Malaysian Dental Council

CODE OF PROFESSIONAL CONDUCT

JULY 2022

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MALAYSIAN DENTAL COUNCIL

Malaysian Dental Council

July 2022

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PREAMBLE

One of the core functions of the Malaysian Dental Council (Council) and the Malaysian Dental Therapists Board (Board) is the promotion of high standards of personal conduct and professional ethics among practitioners. Ethical considerations encompass qualities of honour, integrity, trust and professionalism, and should be motivated by the aim to safeguard the health of the patient, promote the welfare of the community and maintain the honour and integrity of the dental profession.

In line with this objective, the Council established the code of ethics entitled 'Disciplinary Jurisdiction and Code of Practice' in 1983, followed by the 'Code of Professional Conduct' in 1997 and later in 2008. Under the Dental Act 2018, the Council established this Code of Professional Conduct 2022 to be observed by all practitioners. Practitioner means any dental practitioner or dental therapist registered under the Dental Act 2018. This version of the Code of Professional Conduct, in force on 1 July 2022, supersedes all previous versions.

The dental profession has a long and honourable tradition of service and care and holds a position of trust and respect in the community. This reputation is founded on technical knowledge and skills, and a high standard of personal and professional behaviour. This document contains a set of ethical guidelines that guide practitioners on the principles of personal conduct and professional ethics in relation to their patients and their clinical practice.

The Council and the Board take a serious view of noncompliance to the laws, regulations, and guidelines relating to the practice of dentistry, and practitioners should ensure that they are conversant with this and all other relevant documents.

INFAMOUS CONDUCT

Under section 83(3) of the Dental Act 2018, any practitioner who fails to comply with the guidelines or directives of the Council shall be subjected to the disciplinary authority of the Council or the Board, as the case may be.

One of the functions of the Council and the Board is to institute and carry out disciplinary proceedings in regard to a practitioner who has been accused of infamous conduct in professional respect or accused of contravening any provision of the Code of Professional Conduct or any guidelines endorsed or issued by the Council or the Board, as the case may be.

The Council and the Board maintain the principle that 'infamous conduct' means a failure to meet the minimum standards of professional practice expected by profession. It includes any behaviour that reflects adversely on the reputation of the profession, such as acts that are dishonourable, immoral, dishonest, indecent or violent, even if not directly connected with the practitioner's dental practice. Circumstances may arise from time to time in relation to which there may occur questions of professional conduct which do not come within any of these categories. In such instances, as in all others, the Council or the Board has the right to consider and judge upon the facts presented.

PART A: OBLIGATIONS & RESPONSIBILITIES

1. THE PATIENT

1.1 Patient Care

A practitioner is morally obliged to provide professional care to those in need.

a) In the discharge of this duty, a practitioner shall not discriminate in selecting patients for their practices on the grounds of nationality, race, religion, gender, sexual orientation, creed, political views, or social standing.

b) For the elderly, the medically-compromised and physically or mentally challenged patients, a practitioner should exercise his best judgment to ensure the dental needs of these patients are appropriately managed and refer the patient to a specialist or a suitable facility if necessary.

c) A practitioner shall not refuse treatment on the grounds that the individual has a communicable disease for which acceptable methods of protection are available.

d) A practitioner may refuse treatment if:

(i) the patient does not comply with the requirement of being admitted to the clinic;
(ii) it is in the patient's best interest;
(iii) it is beyond his capacity to manage the patient's problems; or
(iv) he is unable to manage the patient.

In such cases, the patient should be referred.

e) In all other cases, unless the patient discharges himself from the practitioner's care, the practitioner remains responsible for the patient's care once treatment commences.

1.2 Patient's Right to Change Practitioner

A practitioner should recognise that a patient is entitled to seek treatment from any other practitioner at any time. In such cases, a practitioner should provide a copy of the medical/dental record upon request by the patient.

Nevertheless, the patient's contractual obligations up to that point in time, with all previous practitioners, should be fulfilled.

1.3 Chaperone

When treating a patient, a practitioner should have a member of his staff or another person present in the dental surgery at all times.

1.4 Visual and Audio Recordings

Visual or audio recordings of patients are often made for security or other legitimate purposes.

A practitioner must handle such recordings ethically. This means:

a) ensuring that visual or audio recordings do not compromise patient's privacy, dignity, confidentiality and autonomy and the presence of the recording device is obvious.

b) a clinic with a visual and/or audio recordings system must display a notice informing the public of the

presence of the recording system before they enter the clinic.

c) obtaining patients' consent for –

(i) any **clinical recordings**. If patients modify or withdraw their consent at any point, this must be respected. Patients must be allowed to view or hear the recordings, if they wish.
(ii) **storage** of the recordings and taking reasonable care to ensure that the recording is secure and that no unauthorised persons have access to it. Such recordings must be accorded the same level of confidentiality protection as dental records.
(iii) **transmission** of the recordings and taking reasonable care to ensure that the transmission of the recording is secure and that no unauthorised persons have access to it. Such recordings must be accorded the same level of confidentiality protection as dental records.
(iv) the **use** of the recordings for purpose of consultation.

d) **separate consent** must be obtained in the following cases:

(i) where audio and/or visual recordings of patients are intended to be **used** for purposes that advance healthcare, such as dental education, research and publication.
(ii) where audio and/or visual recordings are intended to be **used** anywhere in the public domain (such as advertising, public lectures or any kind of media output).

e) if patients are minors (under 18 years) or have diminished mental capacity, consent must be obtained from parents, legal guardians or those with legal

authority to decide for them. Where possible, the patient's consent should also be obtained.

f) if patients or accompanying persons ask to record their consultation, a practitioner may accede to this according to their judgement of the situation.

g) despite taking consent and, where necessary separate consent, the practitioner must take every reasonable measure to remove all identifiable characteristics (unless the patient consents to be identifiable) and ensure that patient confidentiality and privacy will not be breached.

1.5 Consent for Treatment

a) Consent is granting someone the permission to do something they would not have the right to do without such permission.

Specific to dental treatment, it can be defined as the **voluntary** and **continuing** permission of the patient to receive a particular treatment.

b) There are two types of consent; implied and expressed.

(i) Implied consent

It is accepted that consent is implied in many circumstances by the very fact that the patient has come to the dental surgery for dental care.

Nevertheless, it must be remembered that a patient who walks into a dental surgery gives implied consent only for a clinical and oral examination and consultation.

(ii) Expressed consent

Expressed consent may be verbal, non-verbal or written and should be clearly and unmistakably stated. Expressed consent shall be obtained from the patient before the commencement of any treatment.

1. Verbal consent is given using verbal communication.
2. Non-verbal consent is acceptable only in situations similar to verbal consent where the patient is unable to express himself orally.
3. Written consent is consent for treatment signed by the patient, the parent or the legal guardian and duly countersigned by a witness.

c) Where a private clinic is part of the hospital setting or Ambulatory Care Centre, Part VIII Consent under section 47(3) of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006, consent shall be in writing.

d) If patients are minors (under 18 years) or have diminished mental capacity,

(i) written consent must be obtained from parents, legal guardians or those with legal authority to decide for them.
(ii) In a case of emergency, an adult responsible for the child (a person who bears temporary responsibility for the child) may give consent after all possible attempts have been made to get consent from the parents, legal guardians or those with legal authority to decide for them.

e) Before giving consent, the patient and the person giving consent should have all treatment or procedures

explained to him clearly in lay terms so that he understands the treatment to be carried out. The explanation should include information on treatment options (including those of delaying treatment or choosing not to undergo treatment) with the risks and benefits of each, the likelihood of success and/or failure, limitations and cost of treatment.

f) Where the proposed treatment is complicated, a written treatment plan with a cost estimate should be prepared, discussed and agreed upon before treatment commences. The patient should sign consent for this treatment plan, and a copy of the treatment plan may be given to the patient.

g) Specific written consent must be obtained in the following circumstances:

(i) any procedure carried out under sedation, or general anaesthesia; or
(ii) where treatment carries a significant risk.

h) If, in the course of treatment, the treatment plan has to be changed and/or the cost estimate has to be revised, a full explanation should be given at the first opportunity. A revised treatment plan and cost estimate should be consented in writing.

i) Informed Consent

Informed consent is a medico-legal requirement to ensure that a patient knows all the risks and costs involved in a particular treatment.

Informed consent can only be obtained by a practitioner, who is able to explain the procedure in detail, the risks and benefits of the procedure and the alternatives (as stated in paragraph 6 of this section).

Informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. To give informed consent, the patient or a responsible adult concerned must have adequate reasoning capacity and be in possession of all relevant facts at the time consent is given.

j) Notwithstanding the previous provisions, for consent to be valid, it must be:

(i) taken prior to carrying out treatment;
(ii) voluntary; and
(iii) conveyed to the patient in a language that the patient understands.

k) A practitioner should-

(i) not give guarantees or make unreasonable promises about the outcome of treatment;
(ii) not coerce or induce a patient; and
(iii) give the patient sufficient opportunity to seek further details or explanations about the proposed treatment or procedure.

l) For the treatment of children in schools, the specific policy of the Ministry of Health for obtaining consent from parents, legal guardians or those with legal authority must be adhered to, and this policy must be made known to them.

1.6 Quality of Care

The Council and the Board takes a serious view of any neglect of the practitioner's professional responsibilities to his patients for their care and treatment.

In the event where the practitioner utilises technology such as computer-aided diagnosis and artificial intelligence, the practitioner still holds the ultimate responsibility for the patient care.

a) A patient is entitled to expect that a practitioner will provide a high standard of care, which is evidence-based. The practitioner should not undertake treatment that exceeds his training, competence and expertise.

b) Recommending or performing unnecessary dental services or procedures is unethical.

c) The needs of the patient should be the main concern and should be met by a practitioner by offering all **possible** treatment options with, if necessary, the assistance of professional colleagues.

d) Practitioners are obliged to protect the health of their patients by assigning only to qualified auxiliaries those duties which can be delegated. Practitioners are obliged to direct and supervise the work of all auxiliary personnel.

e) Practitioners should take part in activities that maintain, update and develop their knowledge and skills.

1.7 Treatment of Children

A practitioner should place the interests of the child first. There can be no justification for intimidation.

The judicious use of physical restraint in an emergency, in special circumstances, or to treat a difficult patient is acceptable, provided there is consent from the parent or responsible adult.

When faced with an uncontrollable child, it is better to cease treatment, make an appropriate explanation to the parent or responsible adult, and reschedule treatment or arrange for a referral.

1.8 Dental Fees

a) A practitioner has the right to charge such fees as he deems proper and reasonable, which are in compliance with Schedule VII and Schedule XIII of the Private Healthcare Facilities and Services Regulation 2006 (Fee Schedule).

b) A practitioner must have a schedule of fees available for his patients within the clinic premises. These fees may be displayed on the official clinic webpage/ social media platform under the name of the practice.

c) A practitioner should not:

   (i) entice prospective patients by offering packages, discounts or special promotions.
   (ii) offer discounts for the purpose of obtaining the payment of fees promptly or within a specified time.
   (iii) charge the fees for providing care in a misleading manner.

d) Upon request, the patient shall be provided with an itemised bill for all treatment carried out by the practitioner.

e) The patient should be informed prior to the initiation of treatment of the estimated charges and, during the course of treatment, any other charges which may arise.

f) A practitioner may collect a deposit from patients prior to the commencement of treatment. Such deposits

should not exceed 30% of the total cost of the treatment. If treatment is terminated at any point, the deposit should be refunded after deducting the cost incurred.

g) Fee splitting, rebates or any form of kickback arrangements for referrals are unethical.

1.9 Communicating with Patients

a) A practitioner should act professionally, empathetically and courteously towards patients at all times.

b) Prior to the commencement of treatment, the patient should be given complete pre and post-operative instructions. Any post-operative instruction should be reinforced after treatment.

c) Prescribing of medications

A dental practitioner should inform the patient about any medication prescribed to him, including:

(i) the purpose of the medication;
(ii) the possible side effects;
(iii) the need for avoidance of any food or drinks;
(iv) the possible interaction with other medications;
(v) the duration of administration necessary for any medication prescribed; and
(vi) where he can seek medical or dental treatment should the need arise.

All medication prescribed shall be labelled with the name of the patient, name of the drug, information on dosage, frequency, duration of administration and expiry date.

Prescriptions based solely on the information provided by telephone or electronic means may be allowed for continuing care.

d) Electronic communication

There are situations in which a person could initiate a consultation through an electronic medium or via e-mail. In such circumstances, only general information should be given, and the person should be advised to seek a personal consultation. Although no consultation fee may be charged or received, the practitioner is responsible for the advice given.

If a practitioner has already established a professional relationship with a patient through direct personal contact, has made a diagnosis and has commenced treatment, adjusting treatment or providing continued treatment after remote contact with a patient or based on transmitted clinical data may be acceptable.

If, on the other hand, it appears from the communication that the patient has developed a new problem or a significant complication, the practitioner should endeavour to see the patient personally for further evaluation before offering further treatment.

e) Failure of Disclosure

(i) The concealment of the truth about any aspects of a patient's state of oral health, treatment or standard of work done may be construed as dishonesty.
(ii) Lack of disclosure from fear of repercussions is not in keeping with a practitioner's moral obligations and duty of care to his patients.
(iii) The patient should be informed of any complication that may arise during the treatment.

1.10 Consultation & Referral

a) Where a practitioner is in doubt regarding the management of a patient, he should seek consultation from colleagues who have the relevant training, competence and expertise.

b) A practitioner requiring an opinion from another colleague should:

   (i) communicate all available information relevant to the matter upon which an opinion is sought; and
   (ii) seek the patient's consent for the consultation.

c) A practitioner examining a patient for a consultation or who has been referred to him should limit his comments to his professional findings and opinion. He should not say or do anything which may undermine the confidence that the patient has in the referring practitioner.

d) In a consultation, the dental practitioner to whom the patient comes for a consultation, in addition to that which is aforementioned, should report the condition and recommend appropriate treatment direct to the practitioner who sorts the consultation.

e) If a patient requests a referral for a second opinion, the practitioner is obliged to accede to the request.

f) When a patient is referred to a dental practitioner for treatment, the patient should be returned to the referring practitioner upon completion of the particular treatment with a report on the patient's condition.

g) In the event that a dental practitioner requires a medical opinion in the course or prior to managing a

patient, he should refer the matter to a medical practitioner.

h) A practitioner shall only accept a referral from a registered healthcare professional. Any referral from a non-healthcare practitioner for investigation or procedures not limiting to impression taking, dental photography, interproximal stripping, aligner attachment bonding or removal and any other devices approved by the Medical Device Authority are deemed unethical.

1.11 Emergency Treatment

a) A practitioner has a moral and ethical obligation to attend to any dental emergency. The practitioner may refer the patient for any follow–up treatment required.

b) A practitioner should be able to manage medical emergencies which may occur in his dental practice.

1.12 Confidentiality of Information

a) All information obtained in the course of attending to the patient is confidential. A practitioner shall not disclose this information without the patient's consent.

   The patient's consent may be overridden by legislation, court orders or when public interest demands disclosure of such information.

b) A practitioner shall keep all patient's information confidential and take appropriate steps to ensure that it is not accessible to unauthorised persons.

   Particular care should be taken when the information is stored electronically.

c) A practitioner is responsible for ensuring that all members of the dental team and supporting staff are aware of the importance of confidentiality and that they keep patient information confidential at all times.

1.13 Maintenance of Professional Relationships

a) Every patient has a right to be treated with respect and courtesy.

b) A practitioner shall at all times maintain professionalism in his relationships with his patients and not abuse this through personal relationships or for personal gain.

c) Acts of indecency or dishonesty or other acts involving abuse of the professional relationship are unethical.

d) A practitioner should not allow himself to be abused by patients or their relatives. The practitioner is advised to end such engagements with patients as quickly as possible and in a professional manner.

   A practitioner is reminded that in such cases, unless the patient is referred to another practitioner or the patient discharges himself, the practitioner remains responsible for the patient's care.

1.14 Patient Complaints

If a patient complains, the practitioner should make reasonable efforts to resolve the matter at the practice level, as provided under Section 36 of the Private Healthcare Facilities and Services Act 1998.

1.15 Termination of a Practitioner-Patient Relationship

In cases where the practitioner-patient relationship is to be terminated, the practitioner has the responsibility of offering

a referral to another practitioner. The referring practitioner shall also ensure that sufficient information is communicated to the new practitioner, with the patient's knowledge, to enable a seamless transition of care.

1.16 Managed Care Organisation

1.16.1. Introduction

a) There is an increasing presence and influence of Managed Care Organisations (MCOs) or Healthcare Management Organisations (HMOs) in the country in recent years. Panel practitioners serving corporate bodies have come increasingly under scrutiny and pressure to act as primary care practitioners, taking cost controlling risks, or in other words, to act as gate-keepers on a pre-paid fee system. This arrangement requires that the practitioner operates according to schedules and manuals drawn by the MCOs.

   It is good dental practice for the practitioner to remember his primary professional responsibility to his patients, when operating under such stringent financial constraints and controlled patient care, which may be imposed by MCOs. It is important to preserve a good relationship and confidentiality in whatever adverse practice environment, and to remember at all times that practitioners exist because there are patients who need individual care, and the practitioner's primary concern is for their health and well-being.

   Under Section 82 of the Private Healthcare Facilities and Services Act 1998 [Act 586] - "managed care organisation" means any organisation or body, with whom a private healthcare facility or service makes a contract or has an arrangement or intends to make a contract or have an arrangement to provide specified

types or quality or quantity of healthcare within a specified financing system through one or a combination of the following mechanisms:

i) delivering or giving healthcare to consumers through the organisation or body's own healthcare provider or a third-party healthcare provider in accordance with the contract or arrangement between all parties concerned;
ii) administering healthcare services to employees or enrolees on behalf of payors including individuals, employers or financiers in accordance with contractual agreements between all parties concerned.

b) In reference to this document, the term MCO covers a variety of entities and includes, among others Health Maintenance Organisations (HMO), Preferred Provider Organisation (PPO) and Point-of-Service (POS) plans.

c) There are specific provisions in relation to managed care in the Private Health Care Facilities and Services Act 1998. They include, among others:

(i) "The licensee of a private healthcare facility or service or the holder of a certificate of registration shall not enter into a contract or make any arrangement with any MCO that results in-

1) a change in the powers of the registered medical practitioner or dental practitioner over the medical or dental management of patients as vested in paragraph 78(a), and a change in the powers of the registered medical practitioner or visiting registered medical practitioner over the medical care

management of patients as vested in paragraphs 79(a) and 80(a);

2) a change in the role and responsibility of the Medical Advisory Committee, or Medical and Dental Advisory Committee as provided under section 78, the Midwifery Care Advisory Committee as provided under section 79 or the Nursing Advisory Committee as provided under section 80;

3) the contravention of any provisions of this Act and the regulations made under this Act;

4) the contravention of the code of ethics of any professional regulatory body of the medical, dental, nursing or midwifery profession or any other healthcare professional regulatory body; or

5) the contravention of any other written law." (Section 83)

(ii) "A licensee or the holder of a certificate of registration having a contract or an arrangement with a managed care organisation shall furnish such information relating to such contract or arrangement to the Director General as he may, from time to time, specify." (Section 84)

(iii) "A managed care organisation or the owner of a managed care organisation having a contract or an arrangement with a licensee of a private healthcare facility or service or a holder of a certificate of registration shall furnish such information relating to the organisation as may be required by the Director General." (Section 85)

(iv) "The Director General shall maintain a Register of managed care organisations having any contract or arrangement with any licensee of a private healthcare facility or service or any holder of a certificate of registration and such Register may contain such particulars as may be determined by the Director General." (Section 86)

d) The Thirteenth Schedule of the Regulations (2006) to the Private Healthcare Facilities and Services Act contains the professional fees for procedures carried out in private hospitals and other healthcare facilities. These fees are accepted as the maximum professional fees chargeable.

e) Managed care organisations or third-party payers sometimes request for lower professional fees as an inducement to refer corporate patients.

f) Managed care organisations or third-party payers sometimes restrict a practitioner's right of choice of referral to a dental or medical practitioner or health care facility.

The MDC's position is that these practices are unethical.

1.16.2. CONFIDENTIALITY

a) A practitioner may release confidential information in strict accordance with the patient's consent, or the consent of a person authorised to act on the patient's behalf. Seeking patient's consent to the disclosure of information is part of good dental practice.

Disclosures for which expressed consent shall be sought.

b) As a general rule, a practitioner shall seek a patient's expressed consent before disclosing identifiable information for purposes other than the provision of care.

c) Where a practitioner or the healthcare facility in which the practitioner practises have contractual obligations to third parties, such as companies, insurance companies or MCOs, the practitioner shall obtain a patient's consent before undertaking any examination or writing a report for the third party. Before seeking consent, the practitioner shall explain the purpose of the examination or report and the scope of the disclosure. The practitioner shall ensure that the final report is shown to the patient and the patient's consent is thereafter obtained before submission and that the copies of reports are given to the patient, upon request.

d) A practitioner shall ensure that the relationship between the practitioner or that of the healthcare facility in which the practitioner practises, with third-party payers such as insurance companies or MCOs do not contravene the Principles of Confidentiality.

1.16.3. DENTAL RECORDS AND DENTAL REPORTS

Disclosure to Third Party Payers and MCOs

a) Dental records of patients who are employees of corporate bodies, or who are under healthcare insurance cover, belong physically and, as stated above, intellectually to the practitioner (and the healthcare facility or services) and ethically to the patient. Release of information from the medical records to third-party payers and Managed Care Organisations, and through them to the employers,

should only be made with the informed consent of the employee/patient.

b) Employees may be compelled to sign a blanket document of consent by the corporate employers giving the Third-Party Payers or Managed Care Organisations the right to obtain confidential information from the healthcare providers. Such blanket consent, without reference to specifics, is not acceptable. Informed consent for disclosure must be on a case-by-case basis and should be obtained by the practitioner personally from the patient. This is to safeguard the patient's right as some points in the disclosure may adversely affect or influence the patient's employment status.

1.16.4. PRACTITIONERS IN CONFLICT SITUATIONS

a) Private hospitals may enter into business arrangements with MCOs, or directly with the corporate client, to provide healthcare services for employees. Some of these arrangements require practitioners to reveal the diagnosis and treatment details of the employees to the third party. The third party often obtains blanket consent from the employee to facilitate this arrangement. This is not acceptable, and specific consent for disclosure should be obtained as and when necessary.

b) The extent of such disclosures must be explained to the employees while obtaining their consent to release confidential dental information. In such circumstances, too, the practitioner's primary professional responsibility to his patient, in the context of doctor-patient confidentiality, should not be compromised, and the person in charge of the private hospital must be advised as such.

c) Private hospitals are known to act as their PPO by setting up a chain of primary care clinics that refer patients only to the parent hospital for investigations and management. This practice is a hybrid of the managed care system and is not encouraged by the MDC. This restrictive referral system with its implications and restrictions must be explained to the patient, as there are fine ethical issues involved in such arrangements, primarily the employee being limited in his choice of practitioners and hospitals.

Fee-splitting

d) The definition of fee-splitting in the Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006 is as follows:

"Fee Splitting means any form of kickbacks or arrangements made between practitioners, healthcare facilities, organisations or individuals as an inducement to refer or to receive a patient to or from another practitioner, healthcare facility, organisation or individual."

As defined above, referral or acceptance of patients between practitioners must be based on the quality of care (and not on considerations of monetary benefits).

e) Fee splitting, which implies that a practitioner makes an incentive payment to another practitioner for having referred a patient to him, is an unethical practice.

f) Payment of a monthly/yearly retainer and/or a fixed quantum per patient is not considered fee-splitting.

Fee sharing

g) Fee sharing between two practitioners managing a patient is permissible, the basis for such sharing being that the practitioners must have direct responsibility and involvement in the management of the patient.

Practitioners in Managed Care Organizations

h) The practitioners working within the traditional or "classic type" of MCO system can be considered to be under a special kind of employment, since their services are often pre-paid and they are subject to certain prearranged conditions of professional service to employees of their corporate clients.

i) The ethical conflicts are many and primarily involve practitioner-patient confidentiality and rights. Some of these issues are:

   (i) The patient records and documents "belong" or are freely accessible to the third-party administrators, namely the MCO, and dental information on the employee is to be made available at all times (for every clinic attendance) to the MCO. The employee is said to have given blanket consent to this release of information by virtue of having accepted employment with the corporate body.
   (ii) The practitioner can only prescribe medications contained in a schedule prepared by the MCO. Drugs not in the schedule may be prescribed only after approval has been obtained.
   (iii) The practitioner has to obtain prior approval before ordering investigations not on the MCO Schedule, and has to obtain approval before referring the employee to a specialist or a private hospital for further management.

j) The practitioner, acting as the so-called "gate-keeper", takes all the risks in the management of his patients, and is liable to disciplinary action in the event of professional negligence, which may arise because of the unfriendly professional environment in which he operates under the system.

k) The pre-payment scheme imposes on the practitioner to provide professional care within the per capita allocation for each employee. Should he exceed this allocation without seeking prior approval, the practitioner may be blacklisted and fall out of favour with the MCO for continued retention on the panel.

l) In all instances, the practitioner in a managed care system has to place the interests of the patient and confidentiality above all other considerations. He should refrain from entering into a contract with an MCO if there are potential ethical conflicts in his professional autonomy and practitioner-patient relationship.

m) The nature and stipulations of contacts between the licensee or the holder of registration of a managed care organisation and the licensee or the holder of registration of a private healthcare facility or service are laid out in the Private Healthcare Facilities and Services, 1998.

1.16.5. CONCLUSION

All registered practitioners have legal and ethical duties in relation to managed care. A practitioner must not at any time abrogate his duties as the healer and provider of healthcare service, on the ground of the influence of market forces or managed care organisations.

2. THE DENTAL PROFESSION

2.1 Maintaining the Integrity of the Profession

A practitioner should maintain the integrity of the profession and refrain from any action which may compromise that integrity. Practitioners should bring to the attention of the Council or the Board any action on the part of any practitioner which, in his opinion, may undermine the honour of the profession.

2.2 Updating Professional Knowledge and Skills

A practitioner should take steps to continually update his skills and knowledge throughout his career for the benefit of his patients.

A practitioner is responsible to obtain the requisite continuing professional development (CPD) points for renewal of his practising certificate each year and obtaining the points within the required time.

2.3 Advancement of the Profession

A practitioner has an obligation to support the advancement of the profession through membership in scientific and professional organisations locally, nationally and internationally.

2.4 Ethics in Research

a) All research involving patient/ community must have the approval of the relevant research ethics committee, and research should be conducted in compliance with the approval.

b) When undertaking research involving human or animal subjects, current and relevant directives regarding ethics should be complied with.

c) A practitioner has an obligation to make the results and benefits of their investigative efforts available to relevant agencies when it may be useful in safeguarding the health of the individual or the public.

2.5 Professional Indemnity

All practitioners are advised to be adequately covered by professional indemnity insurance as long as they are involved in patient care.

3. COLLEAGUES

3.1 Upholding the Professional Image

a) A practitioner should act in a manner that respects the rules and etiquette of the profession and should be willing to assist colleagues professionally.

b) When a practitioner comes across a treatment that in his opinion is unsatisfactory and it must be retreated, he has an obligation to inform the patient. However, a practitioner should not comment disparagingly, either orally or in writing, regarding the services of another practitioner.

c) A practitioner should always speak out in recognition of good work. Such recognition is just and generous and gives confidence to the patient and much encouragement to the fellow practitioner.

3.2 Justifiable Criticism

When a practitioner has reason to believe that a colleague is incompetent to practice whether but not limiting to by reason of drug addiction or physical or mental incapacity, or evidence of gross or continual faulty treatment, it is his duty to draw this fact to the attention of the Council or the Board.

4. THE PUBLIC

4.1 Oral Health Promotion

a) A practitioner has a responsibility to promote the health of the community through disease prevention and control, education and, where relevant, screening programmes.

b) During oral health promotion activities, practitioners must ensure that they do not solicit for patients or encourage the public to seek consultation or treatment only from them or the organisation with which they are associated.

PART B: PRACTICE MANAGEMENT

5. ESTABLISHMENT OF PRACTICE

A practitioner should abide by the laws, regulations and guidelines affecting the profession. This includes, but is not limited to, those relating to:

a) registration with relevant regulatory bodies;
b) safety and health;
c) employment;
d) data protection; and
e) human rights and equality.

5.1 Location

A practitioner must ensure that the clinic complies with local by-laws and the provisions of the Private Healthcare Facilities and Services Act 1998.

5.2 Name of Practice

Unless the person-in-charge is registered under the Specialist Division of the Dental Register, the name of the clinic should not include the word 'specialist', in any language, or any word that may imply a specialty (for example, the word 'braces' or 'gums' or 'children').

5.3 Practising Certificate

When practising dentistry, a practitioner must display a valid Practicing Certificate at every place of practice.

5.4 Minimum Standards in Dental Practice

The minimum standards in a dental practice are covered by various laws and the guidelines issued by the Council or the Board. They include but are not limited to the following:

a) physical amenities and equipment;
b) infection control;
c) dental radiation protection;
d) use of dental materials and devices;
e) management of drugs and pharmaceuticals;
f) waste disposal;
g) emergency care services; and
h) a patient grievance mechanism.

5.5 Patient Records

a) Maintaining clear and accurate health records is essential for the continuing care of patients. This involves:

   (i) keeping accurate, up-to-date, factual, objective and legible records that report relevant details of medical and dental history, clinical findings including dental charting, investigations, treatment plans, treatment carried out, medication prescribed, information given to patients or family members and any other relevant management, in a form that can be shared with other health practitioners;
   (ii) making records at the time of events or as soon as possible afterwards;
   (iii) ensuring that records are sufficient to facilitate continuity of care;
   (iv) ensuring that records are kept securely, retrievable and are not subject to unauthorised access, regardless of whether they are kept electronically or in printed or written form;

(v) recognising the right of the patients or his legal guardians to access information contained in the patient's medical/dental records, and facilitating that access;
(vi) providing the patient or his legal guardian with a copy of the records or a report, upon request;
(vii) facilitating the transfer of health information when requested by a patient or his legal guardian; and
(viii) keeping patient records for a minimum of seven years from the patient's last visit or the date the patient attains the age of majority.

b) A copy of the dental records may be released to other parties if necessary. However, the practitioner must obtain the patient's consent, and this should be documented before any records are released.

c) All clinical details, investigation results, discussion of treatment options and drugs prescribed should be documented and initialled by the practitioner concerned.

d) A practitioner should never falsify a patient's record.

5.6 Practising as a dental therapist

Practitioners are reminded that dental therapist practising in the private sector are regulated under section 43 of the Dental Act 2018, which state:

a) a dental therapist in the private sector shall practise dentistry only under the direct supervision of a dental surgeon.

b) for the purposes of this section, "direct supervision" means a dental surgeon shall be present at all times

in the healthcare facility when the dental therapist carries out any treatment according to the treatment plan approved by a dental surgeon.

c) a dental therapist who practises dentistry in the private sector shall carry out only the procedures listed in the Fifth Schedule of the Act.

d) a post-basic dental therapist who practises dentistry in the private sector shall carry out only the procedures listed in the Fifth Schedule and the Sixth Schedule of the Act in relation to the discipline for which he is qualified.

6. PROFESSIONAL QUALIFICATIONS, RANKS & AWARDS

6.1 Degrees

Practitioners may display only the qualifications by which they were registered with the Council or the Board, and any other qualification approved by the Council or the Board.

6.2 Use of Degrees and Awards

Only the degrees mentioned in Section 6.1 and state or national honorary awards may be used on nameplates, business cards, letterheads and any other notices or correspondence associated with the practice.

7. NOTICE TO PATIENTS

a) A practitioner may only inform patients already on record of any change of clinic premises or consultation hours. All notifications must comply with the current Guidelines and Provisions for Public Information endorsed by the Council or the Board as applicable.

b) A practitioner about to leave for another practice should refrain from any action which may entice patients away from the current practice.

8. ADVERTISING

Practitioners must comply with the current Guidelines and Provisions for Public Information endorsed by the Council or the Board as applicable.

9. INFECTION CONTROL

A practitioner should practise the highest standards of infection control and comply with the current Guidelines on Infection Control in Dental Practice endorsed by the Council or the Board as applicable.

10. CONTRACTS

a) In entering into any contract, a practitioner should not compromise professional standards or the health of the patient. When contracts are established, they must also abide by the provisions of the Private Healthcare Facilities and Services Act 1998 and its Regulations.

b) A practitioner should not enter into a partnership or association or become financially interested in a practice owned or controlled by a practitioner whom he believes to be unethical.

c) It is unethical for a practitioner to contract out his services under conditions that compromise his patients' health and well-being.

d) When entering into any contracts involving managed care systems, all ethical considerations of the Council and Board must be adhered to.

11. ENDORSEMENT OF PHARMACEUTICAL & DENTAL PRODUCTS

A practitioner should not endorse any dental or pharmaceutical product unless it is in the best interest of his patients.

12. DENTAL RADIOGRAPHY & RADIATION PROTECTION

a) In procedures that require radiographs, all necessary radiographs should be taken. Nevertheless, unnecessary exposure to radiation should be avoided.

b) A dental practitioner who stores machines for the purpose of dental radiography and imaging shall abide by the Atomic Energy Licensing Act 1984 and the current Guidelines on Radiation Safety in Dentistry endorsed by Council.

c) A practitioner who operates machines for the purpose of dental radiography and imaging shall abide by the Atomic Energy Licensing Act 1984 and the current Guidelines on Radiation Safety in Dentistry endorsed by Council and the Board.

13. LICENSING, CERTIFICATION & MAINTENANCE OF EQUIPMENT

Practitioners must ensure that all necessary licenses or certifications are obtained, and calibration and tests are carried out on equipment and appliances at the appropriate times.

14. STATEMENTS & CERTIFICATES

Practitioners should not make statements or declarations, or sign certificates or other documents, or induce any other person to do likewise, which the practitioner knows, or ought to know, to be untrue or misleading.

CONCLUSION

While this code does not cover every aspect of behaviour in every possible circumstance, it will certainly, together with all other MDC guidelines, assist a practitioner in a particular situation to exercise professional care and judgement, and accept personal responsibility. In all situations, it is mandatory that a practitioner adheres to this code and the guidelines and behaves professionally and responsibly and acts in the interest of his patients and the public in general.

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THE CODE OF PROFESSIONAL CONDUCT

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