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ORIGINAL RESEARCH

Knowledge, Attitudes and Practice of Healthcare Ethics and Law among Dental Graduates at the RV Dental College, Bengaluru

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ABSTRACT

Objective: To assess knowledge, attitudes and practices among the dental graduate in relation to healthcare ethics and law.

Materials and methods: A cross-sectional study design was employed using a self-administered questionnaire. A 15 item questionnaire about law and ethics was devised; tested and made available to all levels of gradates including teaching staff, postgraduates and intern at dental college in Bengaluru. A total of 116 graduates participated, with a response rate of 96.5% (n = 112).

Results: Seventy-six percent of the participants said that they are legally bound to treat all the patients who approach them for the treatment. Nearly 32% of the participants have mentioned the various other reasons for the rejection apart from the reason like HIV+, poor patients and patients with the contagious disease.

Conclusion: The study points to the need for appropriate training among graduates including the professional staffs and other graduates, and to devise means to sensitize them to issues of law and ethics in the workplace.

Keywords: Law and ethics, Dental graduates, Knowledge.

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INTRODUCTION

It is now a firmly established belief that legal and ethical considerations are integral to dental practice in the planning for the care of the patient. With the advances in medical sciences and growing sophistication of the legal framework in modern society as well as increasing awareness of human rights and changing moral principles of the community at large, doctors and other healthcare workers alike are now frequently caught in difficult dilemmas in many aspects arising from daily practice. Examples are plenty such as the duty to respect informed consent, truth-telling, breach of confidentiality, disclosure of errors, rationing of scarce health resources, biomedical research, and etc.[1]

There has been growing public concern regarding the ethical conduct of healthcare professionals. This is often reflected as complaints about poor ethical conduct and an increasing use of litigation against healthcare practitioners. This may be a reflection of both an increased public awareness as well as the inappropriate practices by the healthcare professionals.[2] Besides, there is also growing anxiety both within the dental profession and in the community regarding increasing trends of complaints and lawsuits against doctors. From the bitter experience of many doctors who were engaged in complaint or lawsuits in the past, many of them had resulted from failing of their doctor-patient communication skill or inadequate ability to comprehend and resolve dilemmas in clinical settings.[1]

Organizational developments and public and professional attentions to the area of medical ethics, engendered the emergence of dentistry from a virtual trade to a recognized specialty of medicine which the principles of medical ethics should be respected and practiced in it. Dental professionals assume publicly entrusted responsibilities founded on the principles of medical ethics. Despite the self oriented views, there is a wide spectrum of questions which are considered ethically relevant in dentistry.[3] The Institute of Medicine has produced two reports, and a project by a consortium of internal medicine groups has published a document

titled 'Medical Professionalism in the New Millennium: A Physician Charter.' The authors hope that everyone 'involved in healthcare' will use the charter to engage in discussions to strengthen the ethical underpinning of professional relationships.[4] Medical ethics has developed into a well based discipline which acts as a 'bridge' and the goal is 'to improve the quality of patient care by identifying, analyzing, and attempting to resolve the ethical problems that arise in practice'. Fortunately, as a consequence of increasing attention to ethical standards, the patients are paid attention better and receive better services.[1,4]

As dentistry moves into the twenty-first century the attention to ethics will have to be even greater. Nowadays ethical standards in modern dentistry are in a tempo of rapid advance. Learning to handle practical ethics issues and developing one's professional identity are essential steps in becoming a good doctor. With this background, the present study is an attempt to elucidate the knowledge, attitude and practice of the dental graduates in relation to healthcare ethics and law in RV Dental College, Bengaluru.

MATERIALS AND METHODS

The 'descriptive cross sectional' study design was used in the study.

A 15 item self-administered structured questionnaire about knowledge, attitude and practice of law and ethics was devised and tested. It was made available to all levels of teaching staff, postgraduates students and graduates intern at the RV Dental College Hospital in Bengaluru.

The questionnaire was pilot tested on a small group of dentists who are requested to complete the questionnaire and to indicate the questions that they found are unclear. The issue of the confidentiality was maintained by not taking name and address in questionnaire, by giving codes for reference and those codes was known only to chief investigator. The questions in the questionnaire were framed under three sets, i.e. first set of questions are Knowledge based, second set, of questions are Attitude and third set of questions are about Practice of Healthcare Ethics and Law among Dental Graduates. The questionnaire included a full range of response options, designed to identify the practitioner's knowledge, beliefs and attitudes toward patient care, relation to healthcare ethics and law. The questionnaire consisted of 15 questions (in two categories), of which 12 were answered by multiple choices, and the other three had subsequent subquestion were answered by description (open ended). The average time required to complete the questionnaire was about 10 minutes.

The initial part of the questionnaire consisted of demographics such as qualification, gender, the duration of work experience. In the subsequent part of the questionnaire, respondents were asked to answer questions on ethical and illegal issues, if the respondent agrees or disagrees to statements concerning ethical conduct, the source of knowledge of ethics and law, maintaining of records, furnishing of records to someone, informing patient's condition to their spouse, informed consent, prescription of controlled substance drugs, referring a patients to specialist, promotion of work through advertising, universal barrier, doctor-patient relationship, act of negligence by employee, willingness to learn. The respondents were required to answer if they agree or disagree to the statements made on these issues.

Each graduate either of teaching staff, postgraduate or intern were given separate copy of the questionnaire personally or requested to answer the questionnaire and filled questionnaire was collected from them on the same day or next day.

STATISTICAL ANALYSIS

The recovered questionnaires were systemically arranged and coded before entered into datasheet. The master chart is prepared using Microsoft excel 2007 and analyzed using statistical analysis software. Descriptive analyses were done for all data. The statistical software namely SPSS 15.0, Systat 11.0 were used for the analysis of the data and tables, etc. 2 × 3 Fisher Exact test, Chi Square test has been used to find the significance of knowledge, attitude and practice between groups.

RESULTS

A total of 116 graduates participated, with a response rate of 96.5% (n = 112). Of the total 112, the majority of the participants were females with 57.2% and 42.8%, of which, were males. Twenty-four teaching staffs, 44 postgraduate students and 44 interns have participated in the study (Table 1). Nearly 76% of the participants mentioned that they are legally bound to treat all the patients who approach them for the treatment. Nearly 32% of the participants have mentioned the various other reasons for the rejection apart from the reason like HIV+, poor patients and patients with the contagious disease (Table 2). Nearly 84% of the participants said they are legally bound to maintain the records of the patients and nearly 10% of the participants

Table 1: Distribution of the study participants by sex and designations

Sex	*Designation*			*Total*
	Staff N = 24	*Postgraduate N = 44*	*Interns N = 44*	
Male	10 (41.6)	23 (52.3)	15 (34.1)	48 (42.8)
Female	14 (58.4)	21 (47.7)	29 (65.9)	64 (57.2)
Total	24 (100)	44 (100)	44 (100)	112(100)

Table 2: *Responses to various items in the questionnaire*

Item	*Response*				*p-value*
	Interns	*Postgraduate*	*Staff*	*Total*	
Legally bound to treat all patients on approach					
Yes	36 (81.8)	29 (65.9)	20 (83.3)	85 (75.9)	0.1667
No	7 (15.9)	11 (25)	4 (16.7)	22 (19.6)	0.5592
Reason for rejection of patients (if any)					
HIV Positive	2 (28.6)	1 (9.1)	1 (25)	4 (18.2)	0.0908
Poor Pt	1 (14.3)	3 (27.3)	5 (22.7)	5 (22.7)	0.9999
Contagious disease	1 (14.3)	0 (0)	0 (0)	1 (4.5)	0.5600
Other	2 (28.6	3 (27.3)	3 (75)	7 (31.8)	0.6467
Legally bound to maintain records					
Yes	38 (86.4)	34 (77.3)	22 (91.7)	94 (83.9)	0.3014
No	5 (11.4)	6 (13.6)	0 (0)	11 (9.8)	0.1504
Do not know	1 (2.3)	4 (9.1)	7 (6.3)	7 (6.3)	-
It is legal to furnish record on demand					
Yes	32 (72.7)	36 (81.8)	22 (91.7)	90 (80.4)	0.1897
No	11 (25)	5 (11.4)	2 (8.3)	18 (16.1)	0.1504
Do not know	1 (2.3)	3 (6.8)	0 (0)	4 (3.6)	-
Aware of informed consent					
Yes	44 (100)	42 (95.5)	24 (100)	110 (98.5)	0.1965
No	0 (0)	2 (2.2)	0 (0)	2 (1.8)	0.1965
Do not know	0 (0)	0 (0)	0 (0)	0 (0)	-

mentioned that they are not bound to maintain the records of the patients. Nearly 81% of the participants said that the records can be furnished on demands constituted the both circumstances comprising the medico legal cases and referral to the specialist (*see* Table 2). Majority of the participants (98.5%) responded mentioning, they are aware of informed consent. Nearly 92% of the participants were obtaining it, largely in written form (71%). When participants were asked the question whether they will disclose the information to his or her spouse if any one of the individual is suffering with the infectious disease. Nearly 82% of the participants responded that they would disclose the information. Majority (62.5%) of the participants said that are they are aware of the laws relating the controlled substances and the responses were non-significant between the groups, i.e. intern, postgraduate student and staff (Table 3). When the participants were asked about whether they are liable to the patients for nonreferral, majority nearly 85% of the participants responded that they are liable for nonreferral. Nearly 60% of the participants disagreed to advertise, and the responses were significant between the groups. Nearly 64.3% of the participants were aware that dentists are responsible for act of negligence of their assistants (Table 4).

DISCUSSION

The fundamental principles that apply generally to medicine or healthcare at large are: (a) respect of patient's autonomy; (b) the principle of nonmaleficence, i.e. the duty to avoid harm or injury to patients; (c) the principle of beneficence, i.e. the duty to do good to your patients, relieve their pain and suffering and to save life if you can; and (d) the principle of justice and act fairly.[1]

They are considered to be doctor's prima facie duties to the patients and society. Not infrequently, when two or more principles apply, they may be in conflict. These four principles are guidelines which only help us to focus our minds on the problem. We usually cannot use these principles solely to solve ethical dilemmas because we would not always know which principles we should allow to surpass another. They are not prioritized but weighed different for each circumstance. WD Ross the English philosopher, introduced the term 'prima facie' which means that each principle is binding unless it conflicts with another moral principle, and in that case we are to choose between them. Nowadays the above term is generally used to refer to four principles of medical ethics.[3]

Despite their distinctive roles, law and medical ethics overlap in many areas. It is indeed difficult to dissociate the legal and ethical basis of the professional duties of doctors. For instance, both law and medical ethics address to issues of confidentiality, use of dangerous drugs, medical malpractice and the like. Both law and medical ethics aim at safeguarding a good standard of medical practice within the community.[1] At times, a doctor's prima facie ethical duty

Table 3: Responses to various items in the questionnaire

Item	*Response*				*p-Value*
	Interns	*Postgraduate*	*Staff*	*Total*	
Obtaining of "informed consent					
Yes	39 (88.6)	40 (90.9)	23 (95.8)	102 (91.1)	0.6412
No	5 (11.4)	4 (9.1)	1 (4.2)	10 (8.9)	0.6412
Do not know	00	00	00	00	-
Method of obtaining informed consent					
verbal	15 (38.5)	14 (35)	18 (75)	47 (46..1)	0.0018
written	32 (82.1)	30 (75)	10 (41.7)	72 (70.6)	0.0062
Any other	1 (2.5)	00	00	1 (00.9)	-
Awareness of 'Disclose of Information' about the infectious					
Yes	37 (84.1)	34 (77.3)	20 (83.3)	91 (81.3)	0.7435
No	7 (15.9)	5 (11.4)	3 (12.5)	15 (13.4)	0.9357
Do not know	00	5 (11.4)	1 (4.2)	6 (5.4)	-
Aware of Laws for prescription of controlled substances					
Yes	23 (52.2)	29 (65.9)	18 (7)	70 (62.5)	0.1696
No	16 (36.4)	11 (25)	5 (20.8)	32 (28.6)	0.3625
Do not know	5 (11.4)	4 (9.1)	1 (4.2)	10 (8.9)	-

Table 4: Responses to various items in the questionnaire

Item	*Response*				*p-Value*
	Interns	*Postgraduate*	*Staff*	*Total*	
Liable to the patient for negligence for Non referral					
Yes	40 (90.9)	35 (79.5)	21 (87.5)	96 (85.7)	0.3259
No	3 (6.8)	6 (13.6)	3 (12.5)	12 (10.7)	0.6117
Do not know	1 (2.3)	3 (6.8)	00	4 (3.6)	-
Promote work through advertising					
Yes	18 (40.9)	11 (25)	16 (66.7)	45 (40.1)	0.0041
No	26 (59.1)	33 (75)	8 (33.3)	67 (59.8)	0.0041
Do not know	00	00	00	00	-
Use of Universal Barrier					
Yes	39 (88.6)	33 (75)	23 (95.8)	95 (84.8)	0.0575
No	5 (11.4)	11 (25)	1 (4.2)	17 (15.2)	0.0575
Do not know	00	00	00	00	-
Use of Universal Barrier					
Under all circumstances	30 (70.9)	31 (93.9)	13 (56.5)	74 (77.9)	0.2554
Under only specific condition	9 (23.1)	2 (6.1)	10 (43.5)	21 (22.1)	0.2554
Aware of contractual dental patient relation					
Yes	28 (43.6)	19 (43.2)	7 (29.2)	54 (48.2)	0.0179
No	12 (27.3)	19 (43.2)	15 (62.5)	46 (41.1)	0.0173
Do not know	4 (9.1)	6 (13.6)	2 (8.3)	12 (10.7)	-
Dentist is responsible for the act of negligence by assistants'					
Yes	24 (54.5)	26 (59.1)	22 (91.7)	72 (64.3)	0.0038
No	18 (40.9)	8 (18.2)	2 (8.3)	28 (25.0)	0.0063
Do not know	2 (4.5)	10 (22.7)	00	12 (10.7)	-

may clash with his legal obligation. A notable example that often occurs is when the duty of confidentiality has to be breached by a court order and refusal to disclosure amounts to contempt of court.

The malpractice systems in India and the US differ mainly in that in the US such cases are handled by state courts; guilt and retribution are determined by a jury and faced with the stark contrast of a 'poor' disabled patient

against a 'rich' insurance company. In India, special consumer courts handle the cases. Awards are restricted to actual damages. Thus, the kinds of malpractice insurance crises seen in the US are not likely to be in India.[5,6]

It is important to acknowledge two issues in distinguishing ethics and law. First, society does not deal with all issues of morality by legislation, only those moral issues that have a significant impact on societal functioning. Thus while it is morally wrong for one to fail to keep a promise to a friend; in general, failing to do so does violate a law. Second, laws are temporary consensus always to be critiqued (and revised) by referencing the ethical principle of justice.[7] The increase in medical negligence claims and litigation on issues of malpractice in recent years is reflected both in the number of lawsuits and the tremendous sum of monetary value involved.[1] Early dental practitioners were itinerant barbers, and the road to professional status moved from apprenticeship to education through the establishment of professional schools. This led to the public understanding that the professional person's knowledge is linked with service in the interest of the local community.[4]

The major emphasis is placed on recommendations for improving the ethical climate of the dental college community and the teaching, exhibition, and celebration of professionalism. Included in this area are discussions of white coat ceremonies and honor codes, as well as the importance of recognizing the impact of the hidden curriculum in dental ethical education.[8]

On the other side of the spectrum, teaching medical ethics as if it is a scientific body of knowledge could also be dangerous. This is because it may miss the individualistic perception of morality and ethics innate to every professional, which would have been constructed by one's own unique cultural, socioeconomic and geographical background. Hence the curriculum of medical ethics should be tailored to the social and cultural background where it is taught.[2]

In order to act respecting the prima facie, justice, a dentist has the general obligation to provide care to the in need. A decision not to provide treatment to that someone because the individual has a specific situation or condition such as AIDS or is HIV seropositive or treating patients with racial or sex discriminations is unethical.[3] The phenomenon of AIDS has not raised new ethical issues. It has, however, given a new slant and poignancy to many familiar issues, such as confidentiality, triage, and the right to refuse treatment. But perception, rather than reality, controls the generation and resolution of ethical issues, and the perception is that now, because of the new HIV factor, healthcare is potentially a risky occupation.[9]

A dentist is free to refuse to any case so long as the reason for refusal is not based on race, religion or national origin. The dentist is not bound or compelled by law to provide treatment. It may be unethical and immoral to refuse such service but by doing so the dentist will not be subject to civil or criminal sanctions. In our study, contrary response were given by nearly 80% of the participants. Eighteen percent of participants would like to refuse HIV + cases and 23%, 5% participants mentioned the reason for the refusal as financially poor, individual with contagious disease respectively.

Dentists required by law to maintain records of patients. Case law establishes that adequate and accurate records are required. In many jurisdictions (New York, for example) they are also required by state regulation. Patient's records may serve as evidence in legal disputes. Ideally records maintained forever but practically for 7 years. Records ascertains when the patients has underwent treatment and there is a limit of 2 years as the COPRA in the Indian legislation for filing a case against a doctor and if the case has been filed after that period then primarily its admission should be challenged. In our study, the responses of the participants were in accordance to this, nearly 94% participants answered mentioning they are bound to maintain records.

Once a patient presents himself for care and is accepted by the dentist, a contractual relationship is formed. A contract may be express, either oral or written, or may be implied in certain circumstances. Barring the need for proof, an oral contract is as effective as one in writing. In present study, 48% of the participants agreed contractual dental patient relationship. Nearly 11% of the participants were not aware of the contractual relationship.

The 'commercialization' of dentistry is often criticized by dentists for fostering inappropriate, misleading and untruthful advertising, for creating an emphasis on fees (discounts, competition, treatment 'packages'), for encouraging 'dentist-shopping' and stimulating dentists to treat people as customers buying a service rather than patients in need of help. Advertising *per se* is not seen as necessarily unethical but the wrong type of advertising causes concern. In addition, there is a temptation for both patients and dentists to manipulate or defraud health insurance funds. Insurance companies through their advertising may stimulate inappropriate competition between dentists, and in their contact with claimants may create uncertainty about dentists and their fees. In our study, nearly 40% of the participants agreed to advertise, and the responses were significant between the groups. Nevertheless, this survey study has several limitations. A significant limitation of this study is that only graduates of single institution were included. It relies on self-report, and it involved a sample at a single institution. The response rate was high, but does not prevent sampling bias.

CONCLUSION

The findings of this study raise some fundamental and important issues for law education and the maintenance of professional ethical conduct in healthcare. The study points to the need for appropriate training among graduates including the professional staffs and other graduates and to devise means to sensitize them to these issues in the workplace.

REFERENCES

1. HAU Kong-lung. Law and ethics in medical practice: an overview. Medical Section 2003;8:1-7.
2. Hariharan S, Jonnalagadda R, Walrond E, Moseley H. Knowledge, attitudes and practice of healthcare ethics and law among doctors and nurses in Barbados. BMC Medical Ethics 2006;7:7.
3. Jessri M, Fatemitabar SA. Implication of ethical principles in chair-side dentistry. J Allergy Asthma Immunol 2007;6:53-59.
4. Beemsterboer PL. Developing an ethic of access to care in dentistry. J Dent Educ 2006;70(11):1212-1216.
5. Walrond ER, Jonnalagadda R, Hariharan S, Moseley HSL. Knowledge, attitudes and practice of medical students at the cave hill campus in relation to ethics and law in healthcare. West Indian Med J 2006;55:42.
6. Sharp HM, Kuthy RA, Heller KE. Ethical dilemmas reported by fourth-year dental students. J Dent Educ 2005;69:1116-1122.
7. Nash DA. On ethics in the profession of dentistry and dental education European. J Dent Educ 2007;11:64-74.
8. Botto RW. Addressing the Marketplace Mentality and Improving Professionalism in Dental Education: Response to Richard Masella's 'Renewing Professionalism in Dental Education. J Dent Educ 2007;71:217-221.
9. Freedman B. Health Professions, Codes and the Right to Refuse to Treat HIV-Infectious Patients. The Hastings Center Report 1988; 18.