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IDEALS 10th International Dental Ethics and Law Society Congress
3 – 5 September 2014
Cape Town, South Africa

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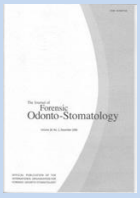

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EDITORIAL

The International Dental Ethics and Law Society (IDEALS), held its 2014 biennial Congress in September in Cape Town and the papers published in this supplement were some of the presentations made at that event. The society is a multi-disciplinary group including dentists, philosophers, lawyers and social scientists with a common interest in international dental ethics and law. The 2014 Congress had the theme of *Patient Rights: Limits to Autonomy*. The 37 papers, and 5 invited speakers provided a wide and varied approach to the Congress theme. Many disciplines were represented and speakers came from 10 counties. The size of the congress permitted and indeed encouraged meaningful discussion during the sessions and in the breaks between sessions. The varied oral presentations included scientific research, reviews on current laws, discussion papers and case studies and are reflected in this supplement.

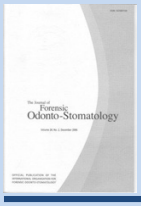
Attendance at conferences is a vital part of professional activities especially for academics and for those involved in framing regulations, as well as fulfilling the continuing professional development requirements for professional registration. Given that most members of societies like IDEALS have interests in more than one discipline and maintain several roles, making a choice of what to attend becomes a perennial balancing act. Although technology offers wonderful opportunities to interact with colleagues all over the world, it supports and enhances the face-to-face contacts made at meeting rather than replacing them. There is something unique and special about being able to watch and feel the reaction of one's colleagues whilst debating, discussing, and presenting one's own ideas, to have those ideas probed and challenged with immediate reply and counter-reply. Meetings establish relations and promote introductions that may later be nurtured via technology with fewer misunderstandings.

International organizations - even those with a wide range of members - seem to have a majority of members in Europe and North America. It is therefore not surprising that most of the international meetings occur in either of these continents. The choice is made on the basis of numbers - more members can afford to attend local meetings than to travel long distances. Countries that host meetings and those that are nearby provide the bulk of participants at these events supported by a solid core of existing active members. The decision to hold the meeting in South Africa was taken with the anticipation that attendance from the northern hemisphere may be constrained by distance plus the time and cost to individuals. However, it was also

made with the knowledge that these costs are borne routinely by members south of the equator and attendance for this group is limited to the few people who can justify the costs.

Providing a meeting in Cape Town enabled local registrants to attend and to present their papers in an environment that reflected both the culture and challenges faced by South Africans. It also offered a relevant context for visiting participants to gain an understanding of the different solutions and approaches taken. The main theme of *Patient Rights: Limits to Autonomy* fitted appropriately into a congress in South Africa after two decades since a constitution was enacted to replace and repair a tumultuous period of human rights abuse.

Suzette Porter



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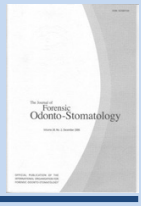

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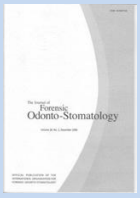

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HUMAN TRAFFICKING: ROLE OF ORAL HEALTH CARE PROVIDERS

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An oral presentation of this paper was delivered at the International Dental Ethics and Law Society (IDEALS) Congress 2014 in Cape Town, South Africa.

ABSTRACT

Trafficking in human beings is a modern form of slavery and is a well-known phenomenon throughout the European Union and beyond. After drug dealing and the weapons industry, human trafficking is the second largest criminal activity in the world today and it is a growing crime. The aim of governmental and non-governmental agencies, which are either directly or indirectly involved in combating trafficking in human beings, is the identification and referral of victims of trafficking and also to encourage self-referrals. Identification is the most important step to provide protection and assistance to victims of trafficking. Victims often have a variety of physical and mental health needs, including psychological trauma, injuries from violence, head and neck trauma, sexually transmitted infections and other gynaecological problems, dental/oral problems and have poor nutrition.

The author's experience in the field of community dentistry in presented within. Volunteer dental services are offered to non-European Union patients held in a centre for asylum seekers in Bari (Italy). Dental professionals can, in fact, contribute to the identification, assistance and protection of trafficked persons, as well as offering forensic services to assist the police investigation in order to identify crimes and find the criminal organizations behind them.

As for domestic violence and child abuse cases, there are ethical concerns involved in the identification and protection of the trafficked persons, as well as the need for interdisciplinary work and awareness. Adequate training in behavioural science and intercultural learning is paramount in order to avoid misunderstandings and increase sensitivity.

KEYWORDS**: :** Human trafficking; community dentistry; dental ethics; human rights

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INTRODUCTION

Trafficking in human beings (THB) is a modern form of slavery and is a well-known phenomenon throughout the European Union and beyond. After drug dealing and weapon industry, human trafficking is the third largest criminal activity in the world today[1,2] and it is a growing crime. Victims of THB can be adults and young children, who are subjected to force, fraud or coercion for the purpose of sexual exploitation or forced labour. UNICEF estimates that more than 1.2 million children are trafficked annually. [3]

It is not possible to make a global estimate of the numbers involved as it is a hidden crime.[4] Additionally, internal trafficking is often excluded from statistical data, while human smuggling is at times included.[5] Anti-trafficking legislation and protocols are in place at a national level in almost all European countries. The aim of both governmental and non-governmental agencies (NGAs) which are either directly or indirectly involved in combating trafficking in human beings is the identification and referral of victims of trafficking and also to encourage self referrals. Identification is the most important step to provide protection and assistance to victims of trafficking.

A variety of identification and legal procedures have been proposed and developed to assist and support victims. Nevertheless, there are differences in national legislation and the legal definitions of human trafficking, and also in the processes used to identify trafficked persons. Standard procedures cannot be yet proposed for the identification and referral of victims of THB as the phenomena is complex and requires a multidisciplinary approach with the involvement of various agencies and interdisciplinary work between law enforcement officers, social care providers, humanitarian and human rights organizations, health services and forensic professionals.

The identification of victims requires a police investigation in order to establish if a crime has occurred and to try and find the criminal organizations behind it. In addition to this, victims of THB need medical and psychological assistance which is tailored to their specific needs if they are to regain trust, feel safe and begin a healthier life. The protection given by medical professionals is fundamental in supporting and/or victims if they are to be persuaded to become witnesses in trials against traffickers and to co-operate in the collection of evidence against them.[6]

The focus of this paper is to raise awareness and develop an understanding in the dental community, to introduce the crime of human trafficking and its correlations with human rights, ethical and health issues. In 2012 O'Callaghan[7] was the first US dentist to emphasize the importance of raising awareness of this phenomena among dental professionals, highlighting the need to be aware of the legal and ethical obligations when treating patients in their routine work. Health care[8] and dental settings[7] can offer opportunities for the identification and referral of trafficked victims, providing assistance to potential victims and support to law enforcement agencies. Oral health professionals can in fact contribute to the identification and protection of trafficked persons, as well as offer forensic services related to evidence, collection of signs of abuse, patient medical history and background, age estimation of adults and minors with no birth certificate.[9, 10]

The author's experience in the field of community and forensic dentistry is presented within volunteer dental services delivered to migrants held in a centre for asylum seekers in Bari (Italy) (Centro Accoglienza Richiedenti Asilo), and the importance of a medical interview to

retrieve any relevant evidence of potential trafficking, torture, abuse and data related to the international criminal organizations behind. All healthcare professionals need to be educated on THB,[11] on their specific healthcare needs[12,13] and on the ethical and forensic concerns. Many of the indicators of THB that the dentist will encounter are similar to those raised in domestic violence and child abuse cases with which the dentist is familiar.[14] However, it is timely to draw dentists' attention to THB victims and note that due to difficulty in accessing health care, their conditions may be severe.

BACKGROUND INFORMATION

The United Nations defined THB as the *recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of detection, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation (The Palermo Protocol).*[15]

THB is a complex transnational phenomenon, rooted in vulnerability to poverty, an absence of a democratic culture, gender inequality and violence against women, and in conflict and post conflict situations. The situation is exacerbated by a lack of social integration and of opportunities for employment, by poor access to education, and issues such as child labor and discrimination.[16] Traffickers also use isolation from family and friends, and society in general in order to control their victims and keep them in captivity, limiting contact with outsiders, thus ensuring that the victim does not begin to form social support networks within the community.[17]

Italy is a destination or transit country for both legal and illegal migrants and for people subjected to forced labour or sexual exploitation, especially from those countries where poverty as well as the legal and social structures place children at risk.[18] Italy prohibits all forms of trafficking in persons through a law introduced in 2003 - Measures against trafficking in persons - which prescribes penalties of 8 to 20 years imprisonment. Nevertheless, Italy has not yet established an autonomous national *Rapporteur* to enhance anti-trafficking efforts and share best practices with other countries on victim protection and identification and as of today there is no national action plan on THB.[19]

Trafficking and smuggling are different phenomena which often tend to be confused because the distinction between the two can be unclear and also because the phenomena are often interrelated. In Italy, for example, human trafficking is carried out mostly through the same channels used for illegal immigration.[19] The basic difference is that smuggling is the illegal access to a country by a migrant through the payment of fees to an international criminal organization. On the other hand trafficking is the exploitation of human beings, most often women and children, who are kidnapped in their country of origin and then traded against their will to another country by international criminal organizations. This is why trafficked persons must be considered victims and should not be considered illegal migrants, even when they don't possess regular identification documents or transit permit.

Health care providers are one of the few professions likely to come into contact with trafficked women and girls while they are still in captivity.[18] Migrants[20] and victims of human trafficking[21] often have a wide variety of physical and mental health

needs, including psychological trauma, injuries from violence and substance misuse, head and neck trauma, infectious diseases, sexually transmitted infections and other gynaecological problems.[21] AIDS, dental problems, respiratory illness and weight loss due to poor nutrition also pregnancy, pelvic inflammatory disease are all conditions which have been found in victims. Because some victims do not have adequate access to health care, it is likely that health problems are well advanced. Physical abuse and torture often occur, which can result in broken bones, loss of teeth or cigarette burns on the skin.[18]

In dental clinics, especially when treating patients of different nationalities who are being held in temporary migration hosting centers and have no official identity, dental professionals should be aware of certain behavioral indicators which could raise suspicions of potential trafficking[21,22] for example non-Italian patients or English speaking patients coming from extremely poor countries who are in possession of a mobile phone which receives frequent incoming calls, or persons showing fear or agitation as if they may be under threat or control. A person may give the impression of being unable to move about at will, or exhibit strong cultural and ritual forms of control (such as Voodoo or Black magic in Nigerian women).[23] In cases of forced labor trafficked victims the International Labor Organization (ILO),[24] highlighted the following conditions and indicators which should raise suspicions: in the work place the patient is isolated; their documents are kept by employer or another person; they may have signs of physical abuse; their relatives may receive threats of violence in the country of origin; they must endure long working hours at derisory levels of pay; the patient shows clear signs of personal neglect and frequently has inadequate access to personal protection equipment in the workplace.

Another form of forced labor is domestic 'slavery'. These cases are characterized by a direct personal relationship with the employer, which often includes the cohabitation.[18] Patients can appear particularly vulnerable and consider themselves a component of the hosting family. However, the patient may report the absence of any rest period or rest day and having no holiday entitlement, and the obligation to be permanently available to fulfill the needs of the family. Some women may show or report signs of physical and sexual abuse. All of these indicators should be considered as potential clues, and in cases of child abuse or domestic violence, suggest the need for further investigation by the health care provider.[15]

DENTAL CARE SETTING

Dentists may visit and treat possible victims of THB in their practice and especially in humanitarian settings with multinational and multiethnic communities. In 2010 the author founded a non-profit solidarity association involved in community dentistry and human rights (Solidarietà Odontoiatrica per l'Handicap e l'Infanzia - SOPHI). In May 2010 the association SOPHI entered into a partnership with the committee of UNICEF in Bari, and in June 2012 an agreed a protocol with the local health administration (ASL – Azienda Sanitaria Locale) of the national health care system, with the scope of providing, together with other volunteer dentists and dental hygienists, free dental screening and care to minors and adults hosted in the Centre for Asylum Seekers (Centro Accoglienza Richiedenti Asilo – CARA) in Bari. A proper dental clinic was also set up in the centre with the support of the association SOPHI. In 2012 alone the center hosted 2,192 people, divided into 1,951 men, 125 women and 116 children. These persons came from 41 different countries, mainly

Afghanistan, Pakistan, Eritrea and Somalia.[25] A temporary stay in this centre is necessary to carry out all the investigations required for the evaluation of refugee status. In 2012 the dental volunteers treated 54 minors and 41 adults at the dental clinic belonging to the National Health System.

Although there is a legal distinction between human trafficking and other high-risk situations afflicting migrants such as smuggling and exploitation for work, there are commonalities between the health needs of people in these different circumstances. For dental care providers, distinctions in a category of migrant should not affect the quality and level of care they provide, but may be important in determining which referral options they can use. All patients received health support and assistance based on human rights and humanitarian principles.[21]

The dental visits begin by verifying the language spoken and the country of origin of the patient. A translator or cultural mediator is always present, not only for linguistic purposes, but also to assist in identifying any cultural aspects or differences particular to the patient's background. It is difficult to know the religious and political background of the nationalities involved so some intercultural awareness is advised before treating these individuals as patients. All the patients seen have no regular or appropriate identification documents, but are not considered illegal migrants.

During the appointments, attention is paid to checking for certain behavioral and universal signs, similar to those recommended when visiting potential victims of child abuse or domestic violence.[26] These are: the patient is alone or is accompanied by a person who exhibits controlling behavior (spouse, friend or parent); where the accompanying person insists on remaining during the visit even if this is not required; patient showing fear or anxiety when interacting with his accompanying person. The confidential interview of the patient should be performed only by the dentist and with the presence of the translator to allow for a more in depth investigation not only into the patient's medical history, but also into their social conditions. The interview is a fundamental tool to retrieve relevant data and to raise any concerns or suspicions of torture, abuse or exploitation, especially when there appears to be discrepancies between the medical history and the clinical findings. However, of all the patients observed and treated in the past 12 months, only one woman from Somalia was referred as a possible victim of trafficking.

DISCUSSION

The indicators of THB may prove useless if applied by untrained persons. Evidence suggests that when victims do not fit the stereotypical definition of THB as defined by law enforcement officials, they may not be identified as victims and may be labeled as criminals.[27,28] In Italy, as in many other countries, dentists and dental hygienists are legally and ethically obliged to report any suspicions of child abuse and neglect. It is not mandatory to report patients likely to be a victim of human trafficking, unless the patient is under 18 years. Nevertheless, dentists could be the first health care providers to assist and identify possible victims of THB and for this reason they have an ethical obligation to share some of the confidential information and clinical findings with law enforcement agencies. The breaching of confidentiality in these cases (as may occur with other criminal activities) has two reasons: the need to protect victims of this crime and assist them to move on to a safer and healthier life, and the need to collaborate with law enforcement agencies in the investigation

which may lead to identifying the criminal organizations involved.

If a patient is suspected of being a victim of trafficking, the dentist must put together a plan of care and assistance which needs to be tailored to the patient's condition and location. The presence of either a translator or a cultural mediator does not guarantee a complete understanding of the patient's behavior. In child abuse cases,[14] human trafficking requires a particular sensitivity, which cannot be gained without training and experience in the area of behavioral and forensic science. In addition, the different cultures and nationalities involved in international THB and migration require extra experience and training in community dentistry and intercultural knowledge and learning to understand both the differences and similarities in habits, attitudes and behavior and the cultural background of each patient.

The dental professionals involved could consider phoning the Italian National Human Trafficking Resource Center.[29] There is a free national referral line is active 24 hours a day and can assist both the victims in finding local resources (the service is provided in different languages: English, Albanian, Russian, French, Spanish, Romania, Arab, Hungarian and Chinese), and also aid law enforcement officials and social workers. A dentist and a dental hygienist must be aware that, although there is no mandatory obligation to report their suspicions, except, as previously stated in the case of a minor, it will be the dentist's decision whether to call the referral line anonymously without the patient's permission. Patient confidentiality must be respected at all times in order to improve or enhance the patient's trust, this will also assist in the aim of encouraging self-referral of THB victims and the recording of clear forensic evidence.[6] In certain cases it can take significant time for victims to perceive themselves as a victim of a crime and trust someone enough to disclose their situation to them.[27] This is one of the reasons why it is not advisable to report suspicions without the patient's consent and respect confidentiality. To combat human trafficking, the police investigation needs the maximum support of the victims to provide evidence against traffickers. In order to achieve this, the victim must feel safe and protected from the criminal organization, and not just secure from the health care point of view. The European Court of Human Rights has ruled that trafficking in human beings falls within the scope of Article 4 of the European Convention for the Protection of Human Rights and Fundamental Freedoms and that accordingly, *States had a positive obligation to put in place an appropriate legal and administrative framework against trafficking, to take measures to protect victims and to investigate acts of trafficking, including through effective co-operation with other States concerned on criminal matters.*[30] This now means that trafficking in human beings can be prosecuted as a violation of the European Convention on Human Rights.[30]

Migration and asylum seeker centers can benefit from *pro bono* dental care assistance. Serving nationally or internationally by volunteering is a rewarding experience which can restore dignity and well being to those individuals who are suffering from exploitation and abuse, or simply because of their refugee status, and can make a difference in the battle against the violation of human rights.[31]

CONCLUSIONS

Dental care professionals should raise awareness in the field of trafficking in human beings and be specifically trained in all forms of human exploitation which

represent a violation of human rights. As with any other form of abuse, victims of human trafficking frequently come into contact with health professionals owing to injuries and illnesses, but also because of the safe and confidential environment they can offer. As a consequence, health and dental care providers may be the first responders, and therefore have an ethical obligation to protect, assist and support minors and adults. The basic obligation is to achieve the best oral health for all, whilst always being focused upon human rights and humanitarian principles. Adequate training in behavioral science and intercultural learning is paramount in order to avoid misunderstandings and increase sensitivity.

The author suggests the establishment of an international working group to study dental and forensic services and then propose a set of actions and recommendations to identify all forms of violations of human rights framed within a dental setting.

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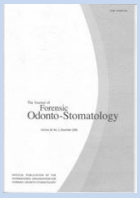

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AN AUSTRALIAN GOVERNMENT DENTAL SCHEME: DOCTOR-DENTIST-PATIENT TENSIONS IN THE TRIANGLE.

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ABSTRACT
Autonomy of participants is challenged when legislation to provide a public health service is weakly designed and implemented.
Background
Australia's Chronic Disease Dental Scheme was instigated to provide a government subsidy for private dental treatment for people suffering chronic illness impacting their oral health or vice versa. They were allocated AUD$4250 towards comprehensive treatment over 2 years with their eligibility determined by their general medical doctor.
Research
A qualitative research study was conducted to explore the experiences from the perspectives of the patient, medical and dental practitioner. One of the research outcomes identified a frequently reported level of discomfort in the patient/doctor/dentist triangle. Doctors and dentists reported feeling forced by patients into positions that compromised their autonomy in obeying the intent (if not the law) of the scheme. Additionally, dentists felt under pressure from doctors and patients to provide subsidized treatment to those eligible. In turn, the patients reported difficulties in gaining access to the scheme and in some cases, experiencing full or partially unmet oral health needs.
Reason for Conflict
Poor inter-professional communication and lack of understanding about profession-unique patient-driven pressures, ultimately contributed to dissonance. Ill-defined eligibility guidelines rendered the doctor's ability to gate-keep challenging.
Outcome of Conflict
Inefficient gate-keeping led to exponential increase in referrals, resulting in unprecedented cost blow-outs. Ensuing government-led audits caused political tensions and contributed to the media-induced vilification of dentists. In December 2013, government financing of dental treatment through Chronic Disease Dental Scheme was discontinued, leaving many Australians without a viable alternative.
Recommendations
There is a need for qualitative research methods to help identify social issues that affect public health policy process. In order to succeed, new health policies should respect, consider and attempt to understand the autonomy of key participants, prior to and throughout

KEYWORDS**:** Autonomy, Australia, Chronic disease, Government Dental Scheme, Qualitative Research

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INTRODUCTION

Australia's Chronic Disease Dental Scheme (CDDS) aimed to alleviate oral health conditions that directly impacted on people with chronic disease.[1] The CDDS paradigm lay within the need to provide people with timely and affordable access to primary care, as a means to prevent the onset or worsening of their chronic health problems.[2]

The Australian Oral Health System is based on privately funded dental practices accessed by 85 percent of the population.[3] It incorporates a publicly funded service for eligible patients that varies from state to state, including children, the disabled, and low income patients. Public dental services are funded through a mix of Federal and State Government reserves. However, the public dental services fail to meet the demand for oral health needs in Australia.[4] The implementation of CDDS made some defining contributions to a particular group of patients many of whom may be eligible for public care but miss out due to prohibitive waiting lists to gain treatment.[3]

Additionally, many Australians consider the cost of private dentistry to be prohibitive.[5] People from low socio-economic backgrounds experiencing pain and infection, often seek symptomatic relief from alternative sources of care such as their general medical doctors. Unlike access to general medical care, private dental treatment is not subsidized by Medicare (the Australian Government's health agency).[6] The CDDS was the first scheme to pay Medicare benefits towards private dental treatment for eligible patients[7] since the 1990s.[3]

Eligibility to be part of CDDS was determined by a doctor, depending on the patient's chronic health experience and not their financial situation. Those deemed eligible were allocated AUD$4250 worth of funding through Medicare, to pay for services rendered by general and/or specialist dental practitioners and/or dental prosthetists over a consecutive two year period.[1] This group will be referred to collectively as dentists unless individual identification is required.

From inception in November 2007, the CDDS was fraught with controversy, receiving highly politicised media coverage alleging exploitation by dental practitioners.[7] By June 2008, 480 000 CDDS services had been provided at a cost of $79 million to the Federal Government. Citing cost-blow outs and over-servicing by dentists, the Federal Government attempted to close the scheme twice in 2008 with both attempts blocked by the Australian Senate. In October 2008, Medicare Australia announced the introduction of a compliance program and proceeded to audit dentists for administrative oversight. In December 2009, Medicare announced the finding of 28 dentists in breach of their administrative and billing requirements and sought redress totaling $21.6 million Australian dollars. After considerable legal, media and political attention, the fines were reduced to $0.5 million and the scheme discontinued on December 1,2012. To date, there is no comparable alternative available to those seeking dental treatment.[8] Despite this controversy and altruistic and theoretical underpinnings, very little research was conducted on the CDDS process and participant experiences, particularly at the user level. This paper will provide an insight into the complexity of the relationship between the three parties and a means of understanding the controversy

MATERIALS AND METHODS

Purposive and snowball sampling were used to recruit participants from diverse backgrounds with experience of the CDDS. The selection criteria were broad to include as many opinions and experiences as possible. However, as the data gathering and analysis process progressed,

participants with known divergent views or experiences were sourced through the initial participant pool.[9] The initial participant pool was also used to gain access to people who are less likely to initiate study participation due to social or geographical isolation.[10]

Thirty-three participants were sent letters of invitation and 31 participated. None refused. Two participants, a patient and doctor were sent letters of invitation, but were not required because the necessary level of data was achieved without loss of participants.

The research was undertaken using focus groups to refine topics identified in a literature review before developing a template used in semi-structured interviews. Two focus group sessions, each consisting of five participants - one consisting of dentists/personnel from the Sunshine Coast and the other. CDDS patients from metropolitan Sydney, were conducted. Each session ran for approximately 120 minutes. Analysis of the focus group sessions allowed for the refinement and development of semi-structured interview templates used in the interviews. Twenty-four in-depth, semi-structured interviews were conducted between April and August 2013. The interviews lasted between 30 and 180 minutes. All interviews and focus group sessions were conducted by the primary author, transcribed verbatim and analysed using content and then thematic analysis[11] with the aid of NVIVO 10 qualitative analysis software.

Ethics approval was provided by the University of Queensland's Ethics Committee (Approval number AW010213).

RESULTS

This paper will focus on the discomfort between patients, doctors and dental practitioners that was generated by the CDDS process and identified in the research.

Access to CDDS

Doctor's reported that Medicare's CDDS entry guidelines were imprecise and vague resulting in varying degrees of influence affecting their final decision to refer patients. One Doctor commented: *"All you had to have was a chronic medical condition that impacts on your dental health. What does that mean? Impact? So vague, so nebulous, that anybody with anything could argue for it." (Doctor 4)*

Whilst many factors influenced a doctor's referral process, a significant number of CDDS referrals were made due to demand from patients. Even doctors who resisted requests by patients who did not have a chronic disease, eventually bent to their demands and provided a referral. Doctor's who reported working in practitioner-saturated markets, felt that the need to please their patients conflicted with their role to be a gatekeeper. This is illustrated in the following statement. *"We're competing with each other for patients. ... there's a lot of doctors thinking, 'Hey I'd better give that person what they want because I want that person to come back to me.'" (Doctor 4)*

Nine patient participants confirmed that pressure was placed on doctors by patients to provided referrals. Patient participants related seeking CDDS referrals after learning of the scheme from sources such as doctors' surgery staff, people receiving treatment through the scheme, dentists or the government dental services. *"Actually I found out through my wife's cousin who's a registered nurse and works out of my local doctor's rooms." (Patient 3)*

Pressures placed on doctors to provide access was further compounded by what was commonly called 'Doctor Shopping'. If a doctor refused to provide a referral, patients would visit many doctors in succession until one relented. Two patients discussed such a process during the focus group session. *"I had to go to two doctors to get it. The first one knocked me back*

and then I went to my doctor. So it wasn't easy to get." (Patient 8)

In addition to pressure from their patient base, doctor's related having patients present to their surgeries seeking referrals on the basis that a dentist specifically sent them for one. This concept was confirmed by dentists in this study, as illustrated below by one dentist justifying their position regarding the requests. *"They were patients who really needed dental treatment and they did have a chronic disease. They were the sort of patients that CDDS was for so I never had my request refused." (Dentist 7)*

However, doctors who reported feeling overburdened with the responsibility of gatekeeping government funds did not welcome requests for CDDS referral by dentists. Some doctors considered requests for referrals from dentists as an attempt to raise dentist's personal revenue. As a result, dentists' requests were often rejected and became a source of professional discord and misunderstanding between the health practitioners.

However, unbeknown to the dentists, doctors reported a secondary reason for not heeding dentist-driven referrals. Some patients were simply deemed ineligible. When this reason was related to dentists, all reported seeing many patients through the CDDS who showed no evidence of suffering from a chronic health conditions, despite presenting with CDDS referrals from their doctors. *"Indeed I had many patients, not several but many patients, who did not know why their doctor had sent them to the dentist except to get their $4,000.00." (Dentist 9) "There was nothing wrong with them. 'Are you taking any medication?' 'No. I'm not taking any medication.'" (Dentist 9)*

In response to such assertions, one doctor conceded that the vague Medicare entry guidelines allowed for some creativity on the doctor's part, to allow patient entry. Doctor's also reported feeling morally challenged when trying to provide access to patients with high needs who were not necessarily considered eligible.

By October 2011, 11 million services had been provided to 680 000 people.[8] Despite such monumental figures, all study participants reported a lack of promotion of the scheme with the result that people known to them, who were deserving, missing-out. Seven patients related that had they not specifically requested CDDS access from their doctors, they would not have received a referral. The failure for doctors to disclose such an important scheme was considered deceptive and unfair as illustrated by a comment made one patient. *"They don't tell you these things. It's as though it's for them to know and you to find out for yourself sort of thing. It's a secret society." (Patient 11)*

In response to patient grievances, all doctors reported a mounting pressure from the public as the predominant reason for failing to volunteer information. Doctors confessed to providing referrals only on request as illustrated by such a comment below. *"But we didn't go actively seeking these people did we? And I think human nature, being what it is, a lot of people that came and asked for it got it and probably didn't deserve, and some of the people who did deserve it didn't ask for it and didn't get it." (Doctor 3)*

Treatment and fees under the CDDS.

Medicare's CDDS schedule of fees was considerably lower than the standard fees for dentists in the study. In addition, dentists reported having to allocate increased administrative time to cover Medicare's needs. Some reported business losses due to Medicare's refusal to pay, or due to significant delays in paying for the treatment rendered. The cost in wages for staff to chase payments was high in relation to some of the missing fees, but the losses added up over time. However, most dentists chose to accept the reimbursement offered by Medicare

('bulk-bill' was the term used). They felt that patients would go elsewhere if they did not.

All the doctors in the study said they referred their patients to bulk-billing dentists unless the patients requested a particular dentist. This would also create tension with dentists who felt compelled to bulk bill.

All patients in this study said they were bulk-billed and eight of the twelve related satisfactory oral health outcomes but four reported incomplete treatment. Dentists reported cases where patients stopped attending once the $4000 mark was reached. Four dentists reported treating some patients for free to complete the patient's ideal treatment plan once funding through CDDS was over. Dentists and doctors also reported cases where people with referrals chose not to seek dental intervention.

DISCUSSION

Doctor-Dentist-Patient Tension

The design and implementation of the scheme required the cooperation between the three main interest groups and Medicare Australia. The results of this study indicate that each group faced challenges that remained unknown to the other significant groups. This led to unnecessary creation of tension and misunderstanding, resulting in avoidable professional divisions between dentist and doctor groups. Additionally, some patients felt disillusioned by their health practitioners billing, practice and referral behaviour, without entirely understanding the situations and limitations faced by the doctor or dentist in their relationship with Medicare.

Failed expectations from all parties led to a few members of each group (dentists, doctors and patients) performing or behaving in morally or ethically challenging ways. Doctors reported feeling overwhelmed by the demand for referrals, by their need to please people and maintain their patient numbers. Dentists felt undervalued due to the lack of inter-professional respect from the doctors. The scheme's limitations coupled with high patient needs resulted in some dentists performing procedures beyond their general scope of practice. Patients felt deceived by health practitioners for non-disclosure about the scheme and let down by the overarching aims of the CDDS, for not being able to overcome their treatment needs.

Moral Dilemma in Public Health Schemes

The CDDS was created to improve access to dental treatment for people with chronic health issues. It used doctors, the patient's most accessible health practitioner, as the gatekeeper. The entry guidelines set by Medicare Australia were designed to promote and support autonomous decision-making by doctors, to enable independent support of their patients' needs. Unfortunately, these guidelines did not envisage the complex behaviours of patient seeking health service and the intricacies of economic forces on the doctor's decision-making processes.

Health economists have examined the processes involved in making health-related decisions over many years. In his foundational paper, Arrow (1963)[12] described healthcare systems using the allegorical context of an economics market. Patients as the consumers were driven to purchase health, not as a commodity, but in a bid to retard death or overcome illness. Doctors were in the business of selling health, but delivered on expectations potentially motivated by altruism rather than pure business transactional efficiency.

However, the complexity of the decision-making process used by a doctor in determining final service delivery is affected by factors such as income for service, relationships with and market for patients and patient-driven service

requests, to name a few. In his concluding statement, Arrow relates how, "the logic and limitations of ideal competitive behaviour under uncertainty force us to recognize the incomplete description of reality supplied by the impersonal price system." (p149)[12] In other words, the unexpected social complexity affects health services and health economies more than we would like to imagine. These were issues faced by the CDDS where the intentions of the scheme's conception were frustrated by unconsidered social processes.

The lack of clarity over eligibility led to discord between various doctors and dentists. The personalisation of the referral process resulted in what was considered by some, to be the provision of unnecessary referrals to undeserving cases. The results of this study indicate the individual differences in opinion regarding who merited referral and who did not, leading to pointless dissatisfaction. Individual patients felt they deserved access over others, dentists found their professional referrals were ignored and doctors found their autonomy threatened by demands to provide referrals from patients and dentists.

CONCLUSIONS

This study provided insight into the effects of multidisciplinary involvement of health professionals when attempting to address the dental side of chronic illness and the resultant overspending on the budget. In the end, CDDS cost the government a considerable amount of money not by manipulative strategies of dentists or doctors, but by the poor guidelines and gate-keeping procedures implemented by Medicare. Had this issue been identified and the terms and conditions of eligibility been more precise, fewer but more carefully selected patients would have received referrals from their doctors, despite public pressure.

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INFORMED CONSENT IN COMMUNITY-BASED ORAL HEALTH RESEARCH

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ABSTRACT

The ethical principle of respect for persons presents multiple dimensions to stimulate debate around issues related to informed consent for participation, data management, confidentiality and privacy. The informed consent process is built on a continuum involving a comprehensive explanation of the proposed study; and the declaration of consent (the right to withdraw from at anytime from the study without any negative consequences). All research involving human participants carry a certain level of risk (physical or informational) and it is not possible for the researcher to know all the consequences of participation before a study commences. This presentation will focus around the key issues of information, consent' and competence in relation to community-based oral health research and outlines some of debates in the informed consent process.

KEYWORDS**:** Informed consent; information; confidentiality; oral health activities; risks-benefit ratio; community

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INTRODUCTION

Ethics in oral health research should be concerned with ensuring first and foremost the respect, protection and the promotion of participant's rights, however not much research related information exists in this area. The informed consent process forms part of the ethical principle that espouses to respect for persons and essentially comprises of three key elements. This includes adequate information to guide the participant into making a decision to participate in the study. Voluntariness refers to rights of the participant to withdraw at any stage of the study without any negative consequences or loss of rights and privileges. Competence refers to the individual's capacity to decide whether to participate or not. This capacity refers not only to mental competence but also takes issues around the vulnerability of participants into account.[1-5]

The informed consent process thus involves the "*ability to understand relevant information; the ability to appreciate the nature of a situation and its likely consequences; the ability to reason through the information and weigh the options logically; and the ability to communicate the choice*".[6p2] The literature indicates that participants understanding of the research process is further diminished when inadequate information is provided or when the information is highly technical, difficult to comprehend and legalistic.[6-8] Studies indicate that participants experience difficulties in really understanding the nature of their participation in a research study, the use of placebos, their right to withdrawal at any time, the right to seek alternate sources of care and the *"confusion around the dual roles of physicians and researchers"*.[6p2] This paper further extrapolates this issue to include the dual roles of oral health service providers and researchers in community-based settings such as schools.

DEBATES IN THE INFORMED CONSENT PROCESS

Several debates arise around ethical issues in community based oral health research. An ethical dilemma that could arise from the research process would be the collection of clinical data. This could include dental caries status, oral cleanliness or periodontal status. Does the researcher have an ethical obligation to refer the participant for further clinical management, should he/she require these services? How does this referral impact on the right to privacy and confidentiality? How can the researcher guarantee confidentiality for participation yet refer the participant for further management? Should the researcher thus qualify the extent to which confidentiality can be maintained?[9]

Another debate revolves around the following: should the researcher conduct a caries risk examination in geographical areas where referral patterns for further clinical management is not possible because of lack of access or availability of oral health services? Should the researcher raise awareness of oral disease status yet be unable to refer the participants for further management? Does the researcher have an obligation to provide an educative component to the research process in order to address unhealthy behavioural practices? The research process is considered a systematic enquiry through the use of scientifically valid methodologies designed to contribute to the body of knowledge in an identified field.[10] However the researcher's responsibility extends beyond the generation of data and should be held accountable for identifying further support for the participants. This could include referral mechanisms for psychosocial or educational support through health promotion efforts.[10-11] Mechanisms for referrals should be clearly articulated in the

information documents presented to the potential participants.

In qualitative research, the right to participant confidentiality, privacy and anonymity could be a challenge. Another scenario could be group focus discussions. A study does not have to be high risk or invasive to bring about social harms.[11] A breach of confidentiality concerning the participant's social status, sexual orientation, dietary practices, perceptions of oral diseases, self-care practices could all become a source of stigmatization even though the study in itself is minimal risk.[10,11] The manner in which information is generated, shared and explored can be a potential source of stress for the participants and the researcher needs to be aware of this.[10,11] It is also possible that at times information not related to the study is revealed in these focus group discussions and the researcher must be able to facilitate and balance the quality and relevance of the information provided. Further ethical dilemmas could arise should a participant decide to disclose sensitive information about him/herself or about the institution that could bring the institution into disrepute for instance, theft of tooth brushes or supplies related to the school feeding scheme programme, or more seriously, abuse at the school. The researcher would need to determine how to manage this information by balancing the rights of the individual to the legal responsibilities of the researcher.[10-12]

The participant's ability to exercise the right to withdrawal can also be difficult to achieve in some settings, for instance a school setting.[11,12] A participant could be reluctant to withdraw from a study for fear of stigmatization and ostracisation. A scenario could be where an oral hygienist is conducting a school-brushing programme as part of service delivery in a low resourced community with high levels of unmet oral health need. He or she then decides to evaluate the services as part of a research study. The school brushing programme, in this context, is already seen as a privileged contribution that is beneficial to the learners. It would be difficult for learners to refuse participation when the programme is part of the daily school activity. Other reasons could include peer pressure or the need to comply with other learners in the school, especially when the study has the support of the parents, educators and the school principal. Thus the power relations that exist between the learners and the gatekeepers and role and influence of the researcher in these settings must also be taken into account.[12]

In addition to obtaining parental consent for learners under 18 years of age, learners are required to provide assent. The rights of the child participant must be upheld even if the parent has consented but the child has refused participation.[13] The provision of adequate information on the risks-benefit ratio can be particularly challenging especially when there is possibility that this information could in fact have a negative effect on the study recruitment process. Disclosure of possible risks associated with participation could be seen as a deterrent to participation and could impact on the recruitment of study participants.[7]

It is also not possible for a researcher to know all possible risks associated with the study before the study can commence. An example of this scenario would be researchers engaging in an experimental study involving the effectiveness of fluoride mouth rinses as a caries preventive strategy. Fluoride is found naturally in low concentrations in food, beverages, fish, wine, vegetables, etc. Fluoride is also found in water obtained from boreholes and natural springs and the fluoride could be in high concentrations depending on the geographical regions. One of the known

long term side-effects of systemic exposure to fluoride is dental fluorosis and this feature ranges from a few white specks on the teeth to an irreversible breakdown and destruction of the tooth structure (mottling of enamel).[14,15] For this to occur the teeth have to be in the developmental stage, thus this side effect is primarily associated with younger children when the teeth are still developing.[14,15] It is not possible for a researcher to know the individual's total cumulative exposure to fluorides and given the debates around the long term exposure to fluoride, the researcher will not be able to conclusively outline all the possible long term effects of combined topical and systemic exposure to fluoride.

This also raises the debate around the researcher's responsibility to address the long term adverse events associated with the study. The question to be asked is: can a researcher be morally and ethically held accountable for dental fluorosis occurring in a community because of exposure to topical fluoride?

Another scenario could be the implementation of a community-based sealant programme using an experimental design. This is a clinical procedure that can be done in community settings where a resin is placed in the fissures of healthy, non-carious (not decayed) teeth. A sealant programme conducted in a community setting would not include supporting diagnostic tools such as use of radiographic examination, hence it is not possible to identify caries that cannot be seen clinically. Furthermore the placement and success of dental sealants are technique sensitive, dependent on the type of dental material used, self-care practices, the individual's caries risk profile, diet, etc. One of the disadvantages of dental sealants is the possible need for re-application.[16-18]

Hence the researcher needs to consider the extent to which post-trial care would be provided, should these dental sealants fall off. The researcher needs to identify pragmatic solutions and build this into the research and funding processes.

OBTAINING INFORMED CONSENT

Obtaining informed consent can be particularly challenging. The greater the potential risk, the greater the need for community engagement to ensure that there is community buy-in and support for the study, to alleviate any negative perceptions around the study, and promote openness and transparency. Obtaining consent from vulnerable populations must be done in a non-exploitative manner that does not compromise their safety or dignity.[2,5,7]

There is a debate on whether consent should be a once-off event or be part of a continuum.[3]
Viewing consent as a once off-process implies that the participant has provided consent to all aspects of the research process. However, the dynamic nature of the research process suggests unexpected changes can occur and it is only ethical to engage with the participant on an ongoing basis. There is also a notion that consent should be re-affirmed after the collection of data because this provides the participant with a different perspective of the study as compared with when he or she enrolled for the study.[19]

Thus the informed consent process should include information explained in simple and easy to understand format. This information should include the aims and objectives of the study, the purpose of the study, the processes involved, data collection processes, the duration of data collection, the time and venue, the possible benefits and associated risks, the mechanisms to address risk, referral patterns for further management, the costs associated with the referral process.[1,20] The researcher should also include the contact details for the researcher, supervisor where

appropriate, and a Research Ethics Committee (REC), overseeing the research process. All other funding agencies or sponsorships should be identified and stated.[1,20]

Consent is only valid if it is obtained voluntarily and without coercion. The participant should be given adequate time to consider the process, benefits and possible risks associated with participation.[1,21,22] The use of implied consent, where participation in the study is seen as a sign of consent, is deemed unacceptable. Consent should be expressed and documented as far as possible. Consent should also be obtained for different phases of a study or if data collection is occurring in multiple sittings, for instance a study involved clinical examinations, and interviews with the participants or a study involving multiple interviews with the same participant. It is imperative to ascertain who will administer the informed consent process, flexibility in the timing and considerations for re-calls or subsequent visits.[22] The researcher also needs to identify mechanisms to address the loss of time, inconvenience and expenses that could occur as a result of participation in the study. However, this must not be seen as undue inducements that could blind the participants to the potential risks associated with the study.[8-11]

Studies involving children must first demonstrate that the same research cannot be done on adults and yield the same effect and impact. The risk-benefit ratio should not only consider individual impact but how this impacts on communities of which these individuals are a part of.[23] There is need for partnerships between the individuals, communities, researchers, and institutions where these individuals are located.

The issues of how confidentiality, privacy and anonymity are maintained, must be outlined. The researcher should indicate how the results of the study would be made public. How will the participant, institutional or organizational rights to confidentiality be maintained? Will the information be de-identified or de-linked? The issue of data management, including storage and access, and its eventual disposal must be outlined. The researcher needs to identify where the data will be stored, who has access to the information, who has ownership of the data and how will the data be destroyed. It is important to note that issues of data management, including confidentiality, should extend beyond the research team and include any person that may come into contact with the data.[1-6]

The issue of future use of collected data must be addressed. Will the data be used only for research purposes? Will the data be used for educational purposes? To what extent will the use of photographs or video recordings be used? How will confidentiality and privacy be maintained with the use of photographs or video recordings? Participants should be given the right to accept or reject data gathering devices such as cameras, video and voice-recorders. Consent for use of this equipment must be obtained explicitly. What mechanisms will be in place to oversee data sharing? Will this data be annoymised or de-identified? How will issues of participant confidentiality and privacy be maintained? Does this include a review by the overseeing Research Ethics Committee?[19-23]

The researcher should identify mechanisms to address any non-disclosure of information that could occur at the start of the study. This non-disclosure could be as a result of study design (for instance a blinded study, masked study or the use of a placebo in experimental studies). The researcher should firstly provide a strong justification for non-disclosure. In the case

of experimental studies, the control group should not be exposed to an intervention that is below the acceptable standard of care. The researcher needs to identify how the participants will be informed of the reasons for non-disclosure at the end of the study and identify referral patterns for further support, if required. The feedback on the rationale for non-disclosure should include issues of potential risks or discomfort to the participants.[9-11]

Gatekeeper permission does not in any way diminish the need for participant consent. Any conditions placed by gatekeeper must be reviewed with caution, eg. access or sharing of data, because this comprise issues of confidentiality and privacy.[20] It is also possible that phrases and expressions used in the interviews can be linked to participants even though the data has been annoymised.

CONCLUSIONS

The process of obtaining informed consent is thus more than a signature on a piece of paper. It involves an intricate network of communication and collaboration based on trust.[23] Researchers in community based oral health research need to take cognizance of the ethical issues highlighted and more debate should be stimulated around this area.

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PROFESSIONAL CONSEQUENCE FOR DENTISTS INVOLVED IN UNETHICAL DECISION-MAKING IN SOUTH AFRICA

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ABSTRACT

The previously gullible and apathetic South African public, generally speaking, is lately becoming increasingly rights-based sophisticated. Patients are no longer accepting inferior quality work and have become more knowledgeable especially regarding the expected skills and professional conduct of dentists. The present study examined archival material as published between 2007 and 2013 of penalties against ethical misconduct. It was found that the majority of ethical transgressions took place in urban settings and the most predominant transgression was charging for services not performed and submitting these claims to medical aids as well as performing sub-optimal interventions. Legally a practitioner who performs such acts may be held liable for the damage or injury suffered by the patient as a consequence of these acts, on the basis of negligence. Penalties imposed by the Health Professions Council of South Africa vary between 5,000 Rand and 15,000 Rand, as well as suspensions of between 9 to 12 months. It is doubtful that transgressors would change their behaviour in the light of the present Continuous Professional Development programmes where attendance is really the only prerequisite and not moral reflection. This study recommends that the Health Professions Council of South Africa need to re-evaluate the effectiveness of their ethical training programmes and adapt the model to incorporate more inclusive learning.

KEYWORDS: Dentists, ethical transgressions, HPCSA, misconduct

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INTRODUCTION

Most professions stipulate guidelines or ethical rules to ensure competent and professional behaviour, as well as to minimize misconduct.[1] These guidelines serve as roadmaps for human coherence and conflict management between the different parties involved in the clinical settings[2] (i.e. practitioner, colleagues and patient/client). Furthermore, the guidelines give the public the reassurance that members of a particular profession will have a minimum level of expertise and skills, and that public interest would therefore be optimally protected.[1] Pettifor and Sachuk[3] argue that ethical codes serve a threefold purpose, namely to supervise, regulate and correct professional behaviour. These are maintained through a reflection on personal values, motives and behaviour.[4]

However, codes alone are inadequate in ensuring professional behaviour.[1] Ho a person will react in an ethical dilemma is often influenced by his/her contextual constraints, personal desires and the idiosyncrasies of a particular situation.[5] Lindén and Rådeström[6] argue that ethical awareness is a crucial aspect for the application of ethics which relies on a practitioner's ability to be open and dedicated to the study and critical examination of their own professional judgement and behaviour. The inability of newly graduated practitioners to deal with real-life complex ethical issues are often ascribed to the simplistic and linear training models which are often applied.[4] Furthermore, inadequate training in ethics can be implicated as an important element in unethical behaviour.[4] Although the causal relationship between ethics training and ethical behaviour is complex and not yet empirically established, it appears as if universities do not always pay adequate attention to this important aspect.[1] It therefore seems that ignorance concerning the importance of ethics and a lack of awareness of the personal and professional consequences that may emanate from unethical behaviour is largely responsible for this state of affairs.

Lockhat[7] rightfully raised a warning for practitioners that the previously gullible and apathetic South African public, generally speaking, is lately becoming increasingly rights-based sophisticated. Patients are no longer accepting inferior quality work and have become more knowledgeable especially regarding the expected skills and professional conduct of dentists. Talk shows, print media, social media and Internet sites offer health care consumers ready access to information about treatment protocols and professional ethics. This information empowers clients and patients to ask informed questions, to become information-sophisticated consumers, and to appropriately address dentists' errors and misconduct.[8] As such, patients or clients feeling aggrieved by the negative effects of a health care professional's perceived misconduct are more likely than before to lodge a formal complaint with the relevant professional board. The regulatory structure followed in South Africa is underwritten in terms of the National Health Act (61 of 2003) by which the Health Professions Council of South Africa, consisting of 12 professional boards linked to specific health professions, is a legal organ with relevant sanctioning (punitive) powers and rights. For health care professionals, the prospects of facing a formal complaint enquiry are often a distressing experience that has the potential to spawn denial, anxiety and depression.[8] Other psychological and physical sequelae include loss of self-confidence, professional isolation, depression, anger, frustration, and increased incidence of somatic symptoms and physical illness.[9] General health care delivery may also be negatively affected as acquitted health care professionals are more likely to avoid seeing high-risk

patients or to focus on practicing "defensive medicine".[8] In addition, they may become socially withdrawn, limiting access to personal and professional support. Each of these responses, if not duly recognized and effectively managed may ultimately result in impaired clinical and ethical judgments, thereby negatively affecting future clinical work and the well-being of patients.[8]

This article reports on the ethical transgressions committed by dentists registered with the Health Professions Council of South Africa (HPCSA) in the period 2007 to 2013, the primary rationale being to empower dentists by informing them about the most frequent ethical misconduct transgressions and to grow in their awareness of ethical professional conduct.

MATERIALS AND METHODS

The objectives of this research project are as follow:

a) To analyse the case content of all guilty verdicts related to professional standard breaches and ethics misconduct against HPCSA-registered dentists in the period 2007 to 2013;

b) To analyse the penalty content of all guilty verdicts related to professional standard breaches and ethics misconduct against HPCSA-registered dentists in the period 2007 to 2013; and

c) To recommend potential strategies to limit these transgressions.

The study was primarily conducted within a qualitative research paradigm while it specifically focused on a historical research approach. The focus of historical research is the interpretation of events that occurred over a specified period of time.[10] Archival material (documents and records) is the primary data source in historical research.[11] In this study the archive refers to the collated information pertaining to complaints, alleged misconduct and outcomes of formal hearings as posted on the official website of the HPCSA.

The specific data gathering process for this study focused on the following data for each guilty verdict from the respective annual lists for the period 2007 to 2013: HPCSA registration category, number of cases per verdict, basic case content, specific penalty/ies imposed per verdict and province. In addition, the qualitative case content of each complaint was recorded in terms of the specific professional standard breach and/or ethics misconduct theme.

In the first phase of data analysis, annual frequency tables were compiled for the following variable combinations: a) the various penalties imposed to guilty practitioners across the total study period; b) geographical distribution of the guilty dentists across the total study period; and c) transgression categories and specific misconduct linked to the guilty verdicts against dentists across the total study period. In the second phase of data analysis, the specific case content of each guilty verdict was subjected to a qualitative content analysis.[11] This involved a systematic coding and thematic description of each case. Initially each of the two researchers independently conducted the qualitative content analysis on selected annual guilty verdict documents, followed by several consensus discussions.

Research projects that exclusively focus on the analysis of publicly available documents are generally exempt from the requirement for ethics clearance from a registered research ethics committee.[12] As such, no formal ethics clearance was sought for this study.

RESULTS

The frequency (%) of the various penalties imposed to guilty dentists (n=61) across the total study period is indicated in Table 1. During this period the average number of registered dentists was 5280 per year. The 61 guilty dentists across the study period were found guilty of 223 counts in total (range between 1 – 133 counts per practitioner). The three most frequent penalties were a suspended suspension between 1 month and 1 year (30%), a fine between R1,000 and R8,000 (28%), and a fine between R10,000 and R15,000 (20%). On closer inspection, the most common transgressions linked to these penalties were charging for procedures/services not rendered and submitting these claims to medical aids; performing sub-optimal intervention; failure to recognise/diagnose/manage post-operative complications; and failure to refer patients to a specialist for evaluation and/or treatment. The highest fine ever levied, however, for this registration category was R60,000 imposed in 2012 for fraudulent conduct where the practitioner submitted three fraudulent claims to a medical aid scheme.

The geographical distribution of the dentists found guilty across the total study period is indicated in Table 2.

Penalty	% of all penalties
Caution or Caution & Reprimand	11%
Fine R1,000 – R8,000	26%
Fine R10,000 - R15,000	20%
Fine R20,000 – R60,000	8%
Suspension 1 month to 1 year	30%
Suspension 1.5 to 4 years	5%
Removal from register	None

Table 1: Percentage of penalties imposed to guilty dentists (2007-2013)

The results indicate that the slightly over half of all the transgressors is from Gauteng, followed by KwaZulu-Natal (23%) and the Western Cape (13%).

The frequency of transgression categories linked to the guilty verdicts against dentists across the total study period is indicated in Table 3. The results in Table 3 indicate that the majority of transgressions were fraudulent conduct (55%); followed by improper professional conduct (23%) and negligence and/or incompetence in evaluating, treating or caring for patients (19%). Guilty verdicts with regards to negligence in the proper keeping of patient records (2%) and performing interventions without patient (or parent) consent (1%) were very infrequent. Table 4 provides a more detailed description of the specific misconduct linked to each transgression category.

DISCUSSION

An analysis of the frequency of the various penalties imposed to guilty dentist across the total study period (Table 1) indicates that the HPCSA mostly opted to impose financial penalties against the majority of transgressors (54%). Some of the imposed penalties were relatively large amounts, especially in those cases where transgressors brought the profession's name into disrepute by being fraudulent –

Province	% of all guilty dentists (n=61)
Gauteng	51%
KwaZulu-Natal	23%
Western Cape	13%
Eastern Cape	5%
Free State	3%
Northern Cape	0%
North-West Province	0%
Mpumalanga	0%
Limpopo	5%

Table 2: Geographical distribution of guilty dentists (2007-2013)

Transgression Category	% of all transgressions
Fraudulent conduct	55%
Improper professional role conduct	23%
Negligence and/or incompetence in evaluating, treating or caring for patients	19%
Negligence regarding patient documents/records	2%
Perform procedures/interventions without patient consent	1%

Table 3: Frequency of transgression categories linked to guilty dentists (2007-2013)

as can be seen with a R60,000 penalty in 2012. However, in the period studied no transgression was deemed serious enough to necessitate a removal from the register.

The geographical distribution of the guilty dentists across the total study period (Table 2) indicates that the majority of transgressors are located in the more urbanized areas of the country, with Gauteng having had the most transgressors (51%). One possible reason could be that the majority of health care providers are located in these areas and also that the patient population in these urban areas are more aware of professional misconduct and their patient rights.

The main contribution of this paper lies in the results regarding the transgression categories and specific misconduct committed by guilty practitioners (Table 3).

Fraudulent conduct

The majority of guilty verdicts were in respect of fraudulent conduct by practitioners. Fraudulent actions often pertain to charging for non-rendered services or procedures, claiming from medical aid schemes for non-rendered procedures and interventions. All these transgressions inflict material harm on the patient in that limited resources (i.e. medical aid benefits, financial resources) are abused to the benefit of the

Fraudulent conduct • Charge for non-rendered procedures/services • Fraudulent medical aid claims • Colluding with unregistered person in respect of medical aid claims • Charge for services rendered by an outsourced non-registered laboratory
Improper professional role conduct • Advertising transgressions • Rude, demeaning and insulting remarks towards patient • Failure to provide feedback to patient's family when requested • Employ unregistered person
Negligence and/or incompetence in evaluating, treating or caring for patients • Inferior / Inadequate patient examination and subsequent sub-optimal intervention / treatment decisions • Failure to diagnose and treat patient in a timely manner • Perform sub-optimal intervention procedure • Failure to recognise/diagnose/manage post-operative/intervention complications • Failure to refer patient to a specialist for evaluation and/or treatment when indicated • Provide sub-optimal implants/prosthesis/dentures • Negligent clinical practice – Not wearing gloves during patient treatment
Negligence regarding patient documents/records • Failure to keep proper medical records and/or clinical notes
Perform procedures/interventions without patient consent • Failure to inform patient of intervention risks • Treat a minor without parental consent • Failure to inform patient about fee structure

Table 4: Specific misconduct by guilty dentists (2007-2013) within each transgression category

transgressor. The fact that practitioners did not inform their patients of charging an above-medical-aid-fee structure significantly impacts on the patient's ability to have made an informed and autonomous decision regarding the affordability of the suggested interventions and procedures. The HPCSA is taking a firm stand on this in that the imposed penalties vary between R5,000 and R15,000, as well as a possible suspension between 9 to 12 months.

South African legislation takes a serious stance on the issue of fraudulent claims for procedures not performed, to the extent that fraudulent behaviour could result in criminal prosecution under Section 66 of the Medical Schemes Act (Act 131 of 1998), as well as the Health Professions Act (Act 56 of 1974). According to these acts, anyone who is found guilty of fraudulent conduct can be punished by a fine, imprisonment (for a period not

exceeding five years) or both a fine and imprisonment.

Improper professional role conduct

The Health Professions Act 56 of 1974 defines "unprofessional conduct as improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act." In the study period, the penalty employed for this kind of behaviour ranged between R6,000 and R12,000. The Department of Health's efforts to empower and educate patients of their rights will possibly see an increase in complaints against health care professionals as patients will increasingly expect higher levels of professionalism and integrity from health care providers. In addition, the influence of media (e.g. TV medical dramas)[8] may also influence the perceptions and expectations of patients regarding appropriate professional behaviour.

Negligence and/or incompetence in evaluating, treating or caring for patients

The principle of non-maleficence requires that health care providers do not purposefully create or inflict unwarranted harm or injury on patients (either through commission or omission). Legally a practitioner who performs such acts may be held liable for the damage or injury suffered by the patient as a consequence of these acts, on the basis of negligence. Negligence refers to the blameworthy attitude or conduct of someone who has acted wrongfully on account of carelessness, thoughtlessness or imprudence the person failed to adhere to the standard of care legally required of him/her.[13]

In the current context of negligence or incompetence, many health care professionals, hospitals or other health-care providers protect themselves against liability for possible negligence by requiring the patient or parent/guardian to sign a waiver of claims, indemnity form or a so-called "disclaimer" prior to any practitioner-patient interactions.[13] No specific current legislation in South Africa exists on the subject of indemnity clauses. Also, there is no case of a health care professional using such waiver clause to claim protection against liability in this manner, raising the question on the position that the court will take on such waiver contracts.[14] One position on such contracts may be to view it as void (unenforceable) because it offends against public policy. As such, a waiver by a patient safeguarding a health care professional against liability for negligence, so it would seem, would be tantamount to a patient "licensing" a health care professional to practice sub-optimal medicine.

CONCLUSION

The law primarily works retrospectively in attempting to prohibit future behaviour of the kind which has been exhibited previously, whereas the focus of ethics is prospective to establish and contribute to an ethical society at large. Although the law and ethics are not mutually exclusive constructs, the respective focus on how to get to a more just society is different. The law applies sanctioning power, whereas ethical awareness informs future behaviour and allows a person to take a meta-view on an issue. Since the HPCSA is an organ of the state constituted by the National Health Act (61 of 2003) it has the legal power to institute a sanction against any transgressor. However, the effectiveness of these sanctions to significantly change a transgressor's unethical behaviour is debatable. The process of changing behaviour inter alia includes some reflection, which, according to the Kohlberg-Blatt method,[15] requires that

health care providers ought to be able to think of their patients' needs in their conduct. Health care providers can only embrace higher levels of moral conduct and development by reorganizing their thinking after they have had the opportunity to grapple independently and actively with significant moral issues or dilemmas. In order to attain these high levels of moral development, the HPCSA should ideally revisit the structure and requirements of its Ethics Continuous Professional Development (CPD) programme where the annually required ethics credits can be attained by merely attending a 2 to 3 hour long workshop and/or presentation focusing on an ethics-related topic. At these CPD training little input/reflection is required from the practitioners, other than physical attendance, which results in the ethics credits being awarded. It is obligatory for all those who want to stay registered (to enable them to practice) to accumulate the said credits. The focus should ideally shift from rather passive learning events to active opportunities where practitioners are challenged to develop and mature in their moral reasoning and development skills.

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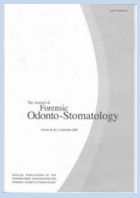

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LIMITED RIGHTS OF MINORS IN DUTCH HEALTHCARE

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ABSTRACT

In many countries, if not all, the autonomy of minors is limited. Especially in countries with comprehensive legislation in the field of health law the (lack of) autonomy of minors may create challenges. These problems become more complex if the costs of treatment are not paid by the government or covered by insurance. Some challenges are: At what age is a minor able to decide about his health? As not every treatment is the same, how should the system take this into account? The Netherlands has a long history of very comprehensive health care legislation. This legislation includes a section about the treatment of minors that addresses the questions of the conditions in which the autonomy of minors is limited. Though this legislation is limited to the Netherlands other countries face the same challenges.

***KEYWORDS*: :** Patient's rights, minors

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INTRODUCTION

In most countries minors cannot buy relatively valuable goods without the approval of their legal representative. The reason for this limitation of rights is that under civil law people can only close a contract when they are able, or should be able, to foresee the consequences of their action. If this is not the case they are considered to be legally incompetent. As making an appointment for dental treatment is seen as an agreement to treat, this agreement is subject to civil law. Based on the general rules for incompetency, one would expect that the rights of every minor who makes an appointment with a dentist are limited and the dentist has to take the opinion of the minor's legal representative into account. As the legal representative of a minor is in most cases his or her parents, we will use the common word "parent" instead of the more legal term "legal representative". It should be taken into account that in some cases a minor has legal representatives besides or instead of his parents. In Holland, as in many others countries this is the case when a family is under the supervision of a child protection service.[1]

Should the triangular relationship between the patient, the parents and the dentist become complicated, the legislation can make things even more complex if the rules for the agreement to treat differ from the general civil rules concerning legal competency.[1]

In this paper we will discuss the complicated rules for treating minors (being younger than 18 years of age) in Holland. We will focus on the practical implications of these rules in the dental office and on the challenges a dentist has to overcome in order to get payment for his services. To keep things simple, we will not address the complications that arise when parents divorce or when minors are placed under legal custody.

DISCUSSION

Patient's rights

In the Netherlands as in many other countries, patients have several important rights: the right to consent, the right to be informed and the right to privacy. Based on the rules of professional conduct there is also a right to be treated in emergencies. In addition to these rights the dentist has the duty to keep records. The most important rights in relation to minors are the right to consent and the right to be informed. Together these rights are referred to as the right to informed consent. When minors are involved three questions arise: Who has to be informed, the minor or his parents, or both? Whose consent is needed? and thirdly Does the dentist need the permission of the minor when the minor is treated in the presence of his parents?

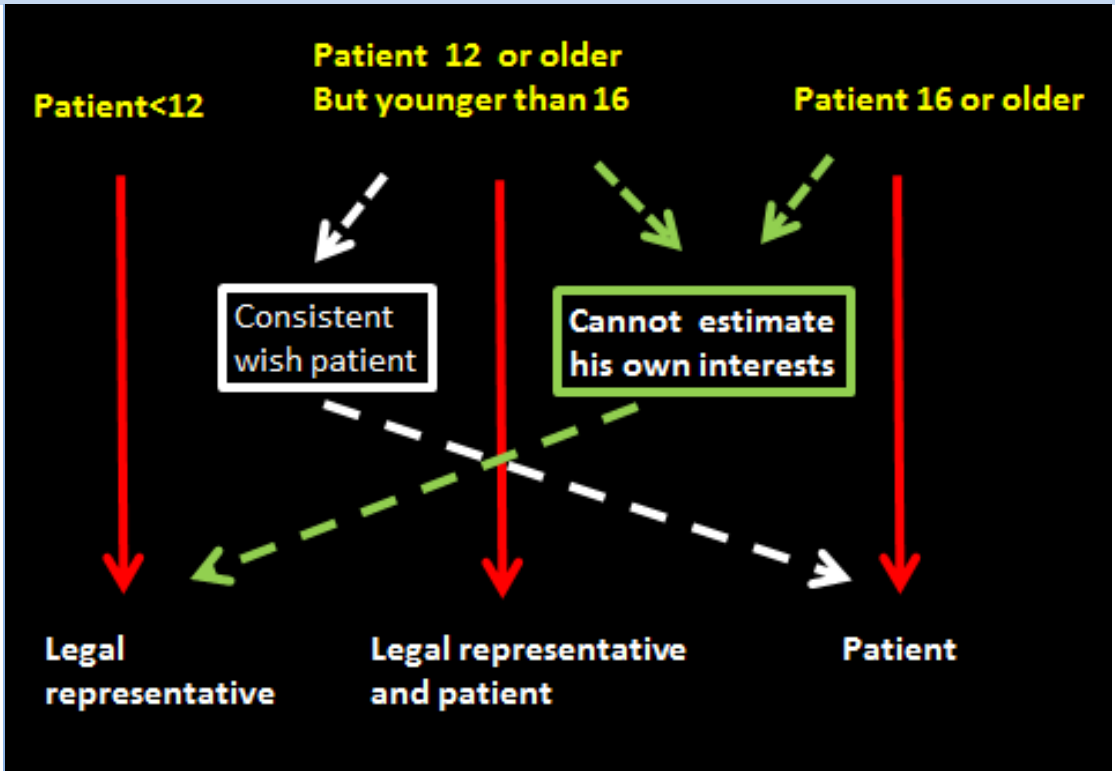
Main rule of age competency

Figure 1 shows the main rule for treating minors in the Netherlands. Based on age, minors are divided in three groups: younger than 12 years of age, 12 years or older but younger than 16, and 16 years but younger than 18 years of age.

If a minor is younger than 12 years of age, the dentist should determine the patients' rights based on the wishes of the parents. As a consequence the parent has to be informed about the treatment and has to decide whether or not the dentist has permission to treat.

If a minor is younger than 16 but 12 years or older, the dentist should determine the patients' rights based on the wishes of both the patient (a minor) and the parents. Both have to be informed and the dentist needs the permission of both parties. If a minor is 16 years old or older, the dentist has to determine the patients' rights even though a minor, without referral to the parent. As a consequence the dentist

Fig 1: Health law rules for minors



needs only the permission of the minor. As a minor has a right to privacy, the dentist has to ask the minor for permission when he invites the parents into his office during treatment of their son or daughter.

Exceptions

When a minor, regardless of his age, is not able to foresee the consequences of his wishes, the dentist has to consider the rights of the patient (a minor) against the wishes of the parents. As this may seem to simplify decision-making, dentists can be tempted to assume that a minor is not able to foresee the consequences of treatment. Legally, a Dutch dentist should be reluctant to assume that a minor is not capable to decide about dental treatment as the consequences of simple dental treatment, such as fillings, are considered easy to estimate. It is more likely for a dentist to assume that the minor lacks the capacity to judge treatment consequences for complicated or long-term treatment such as orthodontics. This may also occur when a wish for dental treatment is solely based on a unrealistic fear for dental treatment. For instance when a minor wants to have all his teeth removed so he will never have to face a dentist again.[2]

The second exception is when a minor is 12 years old but younger than16 years old and the parents want to waive dental treatment, but the minor persistently wishes to be treated. In that case, the dentist should ask the minor for permission for further treatment instead of his parents.

A third exception presents when a minor is 12 years old or older, but younger than 16 and a dentist has the minor's permission, but not the permission of the parents and treatment is necessary to prevent severe health damage. Needless to say, this exception will give rise to many discussions about the meaning of "severe health damage".

A fourth exception occurs when there is an emergency and there is not enough time to

contact the parents. In dentistry this may occur when a child loses a tooth in an accident.

A fifth exception is when treatment is not consistent with an acceptable standard of care. In Holland a dentist is obliged to refuse every treatment that is contrary to the standard of care. So if a parent wants the dentist to remove a healthy incisor, the dentist has to refuse.

A sixth exception occurs when, once consent has been gained, a minor subsequently resists treatment. Ceasing treatment would seem to be a practical solution as it is nearly impossible to treat a patient who is physically struggling. However, one should keep in mind that struggling in Holland is not always a valid reason to stop treatment.

With a certain variation these rules are found in most countries.

Financial consequences

In the Netherlands simple dental treatment for minors is covered by the insurance. For orthodontics, crowns or bridges the patient or his parent has to pay a part of the bill themselves. Under the main rule, the financial consequences are logical. The dentist comes to an agreement with the parent and the parent has to pay the bill. If a minor is 16 years old or older, the dentist closes the contract with the patient and the minor has to pay the bill, although at the end the parents will have to reimburse the minor as they have to pay for the upbringing of their child. The same occurs when the parents want to abstain from further treatment and the minor (a 12 year old) persistently wants to be treated. As a consequence the dentist faces two potential challenges: how to get payment from a minor without an income or how to cope with parents who have to pay for treatment they did not want or in which they were not involved. These challenges are caused by the fact that in Holland and in many other countries health law is designed for the medical care for which costs to minors are usually covered in full by insurance.[3]

A legal solution for these challenges is to avoid any disagreement between a 12 year old and his parents. As orthodontics and crowns are not seen as emergency treatment a dentist will ask minors how they plan to pay for the treatment they want.

CONCLUSION

Many patients and many dentists are not familiar with the complexity of the health law on informed consent when treating minors. As a consequence many Dutch minors are treated under the general principle of not being competent to make decisions. Many Dutch dentists negotiate treatment of minors with their parents omitting the involvement of the minor. Improved discussion with the parties both independently and together as appropriate, will solve many of the problems that are discussed in this paper.

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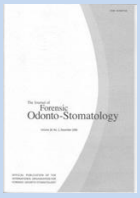

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CAN AUTONOMY BE LIMITED - AN ETHICAL AND LEGAL PERSPECTIVE IN A SOUTH AFRICAN CONTEXT?

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ABSTRACT

The principle of autonomy acknowledges the positive duty on a health care practitioner to respect the decisions of a patient. The principle of respect for autonomy is codified in the International Bill of Rights, the African Charter, The South African Constitution (108 of 1996) and the Patients' Right Charter. The common notion is to protect a person's liberty, privacy and integrity.

Health care practitioners should honour the rights of patients to self-determination or to make their own informed choices. Patients have the right to live their lives by their own beliefs, values and preferences. This implies that a healthcare practitioner should respect the wishes of a patient when a patient makes an autonomous decision.

The principle of respect for autonomy takes into consideration a patient's choice based on informed consent and the protection of confidentiality of the patient. Informed consent is a process whereby information is shared with a patient to enable an informed decision. It is therefore important for a patient to be well informed to give effect to the notion of making an informed decision. The relationship between the healthcare practitioner and the patient is based on trust and communication. Full disclosure to a patient will empower a patient to make a true informed decision.

It is of particular importance for a health care practitioner to acknowledge and respect the decisions and choice made by a patient so as not to violate a patient's autonomy.

Can autonomy be limited? It can, if legally required and duly justified. Section 36 of the South African Constitution (Act 108 of 1996) limits rights in the Bill of Rights by application of a general law.

***KEYWORDS*: :** Ethics, patient rights, autonomy, Constitution of South Africa, Bill of Rights

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INTRODUCTION

South Africa has experienced six centuries of Roman Dutch law but has only enjoyed a quarter of a century of independence under its own constitution that enshrined a system of equality following an intense period of inequality. Those designing the constitution were able to draw on and retain much of the Roman Dutch legal system but to overlay it with the African notion of Ubuntu. Ubuntu promotes the solidarity and sharing of the community and the good of the community is recognized as paramount, yet it also supports the human rights of individuals.[1]

The concept of autonomy in the practice of health care has to find a balance between the good of an individual and the good of the community. This tension presents challenges to health care practitioners in South Africa, especially those in the public sector. This paper explores autonomy in healthcare and whether autonomy is absolute or limited from an ethical and legal perspective in a South African context.

AUTONOMY AS AN ETHICAL PRINCIPLE

Autonomy is a key ethical principle in the health care profession. In essence, autonomy is a manifestation of one's legal and mental capacity to understand and make an informed decision[2]. This principle places the duty on the health care practitioners to have respect for a patient and to value their dignity. A health care practitioner should therefore not act or conduct medical treatments or procedures in such a manner that it will violate a patient's self-worth. The important component of autonomy is to allow patients to make their own informed decisions. A health care practitioner should not interfere with a patient's decision and should avoid undue duress to participate in the medical procedures, treatments or clinical trials. Ultimately, the health care practitioner should offer information about the proposed health intervention that is appropriate and sufficient for a patient to execute an informed decision without infringement of autonomy.[2]

To exercise personal autonomy one needs the capacity to understand what is available and whether it is appropriate for one's purpose. Providing information and assistance is a key ethical responsibility of a health professional. Providing the legal framework supporting autonomy is the role of legislators. These components will be the focus of this paper. Additional requirements of exercising autonomy include having the physical capacity and environment to fulfil one's choice. Age (minors and the elderly), physical ability, socio-economic status, and personality are all issues that may place limits on personal autonomy. A person may have a mental or psychological impairment that requires support from others to obtain a form of autonomy. [3] The last two components, limits due to physical and mental capacity, will only be discussed as they relate to the information context of autonomy.

Savulescu[4] argues strongly that autonomy is not absolute and therefore it is limited. Medical intervention is permitted in a situation where there is evidence of dangerous behaviour. This intervention is permissible in order to prevent any harm to others or self-harm.

AUTONOMY AND INFORMED CONSENT

Rowe and Moodley argue that autonomy is a paramount ethical and legal priority. Autonomy has a close relationship to informed consent. These two values go hand-in-hand with each other and cannot be divorced. The principle of autonomy has bearing on the doctor and patient relationship. The autonomy of a health care practitioner is a privilege not a right.

Society confers professional autonomy and it is limited in comparison to the protection of a patient's autonomy and human rights. The patient is the ultimate person to cast a decision about their health and wellbeing.[5]

Some of the challenges for the health care profession in South Africa are the number of illiterate, uneducated and very poor patients. Language and culture raise barriers to informing and educating patients. This prompts the question of whether patients are truly informed and in the position to give effect to the notion of autonomy.[5]

It has become the health care practitioner's responsibility to ensure that a patient not only understands the information provided to them, but also appreciates the application of information to their condition and circumstances in order to make an informed decision.[2] This additional responsibility adds to the already heavy burden of health care practitioners especially in the South African context where health care practitioners have a high workload in the public health care service and do not the sufficient time to establish if a patient fully understands the information provided. In most cases the patient relies on the health care practitioner to make a decision on their behalf and to act in their best interest. Because of the high rate of illiteracy and low levels of education, many time-poor practitioners accept this situation without attempting to change it. Doubts are expressed about the capacity to change this situation in the South African context.[5]

Furthermore, although a patient may fully understand the medical treatments and consent to it, it can seldom be said the consent and autonomy are truly manifested. A patient will almost never fully grasp all the medical procedures and consequences. In this regard, Caplan[6] argues that consent is "inherently limited". A patient is not in the position to full predict, let alone comprehend or appreciate all the risks associated with the medical treatments and or procedures.[6]

A LEGAL PERSPECTIVE ON AUTONOMY IN A SOUTH AFRICAN CONTEXT

The Constitution of the Republic of South Africa

Chapter 2 of the Constitution of the Republic of South Africa contains The Bill of Rights. The Constitution of South African (Act 108 of 1996)[7] makes provision for the right to bodily integrity in Section 12. This provision grants a person the right to freedom and security of the person. In particular, Section 12 (2) emphasises the importance of personal autonomy and the self-determination in relation to bodily integrity and states:

"Section 12

(2) Everyone has the right to bodily and psychological integrity, which includes the right

(a) to make decisions concerning reproduction;

(b) to security in and control over their body; and

(c) not to be subjected to medical or scientific experiments without their informed consent". [7]

Informed consent is covered in this section and is an integral part of autonomy. The Bill of Rights hosts a range of human rights such as the right to privacy, right to life, the right to freedom of religion and belief (cultural an traditional) beliefs. South Africa has an array of cultures each with its own traditions. The Bill of Rights grants everyone the right to live in accordance to their respective cultural and traditional practices and beliefs. In South African customary law, one would find that permission is required from the head

of the household or tribe for a woman to enter into, *inter alia*, legal actions or agreements. Should a woman need to secure her husband's permission to receive medical treatment, her autonomy may be violated yet her cultural laws and traditions upheld. Two of her human rights will be in conflict. An autonomous person exercises the ability to make a free informed choice in granting permission for a medical treatment or procedure. Full autonomy ceases to exist when another person takes over the decision-making role. Subsequently, autonomy is limited because of one's cultural and traditional beliefs. The argument is therefore that autonomy is not absolute and it can be limited in accordance to a person's cultural, traditional and legal systems.

The legal system of South Africa, as defined in the Constitution of Republic of South Africa, promotes the notion of Ubuntu. Ubuntu is characterized by the principle of solidarity. In comparison to the Western world where individualism has prominence, Ubuntu promotes the community whereby co-ownership and joint decision-making is fostered. This in itself limits autonomy because a decision cannot be based on one's autonomous belief, but rather on the notion of what serves the best interest and good for all members of the community and the tribe can overpower one's decision. In a South African context, culture plays a very important role in the sense of personhood, autonomy and belonging to a communal group.[1]

The human rights enshrined in Chapter 2: Bill of Rights of the Constitution of the Republic of South Africa is not absolute. In fact, Section 36 in the Bill of Rights states that:[7]

"36 (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including -

a. the nature of the right;

b. the importance of the purpose of the limitation;

c. the nature and extent of the limitation;

d. the relation between the limitation and its purpose; and

e. less restrictive means to achieve the purpose".

Section 36 explicitly states that any right in the Bill of Right may be limited provided that the limitation meets a strict set of requirements. Subsequently, Section 12 as indicated above can be limited and informed consent (and autonomy) can be infringed upon.[7] This pragmatic approach adopted in of Section 36, offers protection and facilitates efficiency. The example of a time-poor practitioner could be accommodated under this section. The time needed for lengthy explanations to gain full informed consent may be considered against the delayed treatment for other patients. The paternalistic approach by a health practitioner with the agreement of the patient could be acceptable. The cultural example of the husband making health decisions for his wife could also be accepted if the conditions are met and the decision is appropriate, and if the wife is not under coercion to accept and she agrees to the limit of her autonomy. Indeed, it is possible that many patients in situations similar to those outlined could be more uncomfortable making an autonomous decision.

The Patients' Rights Charter

The Constitution was enacted following a period in South Africa when human right's

violations occurred. Many people in the Republic of South were not used to having access to rights in health care services.[1] The Patients' Rights Charter[8] outlines and educates people in their health care related rights. Every citizen has the right to participate in the decision making on matters impacting on his or her health. Furthermore, it states that a patient can refuse treatment subject to the refusal not endangering public health. The Patients' Right Charter makes provision for disclosure of personal information. Confidentiality and privacy is acknowledged. Personal information is protected and may not be disclosed unless informed consent is given. Some laws and court orders can require disclosure of personal information.[8]

The Patients' Right Charter promotes autonomy and informed consent. As with the Bill of Rights, there are checks and balances in applying the law. Autonomy may be infringed to promote public health. A South African law or court may limit autonomy in the best interest of the

National Guidelines and Organisations

South African Medical Research Council (MRC)

The Medical Research Council (MRC)[9] lists autonomy as the first of the four ethical principles (autonomy, beneficence, non-maleficence and justice). It is stated in the MRC Guidelines that autonomy encompasses respect for the person and necessary for human dignity. An emphasis is placed on the importance of consent and the freedom of patients when making decisions about their health and wellbeing especially in research.[9]

An important principle of solidarity is highlighted in the MRC Guidelines. These Guidelines promote solidarity within communities, in particular within a South African context. In this regard, the MRC acknowledges the individual choices and the increasing conflict between personal autonomy and public safety.[9]

Health Professions Council of South Africa (HPCSA)

"The Health Professions Council of South Africa is a statutory body, established in terms of the Health Professions Act and is committed to protecting the public and guiding the professions." [10] Twelve professional boards operate under HPCSA including two in dentistry- the Medical and Dental Board and a board that registers dental therapists, oral hygienists and dental assistants.[10]

The HPCSA (Booklet 1)[10] makes reference to core ethical values and standards from the Health Professions Council of South Africa (HPCSA). The HPCSA imposes ethical duties on healthcare practitioners while performing their professional role or duty in the society. These ethical values include the following: respect for persons, best interest or well-being of the patient (non-maleficence or beneficence), human rights, autonomy, integrity, truthfulness, confidentiality, compassion, tolerance, justice, professional competence and self-improvement and community.

The Health Professions Council of South Africa (HPCSA) produces a booklet titled "General Ethical Guidelines for the Health Care Professions" (Booklet 1) which captures the ethical values and standards for health care professionals.[10]

The HPCSA has the power to receive complaints about health practitioners and to impose penalties if guilty. This statutory body announces judgements on the public website. In 2014 the concept of autonomy was investigated when several health practitioners had complaints upheld about breaches in obtaining consent or in maintaining confidentiality. These were dealt with under by the HPCSA and the names published of those found guilty.[10]

CONCLUSION

Autonomy is one of the most important ethical values in the health care practice and is the core to informed consent. When the Constitution of the Republic of South Africa was drafted, checks and balances were created between individual autonomy and the culture of Ubuntu or community solidarity and decision-making.

The Bill of Rights provides protection for individual rights including that of autonomy, but all the rights and liberties listed can be limited if the reason is legally justified. This was necessary in the emerging nation which had a large number of illiterate and poorly educated people who had little experience of freedom or access to human rights in their lifetime. Under these checks and balances, it would seem that a public health practitioner may truncate the process of gaining informed consent under the pressure of patient loads or accept cultural traditions that suppress autonomy. However, if the patient is dissatisfied they are able to complain to the HPCSA which has the power to fine or discipline health professionals found guilty of abusing the limits, or seek redress through the courts. One may therefore conclude that autonomy, whilst strongly protected, can be limited in a South African context under strict rules to enable justice for society and without terminating the rights of the individual patients. As the education and understanding of patient rights flows through society, these limits on autonomy may change but this may be well in the future.

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