual Abuse and Maintenance of Professional Boundaries*.

- Sexual exploitation
- Bestiality in the presence of/or by a child
- Voyeurism
- Child pornography
- Publication of an intimate image without consent
- Parent or guardian procuring sexual activity
- Making sexual explicit material available to a child
- Luring a child
- Sexual assault
- Sexual assault with a weapon, threats to a third party of causing bodily harm
- Aggravated assault

TREATING MEMBERS OF YOUR FAMILY

Dental hygienists, who treat members of their family (including spouses), need to be aware this is also considered a dual relationship. Such a relationship can create conflicts and difficulties as it can be hard to define a boundary between both relationships.

You cannot help but be sensitive about asking "embarrassing" questions of a relative (e.g., sexually transmitted diseases, chance of pregnancy). Because of the connection, one does not always have the objectivity necessary to form some professional opinions (e.g., that the tooth is lost; assessing the validity of pain symptoms) or to communicate them candidly and effectively. The personal relationship will colour the evaluation and the communication of information, in both directions (e.g., "there he goes whining again"). In addition, in terms of confidentiality, it is extremely difficult to differentiate between the information that has been communicated because of the professional relationship from the information that has been communicated because of the personal relationship, particularly where chit chat goes on during the visit. Plus, the professional relationship will impact on the family dynamics (e.g., feelings of favouritism, resentment over "bossiness" or "non-compliance").

In addition, conflict of interest concerns can arise where third parties are asked to rely upon the objectivity of a dental hygienist treating a member of his or her own family. A third party payer should not be asked to rely upon the assertion of a related dental hygienist as to the necessity of a course of treatment. For example, a dental hygienist submits a claim on behalf of her/his thirteen-year-old niece for sealants placed on all permanent bicuspids and molars. The insurance provider may have concerns about the need for the sealants and the fact that the provider is related to the insured raises additional concern about how an informed consent was obtained and how the need for sealants was determined. Could the dental hygienist's relationship to the insured have influenced the decision to go ahead with the sealants? Or could it be possible that the child's parent used her/his relationship with the dental hygienist to influence the dental hygienist to provide a service that may not have been necessary? While neither may be the case, the relationship between the dental hygienist and the client raises doubt that treatment decisions were made solely on the basis of client need.

SENSITIVE PRACTICE

Sensitive practice involves providing treatment for your clients who may be survivors of sexual, physical, psychological, and/or emotional abuse in a manner that is sensitive to their needs without inadvertently re-traumatizing them. Research suggests that at least 20 percent of adult women and between 5 to 10 percent of adult men have a history of childhood sexual abuse. Receiving oral health care can be difficult for many adult survivors of sexual abuse, and dental hygienists are likely to work with adult survivors, often unknowingly, on a regular basis. As such, dental hygienists should be familiar with the principles of sensitive practice. The College has made the *Handbook on Sensitive Practice for Health Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse* available to all registrants. The principles in this resource manual can be applied to clients who have been victims of any form of abuse.

BOUNDARIES THAT PROTECT THE DENTAL HYGIENIST

Boundaries do not protect just the client, but also protect the dental hygienist. This is true for all boundaries, but is particularly true in the areas of:

- abuse of the dental hygienist;
- dealing with confidentiality concerns;
- in situations where the dental hygienist works with a team; and
- where the dental hygienist works for third parties.

While rare, some clients can become verbally, emotionally or physically **abusive towards a dental hygienist**. Typically, this occurs where a client has other psychological, personality or emotional issues occurring in their lives. The first thing for you to realize is that the abuse is not about your behaviour, but because of other conditions which have simply been triggered by something that has occurred in your encounter. Often you may be able to review what you know about the client and how they have responded to previous interactions to form a good idea as to the true reason for the client's conduct.

If the abusive behaviour is in its milder and earlier stages, you can sometimes respond successfully by fixing firm boundaries. This boundary establishment could involve advising the client that such conduct is not appropriate and asking the client to be more careful in the future. Sometimes changing the context or circumstances of your interactions can assist (e.g., using a different office near the front desk and leaving the door open). Sometimes an assistant or colleague can join your sessions.

Where the abusive behaviour is significant or repetitive, consideration must be given to terminating the relationship. In most contexts, you would transfer the care of your client. In some contexts however (e.g., a long-term care setting, or a mental health institution where your intervention is desperately needed and alternatives are not readily available), you may still choose to continue with treatment with a high level of safeguards in place. There is a balancing of your own need for protection and safety (which is valid and important) with the client's need for care.

You will want to be sure that the transfer of the client is made in accordance with the professional misconduct regulation, which prohibits the following:

11. Discontinuing professional services that are needed unless,
    i. the client requests the discontinuation,
    ii. alternative services are arranged, or
    iii. the client is given a reasonable opportunity to arrange alternative services.

This prohibition only applies where the services are needed. If the rule does apply, what constitutes "reasonable" notice will include a fair consideration of your safety concerns as well as the availability of alternative services and whether any harm would reasonably result to the client during the period the client is finding new services.

Another boundary that is difficult to maintain at times is that of **client confidentiality**. As discussed in Chapter 4, client consent or other legal authority is required to disclose any client information. The boundary is usually challenged in the area of implied consent where a person assumes s/he has access to the information and is surprised if you raise the issue of their authority. Common danger areas include the following:

- Spouse of client seeking information about the client
- Parents of a teenager client seeking information about the client
- Third parties who pay for the treatment seeking information about the treatment
- Investigators, including police, seeking information and mention that a refusal might constitute "obstruction".

In all of these cases, the dental hygienist must ensure that there is clear authority for the dental hygienist to disclose the information before complying with the request. The *Personal Health Information Protection Act, 2004* now provides a comprehensive set of rules to address this important issue. See Chapter 4 for more detail.

Another boundary relates to a dental hygienist who **works with a team** of other health practitioners. The dental hygienist has a primary duty to her or his client. However, the dental hygienist also has an obligation to be collegial and to work collaboratively with others on the team. It is becoming increasingly common for clients to choose others to be part of their health care team without prior discussion with the dental hygienist. For example, a client might well choose to consult a naturopath or other alternative practitioner at the same time as seeing a dental hygienist. If faced with such a situation, you should consider the following points:

- Avoid uncoordinated care.
  - For example, if both of you are dealing with nutritional advice, there should be some consultation with the other practitioner (preferably with express client consent if you have any doubt that the client would approve of your contacting the other practitioner).
- If you have consent to consult with the others on the team, attempt to resolve any differences in approach with the other practitioner first.
  - Avoid placing the client in the middle of any disagreement if at all possible.
  - If you must involve a client in a disagreement in approach, be diplomatic. Do not criticize the other practitioner or the client for choosing her or him. Simply explain that inconsistent approaches are being followed and that it does not appear that they can be reconciled. Explain the rationale for your approach and encourage the client to discuss the rationale of the other practitioner's approach.
  - Respect the client's choice.

Where a dental hygienist **works for a third party**, s/he must ensure that professional standards can be maintained. Danger areas and methods of maintaining proper boundaries are discussed in Chapter 10.

CONCLUSION

Boundary violations interfere with a dental hygienist's professional relationships and responsibilities towards her or his clients. You have the responsibility of identifying when you or your clients are crossing boundaries and taking appropriate corrective actions. Boundary violations can be insidious and you need vigilance to understand the vulnerability of your clients as well as your own areas of weakness. Sexual abuse is a serious boundary violation and includes both verbal comments as well as inappropriate touching of a sexual nature. However, non-sexual boundary crossings may be even more difficult to recognize and can also be harmful.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 8-1 "Hiring a Client" above, what is the primary concern?**
    a. You are seeing a client in your own home.
    b. Your dual relationship will create conflicting duties.
    c. House cleaning is a demeaning service to perform.
    d. You should not be paying money to a client.

2. **If a client expresses a romantic interest in you, which of the following applies?**
    a. There is no boundary crossing unless you respond.
    b. You should transfer the client's care.
    c. You should politely explain that you can only have a professional relationship with the client.
    d. Tell the client to hold that thought until after treatment is completed.

3. **What is the concern about a boundary crossing?**
    a. It interferes with your professional judgment.
    b. It undermines your client's ability to maintain a therapeutic relationship with you.
    c. It can confuse your client.
    d. It can confuse other clients who observe it.

4. **If a client tells a sexual joke you should?**
    a. Laugh so that the client does not feel bad, but tell the client not to do that again.
    b. Laugh only if no other clients are present, but tell the client not to do that again.
    c. Politely advise the client that such comments are not appropriate in the treatment setting.
    d. Report the client on a mandatory basis for sexual abuse.

5. Which of the following statements are true?

   a. Boundary considerations are designed to protect the client.
   b. Boundary considerations are designed to protect the dental hygienist.
   c. Boundary considerations are designed to protect other clients.
   d. Boundary considerations are designed to protect the client, the dental hygienist and others exposed to the behaviour.

A suggested answer to each question is found in Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 9 — COMMUNICATION SKILLS

NEED TO KNOW

1. Effective communication is the foundation of an ethical, effective and legal practice.
2. Dental hygienists should recognize that there are inherent barriers to effective communication with clients, including the knowledge and status of dental hygienists.
3. There are numerous strategies for good communication available for dental hygienists, such as planning sufficient time with clients and being an active listener.

IMPORTANCE OF COMMUNICATION SKILLS

Communication skills are the foundation of a good dental hygiene practice. Virtually every other chapter of this book illustrates how poor communication can result in difficulty and how superior communication can foster a successful practice. Professionalism, compliance with mandatory reporting obligations, communicating the results of an assessment without communicating a diagnosis, maintaining confidentiality, obtaining consent for treatment, providing meaningful client access to records, avoiding conflicts of interest and preventing boundary crossings or violations are all achieved by effective communication.

Skilled communicators build a rapport, or level of trust, with their clients and colleagues, which is necessary for the required information to be transmitted between them. Clients who feel involved in the process are more likely to commit to it and to make the effort to achieve the goals that have been mutually set. Sensitive communication reduces misunderstandings and avoids conflicts. It is no coincidence that the vast majority of complaints made about health practitioners to their regulatory College are either a result of poor communication, or are triggered by the ineffective handling of an otherwise manageable concern. Poor communication also figures prominently in many lawsuits against practitioners.

Without good communication with clients you:

- Cannot conduct a proper assessment;
- Cannot obtain informed consent;
- Cannot implement treatment plans;
- May provoke complaints;
- Cannot resolve real or perceived concerns.

Compliance with the *Code of Ethics* requires excellent communication skills. Most of the definitions found in the professional misconduct regulation relate to poor communication in one form or another.

Scenario 9-1 "Non-Progressing Client Who May Be the Subject of Abuse"

You have an adult client in your clinical practice, Kim, whose attendance has been sporadic. Despite repeated advice she has not been brushing and flossing regularly to the point where her periodontal health is significantly compromised. You tell Kim after a preliminary review of her periodontal tissue, "Look, Kim, we are not progressing here and now that you finally came we need to talk about it." Kim bursts into tears. You are very apologetic for the frustration contained in the tone of your comment. Kim tells you that it just made her

think of her live-in boyfriend's threat the previous evening to set her straight. You now notice both recent and fading bruising on her wrist and upper arms.

Two distinct communication issues are raised in this scenario. The first is how the dental hygienist dealt with the concerns about lack of progress. The second is the revelation of abuse by the client.

With respect to the first issue, the dental hygienist was legitimately concerned about the lack of progress and was understandably frustrated that it was reducing chances for a successful outcome. However, the communication strategy selected by the dental hygienist did not achieve the desired response, perhaps because:

- The statement by the dental hygienist was made to the client without any **preliminary discussion to gauge the readiness of the client to receive the message**.
- The statement by the dental hygienist was **accusatory, demanding and slightly sarcastic**. Statements to clients with those characteristics are unlikely to provoke a constructive response. The statement has every appearance of meeting the dental hygienist's need to cope with feelings of frustration rather than the needs of the client.
- The statement uses **language that may not be understood by the client**. "Progressing" is almost a professional term which to a dental hygienist means that a client is not carefully following the treatment plan. A client with little familiarity with the health care system might not understand that term.
- While the scenario obviously has omissions, there is no indication that the dental hygienist first explored in a sensitive and cautious way **the cause of the lack of progress**. The dental hygienist simply assumed that the client was wilfully choosing to give the treatment a low priority. As it turns out, there appears to be personal problems preventing the client from focusing on her oral health.
- Also, there is no indication that the dental hygienist **explained the rationale for and importance of** full participation in the treatment program at the beginning of the process. Similarly, there is no indication that the dental hygienist obtained the client's genuine commitment to follow the treatment plan.

The dental hygienist may still be able to salvage the situation. Apologizing for the tone of the statement would be a good start. The key, however, may well be how the dental hygienist deals with the second communication issue; the revelation of abuse by the client. Again, there are a number of considerations including:

- First, the dental hygienist needs to ensure that any guilt feelings about the earlier statement do not cause her or him to **overcompensate** in dealing with the client's abuse revelation. As noted in Chapter 8, proper boundaries must still be maintained and the dental hygienist must approach this information as a dental hygienist, not as a personal friend.
- Dental hygienists should remain aware of the **limitations of their training**. Dental hygienists are not qualified sexual or physical abuse counsellors unless they have received additional education, and then, clarity is needed as to which professional role the dental hygienist is serving. The dental hygienist is probably not capable of providing ongoing abuse counselling and probably does not have the time to do so.
- Perhaps the most important initial response to a revelation of this nature is to **listen empathetically** and without criticism or judgment. Letting the client express her feelings in a safe environment to the extent that the client wishes is appropriate.

- The dental hygienist should explore with the client her **immediate options**. These include a professional counsellor with expertise in this area, disclosure to other friends or family members, leaving the unsafe environment she lives in if the client wishes and/or going to the police. The dental hygienist should make clear that the choice is that of the client and that the dental hygienist will provide resources to assist the client such as names and telephone numbers, and possibly even make an initial call on behalf of the client explaining the background of the referral. The dental hygienist should not pressure the client to make a hasty decision.
- In all likelihood, the planned dental hygiene visit for the day is now a low priority and the dental hygienist should **postpone or reduce the intended treatment session** unless the return to routine is important for the client.
- When resuming dental hygiene treatment, the dental hygienist should recognize and deal with **readiness to change issues** for the client and barriers to implementing goals.
- At all times, the dental hygienist should be sensitive to the client's **literacy level**, which is known to affect comprehension. People who have limited reading and writing skills often find it difficult to understand what is said to them.

WHY EFFECTIVE CLIENT COMMUNICATION IS SO DIFFICULT

Wayne McKerrow, in his article, "Improving Patient Care and Reducing Risk Through Effective Communication",[11] identifies the following complications inherent in communications between health practitioners and their clients:

- **Relative Knowledge.** To become registered, a dental hygienist must complete College or University education and practical experience. They know a lot about dental hygiene and have known it for a long time. It therefore takes effort and sensitivity for dental hygienists to put themselves in the place of their clients and remember what it was like to know nothing about dental hygiene. The dental hygienist's explanation may become technical and may not satisfy the needs of the client. Clients may feel put down and may be reluctant to ask questions.
- **Relationship of the Parties.** The dental hygienist and the client are not on an equal footing. On one "side" is the knowledgeable dental hygienist who is being consulted because of her or his expertise. On the other "side" is the client, who lacks this knowledge, has needs and is asking for help. This relative circumstance is sometimes called an "imbalance of power". Given this inherent imbalance to the relationship, it takes great sensitivity and hard work to ensure that the client becomes a relatively equal partner and is able to take responsibility in the process of making decisions.
- **Non-Verbal Communications.** Clients take in not just the words spoken, but also the non-verbal aspects of the communication. If the words are difficult to understand, the body language might be easier for some clients to read. If there is an inconsistency between gestures and words, clients will be confused or, worse, insulted. Ontario is a multi-cultural society. This diversity of communication styles increases the chances that non-verbal cues may be misinterpreted.
- **Nature of the Information.** Often the message being conveyed by a dental hygienist has an emotional as well as a factual content. Discussing a client's oral health care routine is a private, almost intimate matter. It is easy for a client to take offence (just think if someone said some of those things about how you take care of your home or car). Dental hygienists have to balance their duty to provide information to clients with sensitivity towards their emotional needs.

[11] *Health Law in Canada,* 1997: Vol. 18, No. 1, Pp. 30–32.

COMMUNICATION DURING ASSESSMENT AND TREATMENT

To communicate effectively with clients and to avoid misunderstandings involves different considerations at each stage of the process.

Before the first visit, you will want to ensure that:

- You **describe yourself and your qualifications clearly and accurately**. This includes using appropriate titles and professional designations. Any advertisements (e.g., for those in a dental hygiene-owned practice) should be comprehensible and should not be misleading, even by omission. You should clarify the nature of dental hygiene to the **adequately described the nature of your practice** extent that it is appropriate for the situation.
- You have. If you have a restricted practice or an area of particular interest (e.g., pediatrics, seniors), it is better to make this known before the client arrives.
- Remembering that your client's first impression of your communication skills and style starts with **the staff**. Even if the dental hygienist is an employee, s/he may have influence over the hiring, training and supervision of staff. Staff should:
  - possess basic friendliness skills;
  - give their qualifications;
  - follow a checklist of points to cover with each client in recurring situations;
  - confirm appointment information with the client so there is no misunderstanding;
  - help clients with any questionnaires the client is asked to complete; and
  - explain to the client the reason for each request of information.

On your first visit with a client, consider the following:

- **Be punctual.** If there is a delay that is out of your control, apologize to the client. It is surprising that some health practitioners, who will not put up with waiting in line at the bank for five minutes, expect their clients to wait patiently for 20 or more minutes for a pre-scheduled appointment. What message does that convey about the role of the client in the relationship?
- **Introduce yourself** and your professional qualifications. It is useful to ensure that the client knows what a dental hygienist is and, if the client seems unfamiliar with the oral health care system, that dental hygienists are regulated by a College under the *Dental Hygiene Act*. In some cases, written material about dental hygienists may be given to clients to take away with them. Consider wearing the CDHO pin and wear a nametag that contains both your name and professional status. In an institutional setting, particularly where the client is not feeling well, inquire as to whether this would be a good time to have a discussion with him or her.
- **Listen first.** Just listen. Use active listening techniques such as nodding your head where appropriate, giving eye contact, asking clarifying questions and summarizing in your own words the key points of what you are hearing. Do not take notes for the first few minutes of your meeting. Understand why the client has come to you. Be sensitive to whether there are multiple purposes for the visit.
- At some point during the first visit, you will, of course, have to systematically **conduct your initial assessment**. Explain the overall purpose of the assessment beforehand and the precise nature and reasons for particular aspects of the assessment. Obtain informed consent throughout. Explain the results of the assessment afterwards.

- If you are able to develop **treatment options** on the first visit, describe them. Review the advantages and disadvantages of each. Obtain feedback to ensure the client understands them and appreciates their consequences. Obtain informed consent (see Chapter 5). Explain the importance of each step and the importance of the client's participation. This usually takes more than one visit.
- Discuss **confidentiality and privacy** issues with the client. Explain that ordinarily the information you collect is not available to anyone without the client's consent or some other legal authority. Explain the common exceptions. Describe who would usually have access to the information in your practice context (e.g., others on the treatment team interacting with the client) and for what purposes. Obtain the client's consent. (See Chapter 4 on confidentiality and privacy).
- Discuss the **financial aspects** of the relationship. Who will pay, how much and when? Be clear about terms of payment as clients often complain about this area in private practice. Also, discuss what client information may be disclosed for financial purposes to a payer, such as an insurance company, to ensure that they know about and consent to it.
- To the extent possible, explain how and when your involvement will likely end, particularly in a specialized office where ongoing care is not contemplated. **Discharge planning** is an important part of good client communication.

During **ongoing visits**:

- Continuously **maintain informed consent**. Check with the client that s/he knows what you are doing next and why. Discuss any proposed changes in advance and ensure that the client is in agreement. Ensure that nothing has happened to your client that might alter your treatment or recommendations.
- **Anticipate misunderstandings.** Being alert to miscommunications ensures that they are caught early and remedied. Diligence in this area greatly reduces the disruption that misunderstandings can cause.
- **Continue to plan for discharge** where appropriate. In this way, the client is not surprised and can prepare effectively for the transition of being referred back to their family dental office. This approach also serves as a reminder of anything that you need to arrange so that everything is ready when discharge is appropriate (e.g., transportation home if the client is under the influence of medication, obtaining necessary prescriptions, home instruction sheets, contact and referral information).

On actual **discharge** (e.g., in a speciality practice), remember the following:

- Review with your client whether their **treatment goals were achieved**. If not, review the reasons why and the options available to the client.
- Ensure that the client and, where appropriate, his or her family **agree with the discharge**. If not, additional time may be needed to communicate the reasons for discharge and the implications for the client and the family.
- Make sure that any **post-discharge supports** are in place.
- Obtain **feedback on your service**. This can be an effective part of the continuous quality improvement (CQI) of your practice. In addition, you are most likely to receive candid comments at this point in your relationship.

COMMUNICATION STYLE AND TECHNIQUES

There is no universal approach to communication. Everyone has to develop their own communication style that fits with his or her personality. It is better to use unsophisticated communication techniques that work for you than to imitate notionally effective techniques that just do not work for you. However, there are common styles and techniques that many find useful and effective. Successful communication tends to include:

- **Environmental Considerations.** Dental hygienists can often block out their environment because of their ability to focus in familiar surroundings. However, having other people around, frequent interruptions and a high noise level can interfere with your client's ability to take in your message. Also consider any communications disabilities your client might have such as hearing difficulties and adjust for them. Consider, for example, the communication challenges in working with young children.
- **Cultural Sensitivity.** As has been said, Ontario is a multicultural society. For example, personal space is an obvious issue for dental hygiene. For some cultures the comfortable space is 12–15 inches, in others it is only 8–10 inches. You should consider how different cultures respond to authority (as dental hygienists are perceived by some) and to different communications styles. Some cultures are extremely polite and discourage questioning a health practitioner. In such a case, acquiescence might not constitute true consent. Becoming familiar with the "do's and don'ts" of a culture can significantly improve the effectiveness of communication.

  In some cultures, it is inappropriate to shake hands upon introduction. In other cultures where males traditionally dominate, the dental hygienist needs to consider the expectations of a father, husband or other senior male family member in the counselling of a female family member. Failing to do so may result in ineffective communication. The use of eye contact varies with various cultures. Language barriers require special measures including obtaining an interpreter (family member, colleague or an official translator depending on the context), demonstrating some matters physically, or asking the client to demonstrate what they have learned.

- **Time.** Good communication takes time, particularly at the beginning of the professional relationship. Rushing through each visit (e.g., in order to stay within a brief period of insurance coverage) is a prescription for miscommunication. However, most dental hygienists are busy professionals who have to use their time wisely. Consider developing checklists, handouts and diagrams to assist you in using your time efficiently with clients.
- **Speak Directly to the Client.** It is tempting when dealing with both a client and family members or friends to address the apparent leader/decision maker in the group. Particular difficulties may arise when the client is young, older or mentally challenged. Such a client is more likely to be influenced by family members or friends. However, the client should be the focus of your communication.
- **Repeat Key Points.** Repeating important points and essential messages in multiple formats (verbal, written, video) really helps to confirm that clients have understood your message. If you have a staff person who can go over significant items with clients, retention of key points is even more likely. On subsequent visits, you may want to review them as well.
- **Accessibility.** Make sure that you have as much contact information as possible should you need to communicate with the client outside of formal visits. Some clients are difficult to reach. Having home, work and cell phone numbers, e-mail addresses, fax numbers, contact people and a mailing address is helpful. You need to clarify the degree of privacy that is available for many of these forms of communication.

In addition, should the client need to reach you, provide guidance as to what works best, such as leaving a detailed voice message. If you are not able to access one of the methods of communication frequently, for instance, you cannot get to your e-mail every day, be sure to advise clients that there may be delays and suggest a time-effective alternative. However, once you provide a contact route, you have a professional responsibility for checking it regularly.

- **Handling Disagreements.** You cannot expect to have full agreement in every case. Conflicts or differences of opinion can develop with your clients, a member of their family or members of a client's care team. Being a professional means that you try to understand the full reasons for their concern, clarify your intentions and their expectations, work out a resolution if possible and, if all else fails, refer the issue or the client appropriately and courteously to someone else.

Communication Principles for Dental Hygienists[12]

• Talk before you touch	• Reserve judgment
• Avoid inappropriate comments	• Speak directly to the client
• Avoid external conversations	• Maintain confidentiality
• Treat each client as an individual	• Create a safe environment
• Never make assumptions	• Explain your procedures carefully

Fundamentally, you need to understand the clients sitting in front of you. How much information can they absorb? What type of information do they need to take away with them? What resources do they need? Make everything real for them. For example, do not just tell clients how to brush or floss, show them on a model or, better yet, in a mirror.

COMMUNICATION WITH OTHER PROFESSIONALS

Scenario 9-2 "Disagreement With Colleagues"

Your client has been away from your practice for 4 years. You request a new medical history and he states that he has diabetes and that 8 months ago he had a heart attack. Two months ago, the cardiologist implanted an intravascular pacemaker. You are unsure if you should provide treatment without consultation or medical clearance from the client's cardiologist to determine if antibiotic prophylaxis is required. You research the CDHO Knowledge Network for heart conditions and pacemakers. Based on your research from the CDHO Advisory/Fact sheet, you determine that prophylactic antibiotics may be warranted. You contact the cardiologist to discuss the client's condition. The cardiologist advises a prescription is not necessary. The cardiologist says that he is trying to reduce the over-prescription of antibiotics and does not see the need because you are only cleaning his teeth and not performing an invasive procedure. What do you do?

Sometimes communication with your colleagues, your employer, government agencies, and third-party payers can be more difficult than speaking with your clients. Many of the same strategies and styles discussed above apply to these communications as well. However, in the case described in this scenario, you do not have full

[12] Taken from the CDHO Guideline *Prevention of Sexual Abuse and Maintenance of Professional Boundaries*.

responsibility for successful communication as you would with your own clients. Other people and organizations have a mutual or shared duty to communicate effectively and sometimes one or both parties are not prepared to meet halfway. However, under the *Code of Ethics*, you have a duty to be collegial. You also have an obligation in serving your client's interest to make these ancillary relationships work.

Some suggestions include the following:

- Make sure you **know the facts**. Do your own assessment and provide all pertinent information. Review as much of the record to which you have access. Have the literature references handy.
- Approach the practitioner in a **collaborative way**. Instead of doubting the other's response, engage your colleague in a discussion of what options might best serve the client's interests and wishes. Provide details that would help the cardiologist in understanding the invasive nature of the dental hygiene intervention and any other information that might provide a basis for your colleague to change her or his view (e.g., the relevant advisory from the CDHO Knowledge Network).
- Request information that will provide you with the information you need to change your view.
- Try **not to put your client in the middle** or to "lobby" your client for your position. Of course you should not exclude your client from making informed choices. However, there are constructive ways in which this can be done that does not involve them unnecessarily in treatment-team disputes, particularly in the same office.
- **Document** your discussion and its results.

CONCLUSION

Effective communication is the foundation of a dental hygienist's practice. In recognition of the many barriers to good communication, dental hygienists must continually assess their skills and be deliberate in their efforts to minimize misunderstandings and communicate effectively. Environmental and personal distractions must be taken into consideration. Developing intentional strategies for enhanced communication can make a difference.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. **In Scenario 9-1 "Non-Progressing Client Who May Be the Subject of Abuse", what should the dental hygienist do about the abuse revelation?**
    a. Counsel the client on assault syndromes.
    b. Refer the client to an assault counsellor.
    c. Refer the client to a physician to examine her bruises.
    d. Encourage the client to move out of her current living arrangement with her boyfriend.

2. **Poor communication can lead to which of the following?**
    a. Less than ideal results.
    b. A complaint to the College.
    c. A lawsuit.
    d. Losing clients.

3. You want to provide tobacco cessation counselling to your clients who smoke. You believe that you are in an ideal position to warn clients of risks that they may have not considered. Your employing dentist discourages you from doing so because he feels clients do not want this service and it is probably not billable to the insurer. What should you do first?
    a. See if you can negotiate a compromise with the dentist, such as providing this service to new smokers.
    b. Contact the insurers to see if they will pay for this service.
    c. Provide the service anyway as you are an independent professional.
    d. Stop providing the service as this is an area where your employer's direction should be followed.
4. What is the most significant barrier to effective communication with clients?
    a. Dental hygienists are too knowledgeable.
    b. Dental hygienists' expertise makes it easy to overlook a client's perspective.
    c. Ontario is multicultural.
    d. Dental hygienists are pressed for time.

A suggested answer to each question is found in Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

CHAPTER 10 — WORKING FOR OTHERS AND FOR YOURSELF

NEED TO KNOW

1. A dental hygienist must decline to follow an employer's direction that is contrary to dental hygiene standards of practice.
2. A dental hygienist cannot participate in improper billing activities.
3. A professional corporation cannot be used to avoid your professional responsibilities to your clients, the public or to the College.

WORKING FOR OTHERS

There is nothing inherently unprofessional in being employed by another person or organization. It does not matter whether your employer is a registered health practitioner (e.g., a dentist), a private business, or a government or non-profit agency. As discussed in Chapter 1, what does matter is that you maintain your professionalism at all times and do not let your employer's position interfere with the maintenance of dental hygiene standards.

However, there are challenges in working for others. Dental hygienists must manage those challenges in an ethical and professional way. Fortunately, the vast majority of employers, particularly dentists, have high professional standards and these issues either never arise or are easily resolved. However, occasionally difficulties do arise and need to be addressed appropriately.

(a) Maintaining Professional Standards

One challenge is that the dental hygienist must ensure that s/he maintains professional standards despite the views or wishes of her or his employer. This issue is more likely to occur where the employer is not a registered health practitioner, but can occur with any employer.

Scenario 10-1 "Difference of Opinion"

You work in a dental office. A client has unstable angina and had a heart attack about a month ago. The visit is for deep scaling with local anaesthetic (it was scheduled before the heart attack). You conclude after your assessment that this is no longer an appropriate approach for this client and understand that a 4 to 6 weeks' wait for elective procedures of this nature is indicated. You try to raise the issue with the dentist, but she cuts you off, says that her research suggests there is no risk and demands that the procedure be performed today. What do you do?

This scenario illustrates that some pressures to maintain standards of practice may arise from differences of professional opinion. When employed by a dentist there are some areas in which the dental hygienist would normally accept the employing dentist's opinion (e.g., where assisting the dentist in a procedure that is at the core of the dentist's expertise). In addition, where the issue is managerial in nature, the employer can set the rules (e.g., hours of work, which properly equipped room to use). However, where the issue relates to the professional services being provided by the dental hygienist, s/he is required to exercise professional judgment. Where that professional judgment indicates that accepting the employer's direction would be contrary to maintaining dental hygiene standards of practice, the dental hygienist must decline the employer's direction.

Of course this places some duty on the dental hygienist to be familiar with current standards of practice that relate to her or his practice.

If a dental hygienist follows an employer's direction that is contrary to dental hygiene professional standards s/he faces professional (e.g., discipline) and legal (e.g., civil action) accountability. It is no excuse to say that the employer directed otherwise. Most courts hold that it is an implied term of an employment contract that a registered health practitioner can decline direction that is contrary to that professional's standards of practice (but you should be sure to seek your own legal advice if you are in that situation). Prudent dental hygienists insert such a term in their written contracts of employment.

When faced with a clear direction to disregard professional standards (e.g., to administer radiographs for every client on recall visit without regard to individual indicators), regardless of the best motivation of the employer, the dental hygienist will obviously be under some pressure. Some techniques for coping with this situation include the following:

- **Check the facts.** Is the client's condition really what you believe it is? Review the research to make sure it is still current. Ask your employer what literature s/he is relying upon.
- **Explain the rationale for your position.** In many cases if your employer knows the reason for your concern, s/he will reconsider her or his own position. This is particularly true if you have published literature or a College publication to support your concern. If the employer realizes the risks s/he faces, s/he will not wish to be exposed to them.
- **Explore creative solutions.** It may be that some alternatives besides yes and no exist. Try to consider the reasons behind the employer's direction. Perhaps the employer is concerned about upsetting the client. Perhaps the employer is concerned about having a gap in their (and your day). Addressing those reasons can often find a solution.
- **Use good communication skills.** As discussed in Chapter 9, good communication is the key to resolving many issues. For example, try to keep the discussion focused on the issues and not turn it into a power struggle. Try not to involve the other staff in the office so no one loses face. Try not to put the client in the middle. Be professional in the tone of your communication.
- **Seek outside support.** It may be that the client's physician might be able to assist (if they understand the issues). Discuss the matter with a colleague, both to ensure that your understanding of the professional standard is a reasonable one and for ideas for resolving the situation. Your professional association or the College may be able to help. Your employer's College may be able to offer persuasive information to your employer. In an extreme case, obtain legal advice.
- **Firmly refuse if necessary.** If none of these alternatives, pursued in good faith, produce a solution, you must decline to contravene your standard of practice. Do so in the least disruptive way possible. Consider placing your refusal and the reasons for it in writing (e.g., in the chart, in a memo to your employer, in your personal diary). Of course there may be consequences but that is, unfortunately, part of the price of being a professional.

(b) Billing Issues

Scenario 10-2 "Billing"

In your dental office you are not involved in billing. You record what you do and office staff prepares the invoices both for the client and for the insurer when there is one. By accident you learn one day, when the client calls with a question about the invoice that three units are charged when you are sure you only spent half an hour with the client. You check the chart and your suspicions are confirmed. You check all the charts and bills for that day and see that this rounding up of the units has been systematically done for the entire day. You even see some changes to your record of the time spent with the clients. What do you do?

Dental hygiene services are billed out either to the client or a third-party payer who relies upon the integrity of those invoices. As more dental hygienists consider opening their own practices, billing issues will become increasingly common. In short, a dental hygienist must ensure that any accounts going out in their name or billing number are honest and informed.

To be honest, an account must comply with the following:

- The account must **accurately describe** the service provided. For example, it is improper to portray a missed visit as a treatment service. It is also wrong to portray the service that was actually provided as another service in order to qualify for insurance coverage (e.g., billing oral hygiene instruction as scaling). Similarly, billing for gingival curettage if there is no time left on the insurance plan for scaling is misleading. The date the service was provided must also be accurately portrayed.
- The account must not be **misleading by omission**. For example, billing for a disbursement (e.g., supplies consumed, equipment dispensed) usually implies that only the actual cost to you is being charged (without a mark up).
- Charging a **higher fee for insured clients** than for those clients who pay directly is not honest, appropriate or acceptable.
- Dental hygienists must be **familiar with the insurance requirements** of their client's policies so that they do not submit an account that will be misinterpreted by the insurer. For example, if the policy requires a co-payment, billing the insurer for the services without charging the client for the co-payment is improper. You should not bill the client for the co-payment on the tacit understanding that the client need not pay it. Reasonable, documented efforts should be made to collect the co-payment. Even billing the client directly (with instructions to claim any reimbursement to which they are entitled under their benefits package) does not justify an account that would likely be misinterpreted by the insurer.
- Charging a fee that is **excessive** for the service provided is also a form of dishonesty. While there is no fixed amount one must charge for a service and while there is no specified maximum fee one may charge, at some point a high fee becomes excessive. Charging a very high fee becomes particularly concerning where the client is financially vulnerable, incapacitated, or where a third-party payer has little knowledge of the service provided.
- Offering a **reduction for prompt payment** is prohibited for dental hygienists. This rule is based on the notion that those with financial means will be able to take advantage of the reduction while those with modest means will end up paying more for the same service. This rule does not prevent a dental hygienist from charging interest on overdue accounts.

- Billing third-party payers for treatment of one's self or immediate family members for services that it would be reasonable to expect would be provided at no charge is unethical. For example, while there are numerous reasons why you should refrain from treating family members as discussed in Chapter 7, it would be reasonable to expect that you would not charge your dependant children for services you provided in your own dental hygiene clinic. Should you provide services to non-dependant family members, billing to third-party payers must reflect a true account of services billed and collected by your practice.

To be informed, the client must know the following:

- **How your fees are calculated**. For example, do you follow a fee guide? Do you have an hourly rate, do you charge per visit or is there a flat fee for a course of treatment? This discussion should occur at the beginning of the relationship. The College does not require registrants to document Ontario Dental Association fee codes.
- **Itemization.** At the very least, you should detail the services and disbursements you have billed for if asked. A better policy is to itemize your accounts routinely and provide additional details when requested.
- **Payment options.** Dental hygienists must explain all available payment options to clients. For example, dental hygienists should canvass with all direct pay clients whether they might have insurance that covers the service. Charges for overdue accounts need to be disclosed up front. If the dental hygienist sees that payment is an issue, s/he should consider canvassing with the client publicly available treatment alternatives (e.g., at the local school or community clinic, even if it has a long waiting list) with the client.

A failure to maintain honest and informed billing is professional misconduct. Almost 20 percent of the paragraphs defining misconduct deal with billing issues.

Table: Misconduct Paragraphs Related to Billing

30.	Signing or issuing, in the member's professional capacity, a document that the member knows or ought to know contains a false or misleading statement.
31.	Submitting an account or charge for services that the member knows or ought to know is false or misleading.
32.	Counselling or assisting in the submitting of false or misleading accounts or charges to clients or in respect of their care.
33.	Charging or accepting a fee or amount that is excessive or unreasonable in relation to the services performed.
34.	Failing to advise a client or his or her authorized representative, upon request, of the fee to be charged for a service in advance of providing the service.
35.	Failing to itemize an account for professional services, i. if requested to do so by the client or the person or agency who is to pay, in whole or in part, for the services; or ii. if the account includes a commercial laboratory fee.
36.	Refusing to perform a professional service that a client urgently requires unless all or part of the fee is paid before the service is provided.

37.	Selling or assigning any debt owed to the member for professional services. This does not prohibit the use of credit cards to pay for professional services.
42.	Failing to take reasonable steps to ensure that any information provided by or on behalf of the member to the College is accurate.

Dental hygienists cannot avoid their professional responsibility for honest and informed billing because their employer submits the accounts. Dental hygienists must take responsibility for any billing going out in their name or with their registration number. While this does not mean that each dental hygienist must personally sign every account (which is impractical for some settings), s/he must be satisfied that the billing system is accurate and appropriate. The College recommends that, at the very least, the dental hygienist needs to review the billing procedures and periodically do spot checks as to their continued effectiveness. Where the dental hygienist is employed by an unregulated individual, s/he should take extra care to discuss this issue and make it part of the contract of employment. The dental hygienist may have to engage in some education of their prospective employer as to the balance between an employer's right to run their business their way and the dental hygienist's duty to maintain professionalism.

(c) Consent Practices and Conflicts of Interest

Some employers minimize the need for informed consent from clients. There may be a number of reasons for this including a view that it is a waste of time, an over reliance on implied consent ("if the client doesn't leave the chair they have consented"), an attitude that they know what is best for the client and perhaps a wish to encourage clients to choose high-profit treatment options.

Scenario 10-3 "Management Consultants"

Your employer has hired a management consulting firm to make suggestions for improving the profitability of the practice. The consultant has made a presentation of his findings. One of them is that the office has to start promoting to its clients services that have a higher profit margin and will promote revenues. In particular, all staff is to promote the following services: crowns (or better yet, onlays), bridges (or better yet, implants), tooth whitening, periodontal surgery, tooth straightening, switching old amalgams, and polishing for every client on every recall visit. There will be incentives for staff who generate a lot of revenue. What is your response at this meeting?

Scenario 10-3 "Management Consultants" raises issue about informed consent and about conflict of interest. Clients need to have all of the reasonably available options offered to them for there to be informed consent. In this presentation clients need to be told the pros and the cons. The choice has to be theirs. They should not be steered towards a particular choice because it will be profitable to the office. Where there is a risk (e.g., removal of enamel by frequent polishing) it needs to be fairly presented to the client. The need to obtain informed consent without pressure needs to be part of the discussion of these management consultant recommendations. If an inappropriate direction is adopted by the office the dental hygienist has to, at a minimum, ensure that s/he follows good informed consent practices and documents it. Consent issues are discussed more fully in Chapter 5.

Conflict of interest issues are also raised by this scenario. The offering of incentives to staff undermines the notion that all treatment recommendations are based on the genuine professional judgment of the practitioner.

Depending on the circumstances, the offering of such incentives by a dental hygienist would probably be unethical and might even constitute professional misconduct. So might be the willingness to receive them. There is a fine line between being rewarded by an employer for hard work and being paid to compromise your professional judgment. Conflict of interest principles are discussed more fully in Chapter 7.

(d) Record Keeping

A recurring employment issue is ownership of client records. These records are viewed as central to the goodwill of a practice and what makes it financially valuable or marketable. Employers will often insist, therefore, that they retain the only copy of the records. As discussed in Chapter 6, it is permissible for a dental hygienist to let her or his employer retain the records so long as they are maintained as required by the College and so long as the dental hygienist has access to them when required (e.g., to respond to an inquiry or a complaint).

These issues should be negotiated with the employer at the time of being hired. At the time of leaving there may not be the willingness to discuss the issue calmly and fairly. It is not appropriate to circumvent the contractual understanding by, say, sneaking in some evening or weekend to photocopy the charts or remove original charts to which you do not have a contractual right.

What is sometimes lost in these disputes is that the interest of the client comes first. The information belongs to the client and if it would be better for the client for the original chart to go with the dental hygienist or stay with the employing person, that is what all parties should readily agree to. See Chapter 6 for more information.

(e) Leaving One's Employment

Besides ownership of client records, the next most common area of dispute is what can be told to clients about a departing dental hygienist. This issue becomes particularly controversial if the dental hygienist is moving to a competing practice. Often employees have a contractual duty to avoid soliciting clients of the old practice when moving to the new one.

Again the client's interests come first. One issue is whether the client will be able to receive continuity of care at the old practice. If there will be no dental hygiene care available then the client should be advised of this. Even where dental hygiene care remains available, clients should have a choice of whether to continue to receive it in the old office or to consider moving with the dental hygienist. Dental hygienists who have a duty not to solicit clients of the old office should consult with a lawyer before taking any action.

At a minimum there is a duty on those remaining at the old office to advise clients who ask where the dental hygienist has gone. In many circumstances it would also be appropriate for the departing dental hygienist and/or the old office to advise clients that the dental hygienist is leaving and giving them a choice as to staying or transferring their care. However it is handled, the communications, whether verbal or written, must be professional.

WORKING FOR YOURSELF

Although the majority of dental hygienists practise within dental offices, dental hygienists are able to set up independent practices. The term independent practice is commonly used to describe a dental hygienist-owned practice. It does not mean that dental hygienists who own their own practices work outside the circle of care. By nature, dental hygienists are collaborative practitioners who are motivated to be partners in client care by

recognising and working with all members of the health care team. It is anticipated that more dental hygienists will explore this option to address the needs of clients who are unable or unwilling to come to the traditional dental office.

There are three main business structures for dental hygienists to choose from:

- Sole proprietorship,
- Partnership, or
- Health professional corporation.

You should consult with a lawyer and/or an accountant before choosing which structure is best for you. No matter what business structure you choose, you are accountable for your professional actions both to your client and to the College.

(a) Sole Proprietorship

A sole proprietorship is where you are the sole owner of the practice. People deal with you or your staff directly in your personal capacity. There is no one else responsible for your practice. There are certain business registration and tax requirements that need to be complied with. The Ontario government has some useful information at its Ministry of Public and Business Service Delivery and Procurement website.

(b) Partnership

A partnership involves two or more people joining together to operate a business or other venture. Generally partners are responsible for each other's actions. Typically partners share the profits of the business or venture. Dental hygienists who form a partnership, especially if the other partner (s) is not a regulated professional, are advised to maintain control over the standards of practice, client records, and financial practices.

(c) Health Professional Corporation

Scenario 10-4 "Should You Incorporate?"

Your brother-in-law loves to offer you financial and investment advice, despite the fact that he was just about wiped out when Company XYZ plunged 99 percent in value. At a family get-together, he expresses amazement that you have not incorporated your dental hygiene practice. He says that you could save thousands of dollars in taxes, split income with family members (like your spouse who has a low income as a teacher's aide) and protect yourself from professional liability claims or complaints to the College from disgruntled clients. You begin to wonder if this time your brother-in-law is right. Should you incorporate?

A corporation is a legal entity recognized by the government and the courts that is owned by its shareholders. It can make contracts, own land and other assets, earn income and borrow money just like an individual. It also pays its own taxes.

Until 2002, health practitioners were not able to incorporate their professional practices (the only exception being that pharmacists could operate corporate pharmacies under the *Drug and Pharmacies Regulation Act*). This prohibition against professional corporations was not imposed by the College, but rather by the provincial government under the *Business Corporations Act*. There was some non-compliance with this rule because the

government did not enforce it very strictly. In 2001, the government passed amendments to the *Business Corporations Act* that permitted health practitioners to incorporate under significant restrictions.

(i) *Advantages*

For some dental hygienists, there may be some advantages to incorporating their professional practices. For example, some accountants have said that the following advantages may be available:

- **Small business deduction.** The professional corporation can benefit from the small business deduction. Small businesses are taxed at a lower rate than high-income individuals and, so long as the money is left in the corporation, it can be used for other purposes. This is only a tax deferral as once the remainder of the money is taken out of the corporation, say as a dividend, the remainder of the tax is imposed.
- **Income fluctuations.** As a result, if your income fluctuates from year to year, you can even out your income. That means that you can take advantage of the lower tax brackets each year.
- **Year-end.** The professional corporation can have a non-calendar year-end. This permits the deferral of additional taxes.
- **Capital Gains Exemption.** There is a $500,000 capital gains exemption on the sale of your shares in the professional corporation. However, there are a number of rules and restrictions for which expert advice is required.
- **Other tax advantages.** There may be some minor tax advantages in relation to employment insurance and tax instalments during your first year of operation and a tax-free "death benefit".
- **Trade creditors.** Only the corporation is liable to trade creditors (e.g., suppliers of equipment, supplies and services to your practice). Shareholders are normally not liable for non-payment of those accounts. However, this protection does not apply to professional liability claims from clients.

Not all of these advantages apply to all dental hygienists. For example, the small business deduction deferral does not benefit dental hygienists who use most of what they earn for living expenses. A dental hygienist needs to consult with an accountant and probably a lawyer to assess whether these advantages apply to their circumstances.

(ii) *Disadvantages*

There are quite a few disadvantages to incorporating your professional practice, including the following:

- **Cost.** Incorporation itself will almost certainly require the services of an accountant and a lawyer. Their fees will likely be a few thousand dollars each. Filing your papers with the government will cost a few hundred dollars. The College charges an application fee for processing the required papers. There is also an annual renewal fee with the College and you will likely require annual accounting services of a few thousand dollars. Thus, you will have to achieve some significant tax savings to make incorporation economically worthwhile.
- **Paperwork.** The professional incorporation will require the filing of paperwork with the government and the College each year. The corporation has to file a special income tax return that may be more complicated than what you currently prepare.
- **Accounting disadvantages.** There are some complex disadvantages that you should discuss with your accountant. For example, if the corporation owns an automobile that you use, the rules may be punitive.

- **Transition costs.** Changing from your current practice to a professional corporation may result in some specific difficulties, such as for your "capital account", work in progress and goodwill. Expert advice is needed to minimize or avoid these problems.
- **Restrictions.** As described below, your professional corporation has some restrictions that may make it less than worthwhile for you.

Scenario 10-5 "Responsibility of Shareholders of Professional Corporations"

Your professional corporation hires another dental hygienist to provide services at some of the local nursing homes. An autopsy at one of the homes indicates that the resident died of a blood-borne infection. The family sues everyone involved in the resident's care, including yourself and your professional corporation. Personally you had nothing to do with the assessment or treatment of the resident, but you learn that the corporation's employee (another dental hygienist) saw the resident four months before she died. Can you be sued personally?

(iii) *Restrictions*

There are a number of restrictions on professional corporations. The purpose of these rules is to prevent dental hygienists from avoiding their professional responsibilities to their clients and to the College. These restrictions are spread out throughout a number of provisions in the *Business Corporations Act*, the *Regulated Health Professions Act*, the Minister of Health and Long-Term Care's regulations made under the *Regulated Health Professions Act* and the by-laws of the College.

These restrictions include the following:

- **Shareholders**. All shareholders of the professional corporation must be registrants of the same College. For example, a dental hygienist and a dentist could not be shareholders of the same professional corporation. This restriction effectively eliminates the possibility of income splitting with family members through shareholdings of the professional corporation unless the other family members are also registered with the College.
- **Officers and Directors**. Officers and directors must all be shareholders of the professional corporation. That means that they will all be registrants of the same College (e.g., all officers and directors will then be dental hygienists).
- **Name**. The name of the professional corporation must contain the surname of at least one shareholder, must say "professional corporation", must include a reference to the profession (e.g., dental hygiene), and must contain nothing else. Numbered corporations (e.g., 1234567 Ontario Ltd.) are not permitted. This rigidity in naming ensures that clients and regulators know whom they are dealing with. Some Colleges will permit professional corporations to carry on business in other names so long as the business name is consistent with the College's advertising guidelines and so long as the corporate name accompanies the business name.
- **Duty to Client**. The professional corporation cannot be used to avoid a professional duty to a client or even to a member of the public who is not a client. A specific provision requires that this duty to clients or the public override any competing duty of loyalty to the corporation. In addition, shareholders can be sued for any professional negligence or liability they (or the corporation) itself may have to the clients of the corporation.

- **Duty to the College**. Similarly, the professional corporation cannot be used to avoid a duty to the College. Again, a specific provision requires the primacy of the duty to the College. In addition, no professional health corporation can practise unless it has a certificate of authorization from the College.
- **Scope of Practice**. The corporation can only practise the profession or provide "ancillary" services. For example, selling related products to clients (subject to any conflict of interest concerns, see Chapter 7) is probably ancillary. Investing surplus income is generally ancillary. Selling real estate or life insurance to the public is probably not ancillary. To determine what is ancillary, you should look at the scope of practice statement in your profession specific act. For example, the scope of practice of dental hygiene is set out in section 3 of the *Dental Hygiene Act* as follows:

> The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services.

Any activities that fall within that scope of practice statement would not be ancillary.

- **Certificates of Authorization from the College**. Before a health professional corporation can practise a profession, it must have a certificate of authorization from the College. The primary purpose of this document is to ensure that the shareholders of the professional corporation are known to the College and are accountable for the professional actions of the corporation. A second purpose is to ensure that the requirements and restrictions on the professional corporation have been met (the provincial government having downloaded this responsibility to the Colleges). The application process is primarily an information gathering exercise. See the Health Professional Corporations page on the College's website.

CONCLUSION

There are a number of business models for practising dental hygiene. You can work for others or you can work for yourself. If you work for yourself you could set up a sole proprietorship, a partnership or a health professional corporation. However, whatever your business structure you have to ensure that you maintain professional standards. No business structure will prevent you from being accountable for your professional actions.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice.

1. In Scenario 10-1 "*Difference of Opinion*" what should you do?
   a. Refuse to provide the treatment.
   b. Address the underlying concerns of the dentist.
   c. Tell the dentist she can provide the treatment.
   d. Review the literature and show it to the dentist.

2. In Scenario 10-2 "*Billing*" above, you tell the client you will get back to them. What should you do now?

    a. Meet with your employer to discuss your duties of professionalism and negotiate a solution for both this charge and future billings or quit your job.
    b. Contact the insurance company yourself and straighten it out.
    c. Tell your employer that no further bills should go out in your name without your prior review of it and that this charge must be reversed.
    d. Send the client your office billing policy that states that units are "approximately 15 minutes".

3. A client has a 20 percent co-payment. The client tells you they cannot afford to pay that much and asks you to waive the fee. Should you:

    a. Agree to the proposal.
    b. Refuse the proposal because it is dishonest.
    c. Suggest that you will speak with their insurer, but if no exception can be made, will permit them to pay over time.
    d. Tell the client you will send them an account for the deductible but that you will not try to collect it.

4. In Scenario 10-4 "*Should You Incorporate*" above, should the registrant incorporate?

    a. Probably yes if the registrant has a high income.
    b. Probably no.
    c. There is not enough information to tell. However, many of the advantages proposed by the brother-in-law do not apply.
    d. There is not enough information to tell. However, there is some income splitting potential.

5. In Scenario 10-5 *"Responsibility of Shareholders of Professional Corporations"* above, is the shareholder liable if the employee was negligent?

    a. Yes, if the employee was negligent so was the corporation and, therefore, the shareholders.
    b. No, shareholders are not liable for corporate conduct.
    c. No, while the shareholder was responsible for the actions of the corporation, it is not responsible for the actions of the employee.
    d. Yes, because there is no limited liability partnerships for health practitioners.

See answers to questions at Appendix 3.

For additional resources that complement this Chapter, see Appendix 2.

APPENDIX 1 — SELECTED STATUTES RELEVANT TO DENTAL HYGIENISTS

SELECTED STATUTES RELEVANT TO DENTAL HYGIENISTS

Accessibility for Ontarians with Disabilities Act, 2005, S.O. 2005, c. 11
https://www.ontario.ca/laws/statute/05a11

Business Corporations Act, R.S.O. 1990, c. B.16
https://www.ontario.ca/laws/statute/90b16

Canada's Anti-Spam Legislation (CASL), S.C. 2010, c. 23
https://laws-lois.justice.gc.ca/eng/acts/E-1.6/index.html

Canadian Human Rights Act, R.S.C., 1985, c. H-6 (Canada)
https://laws-lois.justice.gc.ca/eng/acts/h-6/page-1.html

Child, Youth and Family Services Act, 2017, S.O. 2017, c. 14, Sched. 1
https://www.ontario.ca/laws/statute/17c14

Children's Law Reform Act, R.S.O. 1990, c. C.12
https://www.ontario.ca/laws/statute/90c12

Competition Act, R.S.C., 1985, c. C-34 (Canada)
https://laws-lois.justice.gc.ca/eng/acts/C-34/

Consumer Protection Act, 2002, S.O. 2002, c. 30, Sched. A
https://www.ontario.ca/laws/statute/02c30

Controlled Drugs and Substances Act, S.C. 1996, c. 19 (Canada)
https://www.laws-lois.justice.gc.ca/eng/acts/C-38.8/

Criminal Code, R.S.C., 1985, c. C-46 (Canada)
https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html

Dental Hygiene Act, 1991, S.O. 1991, c. 22
https://www.ontario.ca/laws/statute/91d22

Discriminatory Business Practices Act, R.S.O. 1990, c. D.12
https://www.ontario.ca/laws/statute/90d12

Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4
https://www.ontario.ca/laws/statute/90h04

Employer Health Tax Act, R.S.O. 1990, c. E.11
https://www.ontario.ca/laws/statute/90e11

Employment Standards Act, 2000, S.O. 2000, c. 41
https://www.ontario.ca/laws/statute/00e41

Evidence Act, R.S.O. 1990, c. E.23
https://www.ontario.ca/laws/statute/90e23

Fair Access to Regulated Professions and Compulsory Trades Act, 2006, S.O. 2006, c. 31
https://www.ontario.ca/laws/statute/06f31

Fluoridation Act, R.S.O. 1990, c. F.22
https://www.ontario.ca/laws/statute/90f22

Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. F.31
https://www.ontario.ca/laws/statute/90f31

Good Samaritan Act, 2001, S.O. 2001, c. 2
https://www.ontario.ca/laws/statute/01g02

Healing Arts Radiation Protection Act, R.S.O. 1990, c. H.2
https://www.ontario.ca/laws/statute/90h02

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A
https://www.ontario.ca/laws/statute/96h02

Health Facilities Special Orders Act, R.S.O. 1990, c. H.5
https://www.ontario.ca/laws/statute/90h05

Health Protection and Promotion Act, R.S.O. 1990, c. H.7
https://www.ontario.ca/laws/statute/90h07

Home Care and Community Services Act, 1994, S.O. 1994, c. 26
https://www.ontario.ca/laws/statute/94l26

Human Rights Code, R.S.O. 1990, c. H.19
https://www.ontario.ca/laws/statute/90h19

Long-Term Care Homes Act, 2007, S.O. 2007, c. 8
https://www.ontario.ca/laws/statute/07l08

Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998, S.O. 1998, c. 18, Sched. H
https://www.ontario.ca/laws/statute/98m18

Occupational Health and Safety Act, R.S.O. 1990, c. O.1
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https://www.ontario.ca/laws/statute/01o32

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https://www.ontario.ca/laws/statute/07o10

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Patient Restraints Minimization Act, 2001, S.O. 2001, c. 16
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Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A
https://www.ontario.ca/laws/statute/04p03

Personal Information Protection and Electronic Documents Act, S.C. 2000, c. 5 (Canada)
https://laws-lois.justice.gc.ca/eng/acts/p-8.6/FullText.html

Public Guardian and Trustee Act, R.S.O. 1990, c. P.51
https://www.ontario.ca/laws/statute/90p51

Public Hospitals Act, R.S.O. 1990, c. P.40
https://www.ontario.ca/laws/statute/90p40

Regulated Health Professions Act, 1991, S.O. 1991, c. 18
https://www.ontario.ca/laws/statute/91r18

Regulated Health Professions Amendment Act, 2009, S.O. 2009, c. 6 - Bill 141
https://www.ontario.ca/laws/statute/s09006

Regulated Health Professions Statute Law Amendment Act, 2009, S.O. 2009, c. 26 - Bill 179
https://www.ontario.ca/laws/statute/s09026

Retirement Homes Act, 2010, S.O. 2010, c. 11
https://www.ontario.ca/laws/statute/10r11

Substitute Decisions Act, 1992, S.O. 1992, c. 30
https://www.ontario.ca/laws/statute/92s30

Workplace Safety and Insurance Act, 1997, S.O. 1997, c. 16, Sched. A
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APPENDIX 2 — ADDITIONAL RESOURCES

ADDITIONAL RESOURCES

Chapter 1

College of Dental Hygienists of Ontario, *Professional Misconduct Regulation*, Ontario Regulation O. Reg. 382/08.
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Chapter 3

CDHO Standards of Practice for Dental Hygiene Educators.
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Entry-to-Practice Canadian Competencies for Dental Hygienists.
https://cdho.org/cdho-resources/entry-to-practice-canadian-competencies-for-dental-hygienists/

CDHO Contraindications Regulation Resources.
https://cdho.org/cdho-resources/resources-for-rdhs/

CDHO Dental Hygiene Standards of Practice.
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Chapter 4

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CDHO. "Medical History Confidentiality", *Milestones*, Vol. 9, No. 1, p. 9 (Winter 2002).

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CDHO Guideline: Off-site Storage of Records. https://cdho.org/cdho-resources/off-site-storage-of-records/

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Workplace Hazardous Materials Information System (WHMIS) Health Canada. https://www.canada.ca/en/health-canada/services/environmental-workplace-health/occupational-health-safety/workplace-hazardous-materials-information-system.html

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Chapter 7

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Chapter 8

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Chapter 10

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https://www.ontario.ca/page/ministry-public-and-business-service-delivery-and-procurement

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APPENDIX 3 — ANSWERS TO QUIZ QUESTIONS

QUIZ ANSWERS

Chapter 1 — Introduction to Professionalism

1. The best answer is (b). Overusing employer resources and showing independence is almost certainly not intended to apply to this situation. In fact, your employer will probably want you to consult with someone on this issue. If you explained your role properly to the client at the beginning, you almost certainly have actual or at least implied consent to discuss difficult issues with your colleagues. Answer (a) is not wrong, but fails to recognize that your office would want to be involved with this concern. Answer (c), while appropriate in many circumstances, is risky given your background and the seriousness of the issue posed here. Your employer's hints are no justification for taking unnecessary risks. Answer (d), misses the gravity of the situation and, as will become clear in Chapter 3, is incorrect because you are able to assess and even diagnose. What you cannot do is communicate a diagnosis to your client.
2. The best answer is (a). This scenario is a classic case of competing obligations. However, when all is said and done, the ultimate "clients" of your services are the patients you and your colleagues serve. It is for their benefit that your expertise is sought. Answer (b) is a close second because the dentist is seeking information to ensure that the office is operated safely and similar incidents do not occur in the future. The dentist has a reasonable expectation of an answer from registered colleagues who have relevant information. Answer (c) recognizes that you do owe a duty of collegiality to Julia. However, your colleagues are not the primary object of your professional obligations. Answer (d) is not correct in that your duty to affected persons is not equal.
3. The best answer is (d). All of these answers fairly describe the differences as discussed at the beginning of the chapter. Answer (c) uses different language to describe the same concept as (b).
4. None of the answers are perfect by themselves. The best answer is (b). You might also explain that the dental assistant should only be reading the chart if s/he has a professional reason for doing so. Access to your records is on a need-to-know basis and those who read them are bound by confidentiality. Answer (a) is too rigid. While you have to be honest, that does not mean you have to record everything told to you by the client no matter how irrelevant. This answer may also insult the client and discourage further openness. Answer (c) creates a dual charting system, which leads to many problems (see Chapter 6). Answer (d) is misleading, by omission, to the client and is, thus, not honest.
5. The best answer is (a). This question raises issues related to both competency and honesty. The starting point is to ensure that the client knows his options and can make an informed choice. Even if you strongly believe that the client needs two hours of services, the client has the final choice as to what services he will receive. This option also involves a willingness to advocate on behalf of the client. Answer (b) is not being transparent with the dentist, does not necessarily give the client a full choice and conscripts the client in a "secret" option. Answer (c) is a possibility but does not involve the dentist in the treatment decision and is a confrontational approach to your colleague. Answer (d) is even more confrontational. Being collegial involves attempting to work through conflicts with colleagues in a constructive manner whenever possible. This option also does not do anything for the client.

Chapter 2 — Requirements for Dental Hygienists under the *Regulated Health Professions Act* and Other Related Statutes

1. The best answer is (b). If there is a problem in responding, you should always advise the College right away, but late is better than never. You should apologize for the delay and provide a doctor's slip. There is no guarantee that the College will grant your request for an extension, but it will at least try to accommodate you. Answer (a) does nothing to address your responsibility to the College. It is professional misconduct to fail to respond to the College. Answer (c) does not help the College much because it is not a full response. Also, it does not recognize your personal circumstances. Answer (d) could be viewed as an attempt to interfere with the investigation.
2. The best answer is (c). The scenario suggests that there are reasonable grounds of sexual abuse of the client by a registered health practitioner. You cannot include the client's identity in the report unless the client consents in writing. Answer (a) suggests that the identity of the client is included without mentioning the need for written client consent. Answer (b) incorrectly suggests that if a client refuses to consent that a report will not be made. Answer (d) is not correct because the report has to be made to the Registrar of the College of the person who is said to have abused the client.
3. The best answer is (c). You should try to ensure that the parents received the recommendation last year, understand the apparent deterioration since then and appreciate the importance of addressing the problem. Answer (a) is probably insufficient since the situation is more acute now and for some reason last year's recommendation was not followed. Answer (b) may involve a breach of confidentiality (depending on the nature of the consent obtained) and transfers a professional responsibility that is really on your shoulders. Answer (d) appears a little premature as you are not sure that the parents received last year's recommendation or truly appreciate the need for treatment. This option might be followed if answer (c) does not lead to an appropriate response.
4. The best answer is (a). Technically speaking, since the child is over 16, the mandatory reporting requirements under the *Child and Family Services Act* do not apply (eliminating answer (b)). However, if you went to the local Children's Aid Society and they were willing to deal with the matter, you could justify this action under your "duty to warn". Answer (c) fails to recognize that implied consent is lost when you have an express direction to the contrary to "drop the matter" (see Chapter 5). Answer (d) suggests you can shop around for substitutes rather than go to the highest-ranked available substitute (see Chapter 5 again). Bonus points for those who thought that this is really a consent issue and that the dental hygienist should be acting under the *Health Care Consent Act*, either by approaching the Public Guardian and Trustee or to the Consent and Capacity Board (you must have already read Chapter 5).
5. The best answer is probably (d). The resident is capable and should know what is going on. It would help prepare the resident for what will be happening next and will help maintain as high a level of trust as the circumstances permit. Answer (c) is also justifiable, because you do not want to inadvertently jeopardize the investigation, but it would be rare that telling the resident would have that effect. The *Long-Term Care Homes Act, 2007* is silent on the issue, so answers (a) and (b) do not apply.

Chapter 3 — Scope of Practice, Controlled Acts, Delegation and Orders

1. The best answer is (d). There would appear to be a serious risk of harm to the client by the stomatologist's use and dispensing of topical anaesthetic. The conduct might even constitute criminal negligence if the stomatologist knew of the cardiac condition. Sending the topical anaesthetic home, even though it is only topical in nature, is dispensing of a drug.
2. The best answer is (d). The stomatologist avoided getting specific as to what was the problem and focused on the treatment. Answer (a) refers to only part of the definition of the first controlled act. Answer (b) is likely not accurate because "plaque" is more of a symptom than a formal diagnosis. Answer (c) is arguable and so is not the best answer.
3. The best answer is (a). The smoothing of the rough surface of a tooth is a procedure in or below the surface of a tooth. Answer (b) is likely not correct because minor abrasions of the tongue caused by a small chip in the tooth is probably not an emergency. Answer (c) is incorrect in that the reference prohibiting opening of the oral cavity does not begin until one reaches the larynx. Answer (d) is not correct because the Act does not distinguish between primary and permanent teeth.
4. The best answer is (a). This is an emergency and in emergency situations one does not stop to conduct a fine legal analysis. Answer (b) is stretching the definition of a routine activity of daily living. Answer (c) is also arguably correct but is not as clear as (a) because you are not administering the drug to further your own care of the patient, but rather to address an emergency. Answer (d) is not correct because you are not the initial dispensing person, but simply providing the steady hands the client does not currently have.
5. The best answer is (c). The routine activities of daily living exemption applies to this situation. Answer (a) does not appear to relate to a genuine religion. The exception relating to a tenet of a religion refers to an established religion and not a scheme designed to circumvent the legislation. Answer (b) is not correct because insulin injections are not a part of traditional healing. Answer (d) is not correct because registered dentists are not authorized to order or, for that matter, delegate injections.
6. The best answer is (c). A dental hygiene student can only practise scaling as part of her/his dental hygiene program and only under the supervision of a dental hygienist who is employed by the teaching institution. Answer (a) is incorrect because although an informed consent must be present before scaling is initiated, in this scenario the student is not authorized to offer these services. Answer (b) is not correct because an order to perform scaling can only be given to a registered dental hygienist. Answer (d) is incorrect because graduates of dental hygiene programs can not practise their scaling skills until they are registered with the CDHO or received a delegation as described in the Delegation Standards and are practising their skills in preparation for the CDHO clinical competency evaluation.

Chapter 4 — Confidentiality and Privacy Obligations

1. The best answer is (b). Clarification: Any contact information on the file should be treated as confidential and provided only for purposes related to the professional service. Answers (a) and (d) do not recognize the principle that all client information is confidential. Answer (d) is better than answer (a) in that business contact information is not usually associated with personal information, but it still came from the client and would be deemed to be confidential. Answer (c) recognizes the principle of consent, but still uses other confidential information (the client's address) without prior consent and may still upset some clients. It may be that that if the client's telephone number is listed in a public telephone directory that you can look

up the number there and use it. However, it would be prudent to explain that you obtained the client's number from the telephone book.

2. The best answer is (c). If there is imminent risk of serious physical harm, there is probably a duty to warn in these circumstances. In these circumstances, you would probably also have to doubt Beatrice's capacity to appreciate the consequences of her instructions to you. The duty to warn can include a risk of serious physical harm to the client, at least in these circumstances. Answer (a) assumes that there is always consent to speak with members of the health care team, but such consent can be withdrawn. Answer (b) fails to recognize that implied consent can often be withdrawn, as might be the case here. Answer (d), while a possible approach, may lead to severe harm or even death of the client and does not adequately address the concerns about Beatrice's capacity and a possible duty to warn.
3. The best answer is (a). This question raises the issue of only gathering the personal information that is necessary from the client. Using discretion is probably the best approach. Where in doubt, it is probably acceptable to ask the questions, but in some cases some of the questions will clearly not be relevant. Answer (a) may remove the reminder role that keeping the questions on the form provides. You may then forget to ask the questions when they are relevant. Answer (c), while useful, does not address the issue of whether it is necessary to ask the questions. Answer (d) can result in unnecessary intrusiveness in very private areas of a client's life. You can always ask the questions later if they become potentially relevant.
4. The best answer is (d). Answer (a), advising the client, is prudent so that you and the client do not have any surprises at the hearing. Your client can probably tell you more about what to expect and may give you permission to speak with the client's own lawyer, if s/he has one, to help prepare you for what to face. Answer (b) is appropriate because you must obey the summons. It may be that the court will want either the original or a copy of the chart, so making a copy in advance will ensure you have at least a copy afterwards. Answer (c) balances courtesy and self-interest with client confidentiality.
5. The best answer is (a). The case of *McInerney v. MacDonald* (1992), 93 D.L.R. (4th) 415, (mentioned in Chapter 1) is a decision of the Supreme Court of Canada that indicates that clients generally have a right to look at and obtain a copy of their chart from their health practitioner, including consultation reports. This decision has been implemented in the *Personal Health Information Protection Act, 2004*. Answers (b) and (c) fail to recognize that the information belongs to the client. Unless there are reasonable grounds to fear that serious physical harm will occur or one of the other exceptions to access apply, you have an obligation to provide access. Answer (d) sets up artificial barriers, which is contrary to both *McInerney v. MacDonald* and the *Personal Health Information Protection Act, 2004*. While you can establish reasonable procedures to follow in making access requests (e.g., to ensure that the complete chart is made available and to explain any abbreviations and technical language, etc.), you cannot set up hurdles that effectively discourage or deny client access.

Chapter 5 — Consent to Treatment

1. The best answer is (d). While far from ideal, and not permitting much true feedback from the client, this is probably the best that can be done in the circumstances. Answer (a) may be applicable, but it is always prudent to check with the client to make sure they understand and appreciate all pertinent facts and that they have not withdrawn their consent. Answer (b) is quite unreliable. The initial blank consent was probably not specific or informed. Answer (c) while appropriate and useful, does not provide for any form of feedback from the client. It also does not address the treatment you will provide. It is dangerous to take the fact that the client has not got up from the chair as informed consent.

2. The best answer is (b). The scenario does not give you any information at all to help assess the client's understanding of the treatment decision and appreciate its implications for him. Answer (a) is wrong because one cannot assume that a fourteen year old is incapable of consent. Answer (c) is wrong because capable clients are entitled to consider the wishes of relatives and friends in making their decision so long as they are capable of making up their own mind. Answer (d) is wrong because answers (a) and (c) are wrong.
3. The best answer is (a). It involves all of the affected parties in the process and will most likely result in a consensus decision. If the family dynamics are too tense between the spouses you may have to do a bit of "shuttle diplomacy". Answer (b), while not wrong, is too drastic given that no attempt has been made to resolve the dispute and that the procedure is not urgent. Answer (c) does not put the client's interest first. It may be that if consensus cannot be obtained this may be your last alternative. Answer (d) does not recognize that there must be consent even if sealants are the recommended choice. Even if the dentist obtained consent at the time, there is an issue here as to whether it has been withdrawn.
4. The best answer is (c). A signed written consent provides evidence that could later be used to defend yourself from an allegation that no consent was sought or obtained. Answers (a) and (b) both overemphasize the piece of paper. What really counts is that there was a meeting of the minds and that the client truly gave informed consent. A true verbal consent is better than a paper that was signed without thought. A witness' signature is not legally required; it just helps you locate and refresh the memory of a witness who can help you prove that the consent was obtained. Even without a witness you can often prove the signature either through the client's own admission or, failing that, a handwriting expert.
5. The best answer is (a). With very rare exceptions, consent can be withdrawn at any time. Answer (b) is not correct in that consent can be given in one form and withdrawn in another form. However, it is recommended that the client be asked to confirm the withdrawal of consent in writing. Answer (c) fails to recognize that once consent is clearly withdrawn the dental hygienist should stop treatment first and then check to see if the withdrawal is informed afterwards. Continuing with treatment (unless it simply cannot be stopped at the moment) while determining if the withdrawal is informed is risky for the dental hygienist. Answer (d) is not responsive to the question. A power of attorney for personal care authorizes a substitute to make decisions on behalf of the client (usually when the client later becomes incapable) and does not normally deal with the withdrawal of a consent that has already been given.

Chapter 6 — Record Keeping

1. The best answer is (a). These are health care records and should be created and maintained according to professional expectations. In particular, the dental hygienist has not ensured that the treatment she or he has provided is recorded. Answer (b) assumes that dental hygienists must keep their own, separate records. Joint records are acceptable. While clearly it is more difficult to ensure that adequate safeguards are in place for unregulated custodians, it is not impossible. Answer (c) fails to recognize that even if the person is the client of the office, the person is also a client of the dental hygienist. Answer (d) inadequately reflects the independent professional obligation on the dental hygienist to ensure the appropriate records are kept. While there is some consideration of the office's criteria, there is still some responsibility on the dental hygienist to ensure that the records are kept appropriately.
2. The best answer is (c). It provides a means for you to achieve your professional obligations. Another approach is to discuss the concern with the others on the team and develop a compromise approach that will meet your professional needs without disrupting the flow of the office. It addresses the issue in a

consultative and collegial fashion and could provide the best solution. Answer (a) may work as a last resort in some contexts, but likely not this one. It requires that you advise the office of your intent and deprives the others using the chart at the office from access to your records. Answer (b) only addresses the retention and client access issues. It does not address concerns such as the security and confidentiality of the office's copy of the record. In addition, some of the difficulties identified in keeping private records might arise here as well. Answer (d) is not preferred because it likely involves your discrediting the office you work with. In addition, obtaining client consent to compromise professional standards is never an acceptable solution.

3. The best answer is (b). If the custodian agrees to your keeping these separate records and makes appropriate references to them in its record keeping practices then most of the problems are solved. However, this answer places a burden on you to secure and organize the records appropriately. Answer (a) misses the point. Even if the others on the team never want access to the record, there are other issues to be dealt with (e.g., security, confidentiality, access if the client approaches the office for their "complete" record, etc). Answer (c) similarly misses the point. A record, once made, is a record. Even if you would have met your professional obligations if you had never made the record (which is doubtful on these facts) does not detract from the fact that the record was made. Answer (d) is another possible answer. However, it suggests that private records are never acceptable which is not, strictly speaking, true.
4. This question tests your mental agility because you are searching for the worst rather than the best answer. The worst answer is (b) because it may be necessary to remove a record from a facility for some purposes (e.g., a home visit, to testify at a hearing, if the practice has two offices). Thus it is better to have appropriate measures for such eventualities than to try to prohibit them entirely. All of the other answers should be part of the safeguards for client records.
5. The best answer is (c) as it most closely reflects the College's expectations. Answer (a) misses that the triggering event is the last client visit or chart entry. Answer (b) misses the special provision dealing with clients who are minors. Answer (d) focuses on a type of record that would be rare to be in a dental hygienist's chart. In fact that type of record is not specifically addressed in the proposed record keeping regulation.

Chapter 7 — Conflicts of Interest

1. Depending on the circumstances, the concerns can probably be successfully managed by the DORM principle with the possible exception of the expensive shawl. Safeguards would include the following:
    a) Putting the chocolates out for the whole office, while perhaps not strictly necessary for this nominal gift, would set the right tone.
    b) Advising the supplier that the gifts will not affect purchasing decisions.
    c) Advising the dentist of the gifts.
    d) Refusing the gift of the shawl but suggesting that a discount on the order be provided instead.
    e) Giving clients an informed choice about whether to have the gold archwires, at an additional cost.
2. This scenario probably cannot be safely managed by the DORM principle. There are too many complications to make it an ethical arrangement. The income tax evasion aspect of the arrangement, in and of itself, is unethical and unprofessional.
3. So long as the research in support of the product is weak, you will have difficulty in ethically promoting it. The conflict is between your professional obligation to the purchasing dental offices and the ultimate

consumer of the product on the one hand and your paycheque and employment opportunities on the other hand. Coping strategies might include the following:

a) Share the results of your research with your employer and attempt to persuade them to make their claims consistent with the research.
b) Ensure that you clearly identify yourself as a representative of your company.
c) Ensure that your communications are fair and accurate and that if you can make any claims you can base your claims for the product on the evidence.
d) Continue to offer the traditional fluoride products.

4. Depending on the circumstances, the concerns can probably be successfully managed by the DORM principle. Safeguards would include the following:
    a) Separate completely the sale of April products from your professional practice.
    b) In the alternative, only discuss April passively (i.e., if the client raises it first) in a manner approved by your employer and in a way that places absolutely no pressure on the client. Even then provide assurances that if the client chooses not to follow up on their interest that it will have no impact on their dental hygiene care.
    c) Delivering products on a visit to the office might be appropriate if done right. The purchase should have been made outside of the office. The delivery should be done privately where other clients cannot see or hear. If a problem develops (e.g., a product is not suitable for the client) the discussion should be deferred to outside the office.
5. Depending on the circumstances, the concerns can probably be successfully managed by the DORM principle. Safeguards would include the following:
    a) Obtaining all necessary information to ensure that your professional status is not being compromised by participating in the conference.
    b) Explore the possibility of the organizers switching the sponsor with one from another session where the connection to your topic would be less direct.
    c) Confirm in writing with the conference organizers that there are no restrictions on your ability to present your views on the topics and that there will be no "slant" in the session as a whole.
    d) In your written materials and in your verbal presentation, give a disclaimer indicating that you are not affiliated with any sponsor for the conference, have not received any benefit from any sponsor and that your presentation is not to be taken as endorsing any product or service offered by a sponsor.

Chapter 8 — Boundary Issues

1. The best answer is (b). Boundary crossings interfere with the professional relationship often in unexpected ways. Some of the various types of interference are discussed in the text. Answer (a), while a real concern, is not the primary concern in this circumstance especially as the attendance at the home is for a limited, non-therapeutic purpose and there is no romantic or other connotations to it. Answer (c), only has significance because of the boundary issue. House cleaning is honest work. It is because of the power imbalance in the therapeutic relationship that becoming Felicia's boss may become a problem. Answer (d), while a real concern, does not address the core of the boundary concern.
2. The best answer is (c). The responsibility is on you to maintain the boundaries. You may have to take additional action, depending on the response to your attempt to re-establish the boundaries (e.g., transfer

the client's care to another dental hygienist), but re-establishing the boundary is the first step. Answer (a), while perhaps technically true, looks to your responsibility for the client's actions rather than a solution to the problem that has been created. You need to take some action. Answer (b) may ultimately be necessary in some cases but is not necessary in every case. Answer (d) leaves hope that there may be a romantic relationship in the future. Such a response does not deal with the harm that is occurring now to your professional relationship and is inappropriate.

3. All of the answers are true. Answer (c) is really a subset of answer (b). Which answer is most true will depend on the specifics of the particular boundary crossing. Answer (b) is probably the most fundamental concern.
4. The best answer is (c). You can convey this message to the client in a way that does not embarrass the client or attack their self-esteem. Answers (a) and (b) involve your legitimizing the conduct. It is true that answer (a) may not involve sexual abuse on your part and answer (b) does technically involve sexual abuse on your part. However, both answers involve at least a technical crossing of boundaries. Answer (d) is incorrect as the mandatory reporting obligations only apply to health practitioners, not clients.
5. The best answer is (d) as it is the most inclusive. The other answers are all true but are incomplete. The Chapter includes examples of boundary rules that protect the client, the dental hygienist and others who observe or otherwise learn of the conduct.

Chapter 9 — Communication Skills

1. The best answer is (b). Dental hygienists generally do not have the required expertise for this type of counselling and this client probably needs professional assistance. Answer (a) assumes that you have expertise in this specialized and high-risk area. Unless you have that expertise, you may cause harm or do little good. Answer (c), while not wrong, does not address the more important non-physical issues. Answer (d) involves you trying to make the decision on a matter that the client has to decide for herself. Of course you would also document your observations and discussion.

1. All of (a) to (d) can occur with poor communication. Since answer (a) focuses on the impact upon the client, rather than yourself, that might be characterized as the best answer.

2. It is difficult to give a best answer to this question because there are a number of competing values. The best answer may be (a). This is a good first step and there may be a compromise that will have the greatest likelihood of meeting your clients' needs and prevents you from becoming an unwelcome crusader. The compromise might involve some financial aspects (i.e., if you are paid a percentage of the fees you generate you too will lose out on any unbilled services). Answer (b), while valuable, only addresses part of the issue. Even if the service is not paid for by the insurer you might still choose to provide the service sometimes or some clients might even be prepared to pay for it. Answer (c) does not attempt to communicate with your colleague. This might be a last resort decision if an acceptable compromise cannot be worked out and you have a client interested in this counselling. Answer (d) fails to recognize that the issue is more than just a management issue (in which your employer's instructions should be followed) but also involves some professionalism issues. While this question raises communication issues with one's employer, the next logical issue is what the client would want and benefit from. As noted above, some clients might be willing to pay for such counselling and the unique perspective you can give to it.
3. While the best answer may depend upon your particular strengths and weaknesses, the best answer for most dental hygienists is probably (b). Inherent in the dental hygienist-client relationship is that the dental hygienist is the knowledge-possessor and skill-holder and the client comes in the role as a person needing

that expertise. Perhaps the greatest challenge for a dental hygienist is to understand the specific client's perspective. The remaining answers all have an element of truth and are not wrong. Answer (a) perhaps misconceives the point slightly, which really is that because dental hygienists are educated professionals, including possessing obvious intellectual capabilities, it sometimes takes extra care to see the client's perspective. Answers (c) and (d) are factual realities that need to be taken into account when communicating with clients. However, it is probably incorrect to call these the most significant barrier to good communication.

Chapter 10 — Employer / Employee Issues

1. The best answer is (b). By trying to address the underlying issue (e.g., client dissatisfaction, down time) you are most likely to reach a resolution and you are using good communication skills. Answer (a) may be your last resort if nothing else works and you are confident that you are right. Answer (c) does not help reduce the risk for the client. Answer (d) is a good answer if it can be done, but if the client is sitting in the chair it is unlikely you can do this research quickly.
2. The best answer is (a). While harsh, this sets out a process that will generally resolve both the immediate problem and the larger issue in a collaborative way. If that is impossible, the professional thing to do is to leave the position. Answer (b) only deals with the immediate problem and does not prevent future improper billings. Answer (c), while attractive is not collaborative, is probably impractical in most employment situations (how many people can tell their employer what to do) and ignores other possible solutions to the problem (checking each account is not feasible in many settings). Answer (d) does not address the misleading nature of the account.
3. The best answer is (c). It recognizes the client's need and attempts to address it as best as can be done but ensures that no dishonesty creeps into the billing. Answers (a) and (d) are directly or indirectly dishonest and amount to a failure to be professional. Putting the client first does not mean misleading insurance companies. Answer (b) is honest but fails to address the financial circumstances of the client.
4. The best answer is (c). There is not enough information to tell. You need more information, such as the income level of the registrant, whether there is income left over at the end of each year and whether the registrant may be in a position to sell his or her shares in the near future. However, many of the advantages proposed by the brother-in-law do not apply, particularly income splitting and protection from liability from disgruntled clients. Answer (a) assumes that a high income is the key factor. While important, there are other important factors as well, such as how much of that income is spent each year. Answer (b) does not have sufficient information to support it. Answer (d) is wrong, as income splitting through shareholding can only occur where the spouse is also registered by the College, which does not appear to be the case from the scenario.
5. The best answer is (a). There is no limited liability for professional negligence by a professional corporation. Answer (b) is wrong for professional corporations (although it may be true for other types of corporations). Answer (c) overlooks the fact that the employee is generally acting on behalf of his or her employer, the corporation, and thus the corporation will normally be liable. Answer (d) misses the point because the scenario deals with a professional corporation, which is different from a partnership.