On the autonomy of dental patients

Schouten, B.C.

Publication date
2002

Chapter 5

HOW DO DUTCH DENTISTS DEAL WITH SOME PATIENT RIGHTS IN DAILY PRACTICE?[1]

1 Introduction

Until recently, the relationship between dentist/physician and patient was regulated by the codes and standards of the profession in the Netherlands. However, several social developments have led to an attempt to consolidate the legal position of the individual patient within this relationship (Dupuis & de Beaufort, 1998; Legemaate, 1991). The introduction of the Medical Treatment Contract Act in April 1995 has resulted in a more legal approach to the dentist-patient relationship, thereby improving the legal position of the patient.

Since the Medical Treatment Contract Act became effective, various articles have been published on the topic. However, in general very little attention was paid to its implementation in the dental and medical practice (Gevers, 1998; Berkel, 1995a; Berkel, 1995b; van der Horst, 1995; Leenen, 1991; Legemaate, 1991). One argument that is often put forward is that the Medical Treatment Contract Act is mainly a codification of already existing legislation and thus of little consequence for dental practice. However, the few studies that were carried out on the topic clearly indicated that the implementation of the Medical Treatment Contract Act in daily dental practice is by no means what it should be (Schouten, Eijkman, Hoogstraten & den Dekker, 2001; Eijkman & Goedhart, 1995). An earlier study published in this journal reported on the familiarity with the Medical Treatment Contract Act among dentists (Schouten, 2000). It appeared that dentists are far more familiar with some rights and duties of patients and dentists, than with others. A supposed lack of relevance of some of

[1] This chapter has been published as: Schouten, B.C. (2001). Hoe gaan tandartsen in de praktijk om met rechten van patiënten? *Nederlands Tijdschrift voor Tandheelkunde, 108*, 179-183.

the legislation with regard to dental practice could be one of the reasons for the limited knowledge of certain aspects.

So far, we do not really know to what extent the various patient rights are actually taken into account in dental practice. For example, how frequently do dentists ask for a patient's consent with regard to passing on a patient's data to others, and to what extent do dentists allow insight in patient records? The aim of this study was to obtain an answer to these and similar questions and thus a better insight in the daily procedures in dental practice regarding a number of patient rights. Furthermore, we investigated to what extent dealing with patient rights correlates with a number of background variables such as demographic - and practice characteristics.

2 Material and methods

The material in this study consisted of a self-compiled questionnaire which included questions regarding the dentist's concern with the duty to inform patients (three items), patient consent (two items), dental record of patient (three items), and protecting a patient's privacy (two items). The questionnaire contained a total of ten items, seven closed, and three open (table 1). Some of the seven closed items had to be answered according to a scale, ranging from 'always' to 'never' (for instance: 'How often do you explicitly ask for the patient's consent to pass on treatment data to other dental colleagues involved?'). Other items could be answered with a simple 'yes' or 'no' (for instance: 'Has any of your patients ever complained about not being well informed?').

Apart from these items a number of questions concerned the dentist's demographic - and practice characteristics. Furthermore the dentist was asked about his familiarity with the Medical Treatment Contract Act and whether or not he had participated in post-academic courses on dentist-patient communication.

The questionnaire was sent to 806 dentists (643 men and 163 women). The data were analyzed by means of descriptive analysis and frequency distribution. The correlation with the various background variables was analyzed by means of chi^2 tests, t-tests and Pearson's correlation coefficients.

Table 1 The ten items of the questionnaire

Items
1. How many times did you use the following informative material to support your verbal information to the patient? • leaflets and other printed material • audio-visual aids • models • atlas • X-rays
2. How many minutes do you usually reserve per new patient for: • dental anamnesis (including the patient's problem) • examination of oral cavity • discussing the examination with the patient • decision-making with regard to treatment planning and final remarks
3. a. Has any patient ever complained about the way in which you informed him? b. If so, could you describe in a few sentences what the complaint was about?
4. Could you name a number of treatments (max. 3) that in your opinion always require your patient's consent?
5. Some dentists make use of forms which indicate that the patient has given his consent for a specific treatment, that the patient has been well-informed and has comprehended the information. Do you use such forms in your own practice?
6. For the following items the patient's consent may be important. Would you please indicate how often you have specifically asked for the patient's consent in these cases? • passing on treatment data to other treating clinicians • passing on treatment data to parents of a child under 12 • passing on treatment data to parents of a child between 12 and 16 • passing on treatment data to parents of a child between 16 and 18 • passing on treatment data to a patient's family and/or partner • passing on a patient's record to a new dentist
7. Do you allow the following persons to look into a patient's record in your practice without the patient's consent? • dental hygienist • dental assistant • my colleague who works in the same practice • a specialist to whom I refer • a colleague who temporarily replaces me
8. What are the main data that you would include in a patient's record?
9. Do you make use of the guidelines of the Dutch Dental Association on patient records when you set up a patient record?
10. Although in principal a patient has the right of access to his own patient record, there may be circumstances in which you would prefer not to give the patient access to his record. For example: • there are personal professional notes in the record • patient's age • patient's comprehensibility • command of the Dutch language • patient's emotional condition • uncertainty with regard to diagnosis • possibility of a negative effect on patient's confidence in the treatment

3 Results

3.1 *Sample*

335 questionnaires (41.6%) were returned by 264 men and 71 women. 75 Of the questionnaires could not be used for our analysis, mainly because the dentists concerned appeared to be no longer practicing dentistry. In the end, a total of 260 questionnaires (32.3%) were analyzed. There were no differences in age, sex or number of years as a practicing dentist between the respondents and the non-respondents. However, the respondents were significantly more frequently working on employment basis than the non-respondents.

194 (75.2%) Of the respondents works in their own dental practice with an average of 36.8 hours per week. They have been practicing for an average of 15.4 years (sd=10) and the number of patients coming to the practice at least once a year averages 2511 (sd=1893). The mean age of the respondents is 42.6 years. 47 Respondents are not familiar with the Medical Treatment Contract Act (18.8%) and 52 respondents have participated in some kind of post-academic course on dentist-patient communication (20.7%).

3.2 *Information*

Table 2 shows to what extent dentists make use of additional material to support their verbal information to the patient. Although self-drawn sketches, leaflets and X-rays are often used, the majority of the respondents claim that they only sometimes or never use any additional informative material at all.

Table 2 Use of additional informative material to support verbal information

Material used:	N	Always (%)	Most of the time (%)	Sometimes (%)	Never (%)
• self-drawn sketches	213	6.1	39.4	48.9	5.6
• leaflet and other printed material	249	6.4	36.9	53.8	2.8
• X-rays	247	28.7	49.4	20.2	1.6
• models	235	4.7	26.4	66.8	2.1
• atlas	217	2.8	11.5	33.2	52.5
• audio-visual aids	197	1.5	2.0	11.2	85.3

Background variables related to the use of additional supportive means of information are sex and participation in post-academic courses. Male dentists use

leaflets more often than female dentists (chi^2=5.2; p=.022) and dentists who did participate in post-academic courses on dentist-patient communication significantly more often use additional supportive material than dentists who did not (p=.000).

The average time for a new patient is 29.6 minutes (sd=17.0 minutes), most of which is spent on decision-making with regard to treatment and final remarks (mean=8.5). The least time is spent on discussing the oral examination (mean=7.0). Dentists who participated in post-academic courses reserve significantly more time for a new patient than dentists who did not (p=.007). There are significant, though moderate, correlations between the duration of a patient's appointment and the dentist's age (Pearson's correlation coefficient r=.14; p<.05), size of dental practice (Pearson's correlation coefficient r=-.23; p<.01) and number of working hours per week (Pearson's correlation coefficient r=-.14; p<.05).

33.5% Of the respondents were faced with a complaint from a patient who claimed to be inadequately informed at some time or other during their years as a practicing dentist. The three complaints that were most often mentioned concerned too little information regarding treatment or prevention (34.1%), inadequate information about treatment costs (34.1%) and inadequate information about treatment outcome (18.3%). Male respondents appear to receive complaints about information significantly less frequently than their female colleagues (chi^2=6.4; p=.042). Dentists who are not familiar with the Medical Treatment Contract Act have more often received complaints about information than dentists who are (chi^2=6.8; p=.033).

3.3 Consent

The respondents were asked to indicate for which specific treatment they felt that they explicitly required patient consent. The following three items scored highest (N=218): extractions (71.1%), crown- and bridgework (59.6%) and endodontic treatment (29.4%). Furthermore, they were asked to indicate if they ever made use of informed consent forms. The purpose of these forms is to obtain the patient's official consent with regard to a specific treatment as well as a statement that he has received adequate information. It appears that only a small minority of the respondents does actually use such forms (5.9%).

3.4 Privacy protection

Table 3 shows to what extent the dentist explicitly asks for the patient's consent to pass on personal data to third parties. Although the Medical Treatment Contract Act stipulates that patient consent is always required before personal data are passed on to others (except when it concerns dental colleagues who are directly involved in the treatment of the patient), it appears from table 3 that a

considerable number of dentists hardly ever comply with these regulations. This even amounts to over 75% when it concerns passing data to new dentists.

Table 3 Passing on personal data to third parties

Ask for a patient's consent to pass on data to:	N	Always (%)	Most of the time (%)	Sometimes (%)	Never (%)
• parents of a child between 16-18 years	242	28.1	40.9	16.5	14.5
• parents of a child between 12-16 years	245	37.6	21.6	27.8	13.1
• parents of a child younger than 12 years	245	47.3	9.8	16.3	26.5
• family/ partner	243	30.9	26.3	11.1	31.7
• colleagues also involved in treatment	244	29.9	16.8	17.2	36.1
• new dentist	245	15.1	9.8	14.7	60.4

Dentists who have participated in post-academic courses on dentist-patient communication less frequently ask permission to pass on data to colleagues directly involved in the treatment of the patient (chi^2=5.6; p=.018), parents of children between 12 and 16 (chi^2=4.4; p=.037), parents of children between 16 and 18 (chi^2=5.2; p=.023), and new dentists (chi^2=5.5; p=.019), than dentists who did not participate in any such course. Dentists who are not familiar with the Medical Treatment Contract Act more often ask for patient consent to pass on data to colleagues who are involved in the treatment (chi^2=4.3; p=.04) and to a new dentist, than dentists who are familiar with the Medical Treatment Contract Act.

Table 4 shows to what extent colleagues who are involved in the treatment of the patient are allowed insight in the patient's records without patient consent. It appears that in such cases most of the respondents allow access to patient records without consent. Colleagues who temporarily replace the dentist as well as specialists who are referred to are relatively less frequently allowed insight in patient records.

3.5 *Patient records*

The respondents were asked to indicate what they considered the most important data they would include in a patient record. The following three scored highest (N=247): medical anamnesis (80.6%), treatment performed (55.1%) and personal particulars (49.8%).

Table 4 Percentage of respondents who allow others involved in a patient's treatment access to a patient's records with/without consent

Others involved in treatment:	**Without consent (%)**	**Not without consent (%)**
• dental assistant	90.5	9.5
• dental colleague	87.0	13.0
• dental hygienist	84.3	15.7
• colleague who temporarily replaces dentist	76.1	23.9
• specialist referred to	51.9	48.1

They were also asked if they made use of the guidelines as recently developed by the Dutch Dental Association for setting up patient records in dental practice. The majority of the respondents (71%) claimed not to do so. Finally we have tried to find reasons for not allowing patients insight in their personal patient records, irrespective of the fact that in principal they always have the right to access. As can be read from table 5, the most mentioned reason for not allowing a patient access to his own patient record is the fact that the record may contain a dentist's personal notes and remarks. The emotional condition of the patient is also often mentioned as reason for refusing access. Dentists who are not familiar with the Medical Treatment Contract Act more often consider a patient's emotional condition as well as the patient's comprehensibility reasons for not allowing access than dentists who are familiar with the Medical Treatment Contract Act (resp. $chi^2=5.8$; $p=.016$ and $chi^2=6.1$; $p=.013$).

Table 5 Percentage of respondents who for various reasons do not allow a patient insight in his own record

Reasons	**Insight allowed(%)**	**Insight not allowed(%)**
• record contains personal notes	71.8	28.2
• patient's emotional condition	79.1	20.9
• command of Dutch language	85.3	14.7
• patient's comprehensibility	86.7	13.3
• uncertainty of diagnosis	89.4	10.6
• patient's age	89.8	10.2
• possible negative influence on patient's confidence in treatment	90.5	9.5

4 Discussion

The results of this study demonstrate that dealing with patient rights in dental practice is far from what it should be. A relative large number of dentists face complaints about inadequate information. Quite often dentists pass on data to third parties without patient consent and for too many respondents insight in dental records is not a matter of course. Nevertheless, there are reasons for optimism. Although the design of this study does not allow for any causal conclusions, it appears that post-academic education correlates with an improvement in dealing with a number of (though not all) patient rights. For instance, dentists who have participated in post-academic courses on dentist-patient communication take out more time for an appointment with a new patient than dentists who have not participated. They also make use of additional informative material more frequently. More attention for dentist-patient communication in the dental curriculum and in post-academic education within the frame of the Medical Treatment Contract Act would be a relative simple way to improve the dentists-patient relationship with regard to patient rights in today's dental practice.

A possible explanation for the lack of compliance with patient rights could be the fact that dentists do not know how to translate and apply these rights into every day dental practice. The Medical Treatment Contract Act creates a general framework for the dentist-patient relationship, but is not very specific. For instance, according to the Medical Treatment Contract Act it is the dentist's duty to keep records of all his patients, which should include those data essential for an optimal dental treatment. The Medical Treatment Contract Act does not exactly give clear indications as to the specific nature of these data. The Dutch Dental Association has tried to solve this problem by developing her own guidelines for keeping patient records in dental practice. When dentists were asked for their opinion about the concept of these guidelines it appeared that the majority of them approved (Heetman, 1998). However, this study has shown that a considerable majority of the respondents does not make use of these guidelines when setting up their patient records.

Another topic on which the Medical Treatment Contract Act is not specific is what is meant by invasive and non-invasive treatment. This distinction is important since for invasive treatment a patient's consent is explicitly required whereas for non-invasive treatments consent may often be taken for granted. It is obvious that the problem is a clear definition of invasive and non-invasive treatment and how the dentist can discover beforehand whether a patient will regard a certain treatment as non-invasive (Spreeuwenberg, 1991). One useful guideline could be that the perception of the treatment should not only be based on the treatment itself but also on the outcome. The answers of the respondents to

the question regarding the type of treatment for which they always ask explicitly for patient consent (extractions, crown- and bridgework) indicate that treatment outcome is indeed taken into account.

The Medical Treatment Contract Act clearly indicates which information a patient is generally entitled to, and in what situations deviation from the regulations is allowed. It should be noted that quite often it is taken for granted that the average patient is able to comprehend the information that is offered and that he is forward enough to ask for further information (Eijkman, Duyx & Visser, 1998). However, quite a few studies have demonstrated that patients do not always understand and remember all information offered. The results of this study also demonstrate that quite a few dentists have had to face patient complaints regarding (too little) information (cf. Lipschart-van der Linden, Eijkman & Spruijt, 1995; ter Horst & Boon, 1989). A more extensive and frequent use of additional informative material might contribute to the understanding and remembering of the information provided (Uden & van Dam, 1986).

Only few dentists make use of informed consent forms. Although the fact that the patient can indicate on the form that he has understood the information seems an advantage, it is doubtful if these forms really contribute towards the patient's actual understanding. Another disadvantage is the danger of defensive medicine. These forms can easily shift the emphasis from a satisfactory discussion between patient and physician to an easily obtained consent from the patient so that the physician feels that he has been covered against possible future complaints. It is obvious that this is not what the Medical Treatment Contract Act intended.

References

Berkel, E. (1995a). WGBO is neerslag van wat goede hulpverlening moet zijn. *Nederlands Tandartsenblad, 50,* 72-75.

Berkel, E. (1995b). Informatieplicht en toestemmingsvereiste. Tandarts moet WGBO positief zien. *Nederlands Tandartsenblad, 50,* 122-125.

Dupuis, H.M., Beaufort de, I.D. (1988). Informed Consent. In: *Handboek Gezondheidsethiek* (Dupuis & de Beaufort, eds.). Assen Maastricht: van Gorcum.

Eijkman, M.A.J. & Goedhart, H. (1995). De Wet op de Geneeskundige Behandelingsovereenkomst. Opinies van tandartsen. *Nederlands Tijdschrift voor Tandheelkunde, 102,* 142-145.

Eijkman, M.A.J., Duyx, M.P.M.A., Visser, A. Ph. (1998). *Patiëntenvoorlichting en mondgezondheid.* Houten/Diegem: Bohn Stafleu van Loghum.

Gevers, J.K.M. (1998). De tandarts als communicator: de wet. *Nederlands Tijdschrift voor Tandheelkunde, 105,* 49-51.

Heetman, P.G.A.M. (1998). Een praktijkrichtlijn patiëntendossiers. *Nederlands Tandartsenblad, 53,* 538-540.

Horst van der, J.A. (1995). Wet Geneeskundige Behandelingsovereenkomst geen omwenteling in gezondheidszorg. *Nederlands Tandartsenblad, 50,* 22-23.

Horst ter, G. & Boon, G. (1989). Klachten over tandartsen. *Nederlands Tijdschrift voor Tandheelkunde, 96,* 322-325.

Leenen, H.J.J. (1991). Informatie en toestemming in de WGBO. *Medisch Contact, 36,* 46-48.

Legemaate, J. (1991). De WGBO en het vertrouwensmodel. Tegenspraak of harmonie? *Medisch Contact, 39,* 1151-1153.

Lipschart-van der Linden, H. T., Eijkman, M.A.J. & Spruijt, R.J. (1997). Problemen rond tandheelkundige informatieverstrekking aan patiënten. Een dossieronderzoek bij de Consumentenbond. *Nederlands Tijdschrift voor Tandheelkunde, 104,* 152-154.

Schouten, B.C., Eijkman, M.A.J., Hoogstraten, J. & Dekker den, J. (2001). Informed consent in Dutch dental practice: knowledge, attitudes and self-efficacy of dentists. *Patient Education and Counseling, 42,* 185-192.

Schouten, B.C. (2000). De Wet op de Geneeskundige Behandelingsovereenkomst: kennis van tandartsen. *Nederlands Tijdschrift voor Tandheelkunde, 107,* 238-241.

Spreeuwenberg, C. (1991). Arts en WGBO. Inleiding op een themaserie. *Medisch Contact, 36,* 1030-1032.

Uden, M.M.A.T. & Dam, F.S.A.M. (1986). Informed consent bij klinisch kankeronderzoek; psychologische aspecten. *Nederlands Tijdschrift voor Geneeskunde, 130,* 2078-2082.