

REVIEW OF THE CODE OF ETHICS

Final Report



THE CANADIAN DENTAL
HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE
DES HYGIÉNISTES DENTAIRE



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Contents

1.0	INTRODUCTION	3
2.0	APPROACH AND METHODS.....	3
3.0	REVIEW OF THE LITERATURE	4
3.1	General Trends in Health Care and Dental Hygiene	4
3.2	Comparison of Health Professional Codes of Ethics.....	6
3.3	Multiple Codes of Ethics	8
4.0	CONSULTATION.....	9
4.1	Phase 1 Consultation: Key Informant Interviews (Nov/Dec 2011).....	9
4.2	Phase 2 Consultation: Code of Ethics Committee Workshop (Feb. 3-4, 2012)	11
4.3	Draft CDHA Code of Ethics and Validation Survey to CDHA members.....	12
5.0	CONCLUSIONS AND RECOMMENENDATIONS.....	15
6.0	REFERENCES	16
	APPENDIX A: CDHA Code of Ethics Committee.....	19
	APPENDIX B: Provincial/Territorial Regulatory Authorities for Dental Hygienists	20
	APPENDIX C: Key Informant Interview Questions.....	22
	APPENDIX D: Validation Survey Questionnaire.....	23

1.0 INTRODUCTION

In September 2011, the Canadian Dental Hygienists Association (CDHA) initiated a project to review and update its Code of Ethics. The Code was last reviewed and redeveloped in 2002. Over the past decade, there have been a number of changes in dental hygiene practice, in health care, and in society that have potential implications for the Code. This timely review will serve to assure Dental Hygienists and the public that the CDHA Code of Ethics is current in the context of the contemporary social, technological and health care environment.

The decision to undertake the review was further influenced by CDHA recently assuming responsibility for the former Dental Hygiene Educators Canada (DHEC), now known as the CDHA, Educators Advisory Committee. DHEC had developed a code of ethics for Dental Hygiene educators in 2005. As part of the transition to the new CDHA Education Advisory Committee it was noted that some areas of both codes of ethics overlap and were similar to one to another in a number of areas. A second requirement of the project was to determine if there was a need to integrate the educators' code of ethics into the CDHA code of ethics.

Recent trends in Dental Hygiene practice involve new paradigms which give rise to ethical considerations. For example, self-regulation is relatively new for dental hygienists with legislation that requires provincial/territorial bodies to have their own official code of ethics. This has highlighted the issue of accountability to multiple codes. Dental hygienists work in a growing variety of clinical settings such as independent practice where the ethics of managing a business needs to be considered. Regardless of role and setting, direct care, education, research or administration, relationships are complex and present their particular ethical challenges.

2.0 APPROACH AND METHODS

At the outset of the project, CDHA established a Code of Ethics Committee (CEC) (Appendix A) made up of 10 Dental Hygienists, all of whom had knowledge and experience with the Code of Ethics. They represented a broad spectrum of roles and settings including education, research, administration and practice. Their role was to provide expertise, advice and guidance in the review and development of a revised Code of Ethics for CDHA. In addition, CDHA contracted with the consulting firm *Health HR Group* to work with the CEC. CDHA's Policy Communications Specialist acted as a resource and provided the liaison and coordination role between the CEC and the Health HR Group.

The Project began with a review of the literature to determine current trends and approaches to professional codes of ethics; trends in health care and dental hygiene practice; societal changes; and emergent ethical issues requiring discourse and debate and which could have implications for revisions to the CDHA Code of Ethics. Electronic searches of scholarly publications were conducted to identify current issues that may impact professional codes of ethics. Literature was searched using

Google scholar, Pub Med, CINAHL, and Social Science Research Network. Codes of Ethics for other health professions were examined for new material that could be considered in the revisions to the CDHA Code. The codes of ethics for the provincial dental hygiene regulatory bodies were reviewed to determine consistency. Finally the former DHEC Code of Ethics was compared with the CDHA Code for possible integration with the revised code.

Consultation was a key component in the development of the revised CDHA Code of Ethics and was undertaken in three phases:

- Key informant interviews for evaluation of the current Code and ideas for change.
- CEC workshop for review of initial drafts and discussion/decisions on content for the revised Code.
- Draft CDHA Code of Ethics and Validation Survey to CDHA members.

Survey results were summarized, considered by the CEC, and incorporated as appropriate in the development of the final Code of Ethics.

3.0 REVIEW OF THE LITERATURE

3.1 General Trends in Health Care and Dental Hygiene

The literature identified a number of trends in health care in Canada that have potential implications for dental hygiene practice and revisions to the code of ethics. Examples include the increasing emphasis on health promotion, increased focus on patient safety, a better informed public, and the emerging impact of technology and social media in health care practice.

Good oral health is the focus of dental hygiene making health promotion an integral aspect of the profession. Recently the World Health Organization recommended the integration of oral health into primary health care to strengthen health promotion (Monajem, S. 2006). Such integration would place the dental hygienist in an important role in primary health care and in a collaborative role with a broad range of other health professionals and groups who advocate for health locally and internationally. Health promotion has also been identified as a logical component of interprofessional education (Thistlethwaite, J., Barr, H., Gilbert, J. 2011). These trends suggest that dental hygienists, as they become more integrated with other health professions, could face different ethical considerations and potential tensions.

A focus on patient safety has implications for all health professionals. The recently created Canadian Patient Safety Institute develops evidence based tools to improve patient safety and quality of care. It addresses all areas of health care and raises awareness of “Do No Harm” which is implicit in most professional codes of ethics.

People, today, have significantly more information about health, disease and current approaches to treatment including self-management of their own health. This is a positive trend in terms of strengthening healthy lifestyles but it can also lead to tensions between clinicians and clients when they don't agree on a course of treatment. Resolution of differences may well invoke ethical decision-making.

Electronic records are becoming more normative raising the need for health professionals to be more vigilant about the privacy and confidentiality of client information. Because these records can often be shared among different health care providers working with the same group of clients, there is additional concern about the nature of the information required for optimal care. Information that is more personal may not be required by all members of the health care team.

From a societal perspective there are a number of trends which impact health care and healthcare professionals. A rapidly growing aging population has put increasing demand on a health care system which has traditionally focused on acute care. Today's elderly frequently have one or more chronic conditions requiring long term care. The development of long term care facilities is a pressing need as witnessed by the long waiting lists for admission. These facilities have been the subject of concern for many families and have been highlighted frequently in the media. Reports of elder abuse, poor quality of care, lack of concern for privacy and dignity are just some of the issues. Dental hygienists work in these facilities and need be aware of the ethical implications of these issues. They may find themselves witnessing unacceptable staff behaviour which would in turn require an ethical decision to report such incidents.

Canada is a multicultural society which places additional requirements on healthcare professionals to be sensitive to cultural diversity. The Joint Commission Resources Inc., an affiliate of the United States (U.S.) Joint Commission on Accreditation of Healthcare Organizations, published a pocket guide for healthcare professionals on the subject of cultural sensitivity which is widely distributed in the U.S. (Joint Commission Resources, 2007). Similarly, many immigrants to Canada and the U.S. were educated as health professionals in other countries and their integration into their particular health profession here has a number of regulatory and ethical challenges (Jeans, M E. 2005).

The rapid growth of social networking and different modes of communication bring with them both opportunities and potential risks. Increased access to the Internet and mobile communication, combined with strategic uses of social media, can bring public health information to many more people more quickly and directly than at any time in history. Guidance on how health professionals should behave on social networking sites and how to work with it in an ethical and responsible way is important as the technology expands and social media etiquette and culture continue to evolve. The casual and conversational style of social media can make it easy to unintentionally cross professional boundaries (Fraser and Kalia, 2011).

Some Federal policy documents have implications for ethical practice in healthcare. Recent additions to human rights policies require health care professional and regulatory organizations to consider them in their conduct and foundational documents such as codes of ethics (Canadian Human Rights Commission: Annual Report, 2011). In the U.S. there has been a Patient's Bill of Rights (Rovner, 1999) which gives direction on the ethical issues of informed consent and treatment decisions. Canada does not have a national Patients Bill of Rights but many healthcare organizations and health professions produce guidelines describing these rights. Finally the Canadian Panel on Research Ethics has published a revised Tri-Council policy statement on ethical conduct for research involving humans (Tri-Council Policy Statement, 2010). It outlines a number of ethical requirements of scientists in all areas of basic, applied, social and health research. This policy is widely used by the three Research Councils and the academic community. Many professional codes of ethics reflect the importance of ethics in research in the particular discipline.

Westerholm (2009) refers to the significant increase in recent years in the number of legal and non-legal rules and regulations that often lead to problems with ethical codes. The first problem is *interpretation* that stems from the fact that there is a gap between the terms of an abstract code and real life. As well, ethical guidelines themselves often contain internal contradictions that make interpretation difficult. A second problem is the *multiplicity* of ethical codes, an issue that has been identified in relation to the dental hygienists codes. It has to do with the number of ethical codes and guidelines in effect which can be confusing and pull professionals in different directions. The third problem is *legislation* in which ethical issues are interpreted as legal problems and raise questions of what needs to be done vs. what is legally required or permissible. However, despite reservations about the number of professional codes, there is a high level of consensus within the literature that these problems are balanced by positive aspects. For example, ethical codes assist to define accepted behaviours, promote high standards of practice, provide a benchmark for members to use in self-evaluation, and establish a framework for professional behaviour and responsibilities.

3.2 Comparison of Health Professional Codes of Ethics

In addition to examining scholarly publications and policy documents for current issues and trends, several health professions codes were reviewed to identify recent revisions, and areas of similarities and differences in structure and content which may also be informative. The codes included were from the following professional organizations: Canadian Dental Association, Canadian Psychological Association, Canadian Nurses Association, Canadian Physiotherapy Association, American Dental Hygienists Association, and the American College of Dentists.

It was noted that the majority of the codes had not been recently updated. The exception was the Canadian Nurses Association Code of Ethics which was updated in 2008. The published scholarly literature and some national policies referred to current issues that need to be considered in professional codes of ethics. Many of these issues were not formally addressed in the codes reviewed.

All of the codes had similar structures which usually included the purpose, a preamble, basic values of the profession, ethical principles, and standards. Labels for the various components varied.

The “purpose” of the codes of ethics was remarkably similar across all health professions. They included the following themes: guidance for members in ethical conduct in the practice of the profession; relationships with patients/clients, peers, other health professional colleagues and the public; assurance to the public of a high standard of ethical conduct by members of the profession. Preambles were also quite similar and included the scope of application of the code to all practice settings and professional roles. The Canadian Psychological Association (CPA) Code of Ethics provides a clearly written description of the relevance of the Code to various professional roles in psychology. Reference was often made to other codes of ethics for the same profession, such as provincial regulatory codes of ethics. Again the CPA preamble expressed a reasonable approach to multiple codes and the facilitating role of the national code.

The values described in all health professions’ codes were similar and included the following examples:

- ✦ providing safe, compassionate, competent and ethical care
- ✦ promoting optimal health and well being
- ✦ respecting informed decision making
- ✦ respect for human dignity
- ✦ maintaining privacy and confidentiality

These values were sometimes outlined in a separate section in the codes but more commonly reflected in principles and standards. In fact the values gave direction to the principles reflected in the codes.

All of the codes included principles, sometimes called responsibilities. They vary in number but reflect the standard principles recommended as fundamental concepts of codes of ethics (Yeo et al., 2010). These include: beneficence, autonomy, truthfulness, confidentiality, justice, and integrity. While these concepts are expressed in classical language, some codes have attempted to translate the concepts into more common language.

All of the codes included standards or sub responsibilities which give more specific direction to the principles. They tend to be more prescriptive in terms of acceptable and non-acceptable behaviour in professional practice. Again, there were common standards across health professions which provide more specific support to ethical decision making. Codes are often accompanied by descriptions of cases or scenarios depicting real situations that a practitioner may encounter. Several of the codes were also accompanied by decision-support tools such as logical steps in making an ethical decision.

There were different themes in the content of standards in the codes examined. Much of the language was expressed in profession-specific terms and related to the scope of practice of the profession. For example, the codes of ethics for dentists have considerable content on the topic of being a professional and professionalism as well as content related to compensation, management of a private business, advertising, and so on. The psychologists have language around patient-therapist relationships which reflects sensitivity to client emotional engagement.

While there are a few characteristics of all the codes that could be informative in the revision of the CDHA code, the most comprehensive code is the Canadian Nurses Association Code of Ethics. It is well grounded in ethical theory and philosophy. The Code is supported by a number of adjunct documents. These include references to literature consulted during the 2008 revisions of the Code, ethics reading resources, a series of short papers on ethics in practice, a study guide, "Everyday Ethics: Putting the Code into Practice", a separate document on Ethical Research Guidelines, as well as specific formal Position Statements addressing health and healthcare issues, social justice, human rights etc., from an ethical perspective. The CNA material is available online

It was also noted that some professional/regulatory organizations create supplementary documents to their codes of ethics. These may include pocket cards, wallet cards, and separate guides on how to use the code, journal articles, web discussions, conferences and posters.

3.3 Multiple Codes of Ethics

The early development of professional codes tended to focus on provider-client relationships. These paved the way for professions to develop more detailed standards of practice or guidelines, specific to particular roles and/or settings. The CDHA Dental Hygienists Educators' Code is an example of a more focused code as are to some extent the regulatory codes. An answer did not clearly emerge from the literature on whether a single code or multiple codes are preferable but there is acknowledgement that they can serve multiple purposes.

Through self-regulation, society relegates control to a profession for ensuring that if ethical issues arise in a professional relationship, clients have the right to expect that his or her interest will be best served. A breach of the obligations under professional codes of ethics may be considered professional misconduct and result in disciplinary proceedings before the relevant professional regulatory body.

Dental hygienists are currently self-regulating in nine of the Canadian provinces and territories. The requirement for a code of ethics is commonly in bylaw. In British Columbia the regulatory code of ethics is incorporated in bylaw in its entirety. Several provincial regulatory authorities have adopted the Code of Ethics developed by CDHA to meet the legislative requirements. A number have stand-alone documents. All existing provincial codes were reviewed for this project. They are readily available on the web sites of the relevant regulatory authorities which are listed in Appendix A.

4.0 CONSULTATION

Feedback from the ultimate users of the new Code of Ethics was a key component of the development process. It provided an ongoing check on the goal of working towards a user-friendly product that reflected the professional needs of dental hygienists. Consultations were held at three phases of the project: early on to assess the satisfaction level with the 2002 Code and suggestions for improvement; mid project to work through the key components of a revised Code; and at completion to validate a final draft of the revised Code of Ethics.

4.1 Phase 1 Consultation: Key Informant Interviews

Twenty telephone interviews were held with dental hygienists inclusive of the 10 members of the CEC over November and December, 2011. Participants represented a variety of work settings and localities across Canada. The interviews lasted approximately one hour and consisted of discussion of 11 questions that were pre-circulated. The questions (Appendix C) were designed to encourage comment on the current CDHA Code of Ethics and Educators' Code, and provide input to the development of a revised Code of Ethics.

Despite the variation in the respondents' backgrounds, roles and responsibilities, there was a high level of consistency in the feedback. Many of the issues raised by key informants were the same as or similar to those found in the literature review, thus providing a degree of subjective validation to the information gathered from other sources. The respondents were well prepared for the interviews, and were helpful and forthcoming with their comments and suggestions. All were familiar with the CDHA Code and most had read the Educators' Code.

A summary of the feedback from the consultations follows. A more fulsome description is included in the Interim Report that was prepared for the CEC February, 2012 workshop (Phase 2 Consultation).

All those interviewed liked the current CDHA Code and did not feel that a major revision was necessary. The extent of consensus varied and where a gap was significant it was flagged for discussion at the CEC workshop.

A number of themes emerged in response to the questions. The characteristic that was most often identified was the "principles" in identifying the strengths of the current Code. They were seen as broad enough to enable situational interpretation, and well matched to the standards. Consensus was high on retaining the principles: Beneficence, Autonomy, Privacy and Confidentiality, Accountability. They were perceived as encompassing and relevant. The one principle that was questioned was "professionalism", not as lacking importance but rather as representing an overriding attribute inclusive of the body of knowledge that is fundamental to "dental hygiene". It was seen as broader than a principle.

Alternatively, there were a number of weaknesses identified in the 2002 Code of Ethics. The most common was the document's length and wordiness. It was suggested that the document would be strengthened with a crisp and concise introduction or preamble at the outset to set the stage and pull it together.

Informants were interested and sensitive to changes over the past decade in the dental hygiene profession and in society, and indicated the need for them to be reflected either directly or through examples/scenarios in a revised code. They included:

- expanding technologies and their usage, particularly social networking as having potential implications to issues such as privacy, confidentiality, security of information, and professional/client boundaries;
- advent of self-regulation and need for accordance with regulatory standards and legislation;
- increase in dental hygienists moving to private practice and the push/pull relationship of the business and professional model;
- high cost of dental services and inability of people to pay;
- growth and expectation of collaborative practice not only with dentists but with other health and social service professions in the health care system as dental hygienists expand their practice to the broader community and long term care; and,
- growth of multiculturalism and the need for sensitivity to cultural diversity and beliefs.

Most informants felt that the Code needs to be more user-friendly and they were forthcoming and creative with ideas for improvement. In relation to the document itself, despite strong support for it, there were many who felt the document could be shorter and include a companion piece with a broad range of scenarios and case studies. A number mentioned that it would be helpful to have an easy-reference tool such as a pocket or wallet edition, or even an app.

Many of the provincial regulatory authorities have their own code of ethics. Most of the informants supported a single code although acknowledged the legislative requirement for a regulatory code. A number of informants felt that in a situation posing an ethical dilemma, dental hygienists would tend to choose their regulatory code over the CDHA Code because of the potential consequences of being non-compliant. Nevertheless, support for the CDHA Code was high. Its ability to be less prescriptive was seen as an important opportunity for the Association to provide leadership and guidance to broad ethical thinking within the profession and offer behavioural examples (e.g., principles and scenarios). Reference to the regulatory role was seen as important to include up front in the revised CDHA code.

As stated in the introduction to this report, a second requirement of the project was to determine if there is a need to integrate the CDHA Educators' Code of Ethics with the CDHA Code of Ethics. The former was designed to provide a guide for educators in their day-to-day work in conjunction with the other documents and is specific in its content and focus on one particular sector of a dental hygienists work. Alternatively, the CDHA Code is designed and developed to apply to all roles and work settings.

The feedback from the key informant interviews regarding the need to integrate the documents was mixed among the educators themselves with some indicating that the Educators' Code is a useful guide and others feeling that the CDHA Code is sufficient. A possible approach was suggested to retain the Educators' Code but consider changing the title to *Ethical Guidelines for Dental Hygiene Educators*. This would reduce confusion and clearly acknowledge it as an adjunct to the CDHA Code.

In summary, key informants supported CDHA's current Code of Ethics with some updating and making the document more user-friendly. The current principles were seen as still applicable with the possible exception of "professionalism" which merited further discussion. Numerous changes/development was identified in the dental hygiene profession, in practice, and in technology, but were not seen as necessarily requiring much change to the Code itself; rather suggesting extensive scenario development to promote and facilitate understanding of the ethical issues involved in a variety of potentially difficult situations.

4.2 Phase 2 Consultation: Code of Ethics Committee Workshop

A face to face meeting (workshop) of the CEC, CDHA staff and the consultants was convened in Ottawa February 3 and 4, 2012 to review the results of the phase 1 consultation and document/literature review and make preliminary decisions on the content for the revised Code. An Interim Report that included the literature review and feedback from the key informant interviews, and drafts of sections for a revised code, were circulated in advance. Slides were prepared to guide the discussion and assist in decision-making. The committee met for a day and a half and had in-depth discussion and debate on all aspects of the Code. Several decisions were made and inclusions for the revised Code of Ethics recommended.

The issue of multiple codes of ethics was discussed at length. They agreed that dental hygienists are guided by a number of Codes of Ethics including those of their provincial/territorial regulatory authority, their individual work places, and specialized areas of practice. After considering the input from the key informant interviews, the members of the CEC recommended that the Educators' Code be retained but that the title changed to "Ethical Guidelines for Dental Hygienist Educators". In addition, they supported a reference to other codes of ethics in the Preamble of the revised Code with the statement that they are complementary and guide Dental Hygienists behaviour.

The CEC undertook an intensive review of the principles for the revised Code and made a number of decisions. They opted to remove the principle "Professionalism" as it was considered to be a broader concept than an ethical principle. They felt the concept could be reflected in the preamble. The principle "privacy and confidentiality" was changed to "confidentiality". A new principle "integrity" was added and intended to subsume concepts such as veracity (truthfulness), justice and authority. The descriptors for the five principles were reviewed and a number of editorial suggestions made. The "standards" in the original Code were analyzed in the context of the principles they were

supporting, and renamed “responsibilities”. The change in name was made to reduce confusion with practice standards.

Considerable time was spent discussing the concepts of “ethical challenges”. The final decision was to retain the concepts as an integral part of the Code of Ethics and to order them ethical distress, ethical dilemma, and ethical violation. Editorial suggestions were made to clearly define the three concepts and to differentiate them one from another.

On the second day of the meeting participants reviewed the changes that had been incorporated into the draft Code. They suggested several more revisions to the preamble including changing “patient” or “client” to “person” throughout the document. (“Person” was later changed back to “client” in accordance with CDHA policy).

A review of the three appendices was approved but suggested that the wording could be more succinct.

The remainder of the meeting was spent revising the “responsibilities” for each of the “principles”. A summative discussion took place to ensure there were no missing concepts that needed to be included in the revised Code of Ethics.

The consultants took all of the recommended changes, including editorial suggestions, into consideration as they prepared the next draft of the revised Code. Following a series of consultations with the CEC and CDHA staff, the final draft of the Code of Ethics was ready for circulation to the members for validation.

4.3 Draft CDHA Code of Ethics and Validation Survey to CDHA members

The revised draft Code of Ethics and a 30 -question survey were distributed electronically to 15,300 members of CDHA and to 23 key stakeholders who were identified by CDHA staff and members of the CEC. The survey included 19 statements to which respondents indicated their level of agreement on a 5 point scale, nine questions asking for further comments, and two demographic questions. The questions addressed all sections of the draft Code of Ethics (Appendix D). The survey was open for three weeks from mid-April to early May, 2012.

A total of 258 completed surveys were returned, representing a response rate of 1.8%. The composition of the respondents, in terms of place of work, was as follows: 69% were in clinical practice with half in a dental hygiene practice and half in a dental practice; 13% were educators; 4.7% were in public health; and the remaining 13.3% were identified in administration, regulation, professional association.

Respondents were also asked how long they had practised as a Dental Hygienist. The results indicated that 30% had practised from 1 to 5 years, 10% from 6 to 10 years, 11% from 11 to 15 years, 12% from

16 to 20 years and 37% for 20 or more years.

The survey question responses were subjected to both qualitative and quantitative analysis. The nine questions asking for comments comprised the qualitative data, while the questions scored on a 5 point scale made up the quantitative data.

The responses to the 5 point scale were overwhelmingly positive for all sections of the draft Code of Ethics. Ninety-seven percent of respondents strongly agreed or agreed that the Preamble clearly explained the purpose of the Code of Ethics, while 91% strongly agreed or agreed that the Preamble clarified the complementary relationship between the CDHA Code of Ethics and other Codes of Ethics that apply to Dental Hygienists.

In response to statements about the Principles, 97% strongly agreed or agreed that the descriptors of the principles were easy to understand and 96% strongly agreed or agreed that the five Principles encompass a broad range of ethical issues commonly encountered in the Dental Hygiene practice. Ninety percent of respondents did not believe there were any ethical principles missing from the draft Code of Ethics, while 10 % suggested additional principles.

Across all statements made about the responsibilities associated with each of the five principles, 98% of respondents agreed or strongly agreed that the responsibilities were relevant to Dental Hygiene practice.

With regard to the ethical challenges presented in Appendix A of the revised Code, 95% of respondents strongly agreed or agreed that the concepts of ethical dilemma, ethical distress and ethical violation were clearly differentiated. The same number agreed that the definitions were clear.

In response to Appendix B of the Code which provided an ethical decision making model, 94% strongly agreed or agreed that it was a useful tool. In response to Appendix C of the Code which related to reporting unethical behaviour of colleagues, 94% strongly agreed or agreed that it provided appropriate guidance.

In response to two questions asking for the respondents' overall impression of the draft Code of Ethics, 97% strongly agreed or agreed that it was easy to understand and 92% of respondents strongly agreed or agreed that it was comprehensive enough to address a broad variety of ethical situations encountered by Dental Hygienists.

In addition to the above analysis of the survey, cross-tabulations were conducted between the responses to the statements for the 5 point scales and the two demographic questions: area of work and length of time working as a Dental Hygienist. No statistically significant differences were found. However, there was a slight tendency for those with fewer years of experience to be less positive in response to Appendix C related to reporting unethical behaviour in others. This is a complex issue and it may be that other types of support are required in addition to the Code of Ethics.

Qualitative analysis was carried out on the nine survey questions asking for written comments. A total of 350 comments were received from a low of 24 completed surveys to a high of 55 completed surveys. The mean number of comments per question was 38.9%. This represents approximately 15% of the respondents. This is actually an over -estimate as some respondents made more than one comment to several questions. The electronic analysis counted multiple comments as one comment.

The majority of comments were positive about the draft Code of Ethics and supported the very positive results of the quantitative responses.

The comments fell into three major categories:

1. Endorsement of the draft Code of Ethics as presented.
2. Endorsement of the draft Code of Ethics with clarification and/or revision of terms including of editorial suggestions.
3. Endorsement of the draft Code of Ethics with some concerns.

The comments that raised concerns were further analyzed for any themes or recurring suggestions. Five themes were identified as follows:

1. Strengthen the definition of client to reflect Dental Hygienist's broader obligation to society.
2. Strengthen the applicability of the Code of Ethics to address work settings. The focus is too clinical.
3. Add or re-order some of the responsibilities and add or delete some principles.
4. Supported the use of the Code of Ethics in addressing workplace tension and conflict but did not make specific suggestions for change to the Code.
5. Suggested that the issues of ethical decision making and reporting unethical behaviour of colleagues were more complex than the appendices reflected.

Finally, three respondents made relatively negative comments about the draft Code of Ethics. This represented slightly more than 1% of the respondents.

The results of the validation survey, including the comments, were presented to the CEC for discussion and final decisions about changes to the draft Code of Ethics. These decisions were then incorporated into a final draft of the Code of Ethics. This final draft was sent to the CEC for approval.

In summary, the vast majority of respondents endorsed the draft Code. A small percentage of comments contained suggestions for minor editorial changes. These were discussed by the CEC and many approved for incorporation into the final draft. In relation to the negative comments, their complexity suggested a greater depth of knowledge of the field of ethics.

5.0 CONCLUSIONS AND RECOMMENENDATIONS

An iterative approach was taken to the development of the revised Code of Ethics. The literature review, combined with the three phases of consultation, provided ongoing reassurance that the final document would reflect current thinking and concepts relevant to today's professional codes of ethics. The process enabled continuing refinement of the changes to be included and provided a level of validation. In the end, there was overwhelming support for the revised draft Code of Ethics.

Every dental hygienist will be faced with an ethical dilemma sometime during her or his working career. Ethical situations are complex and while no one document can resolve them, the revised CDHA Code of Ethics has been designed to be an easily accessible reference for dental hygienists in all roles and settings. The Code identifies the broad principles, enhanced by specific responsibilities, to guide actions and behaviours in most situations. The literature is clear, however, and reinforced by the feedback received on the draft Code of Ethics, that additional supports are necessary companions to professional codes to facilitate there use and promote understanding of the complexities of ethical issues.

The following recommendations emerged as the development of the Code progressed:

1. The revised Code of Ethics (2012) is adopted by the CDHA Board of Directors
2. A comprehensive communication plan is developed to accompany the release of the revised Code of Ethics.
3. Supporting documents, such as scenarios or guides, are developed or located to assist dental hygienists in the application of the Code to actual situations.
4. Ongoing awareness strategies are developed to inform members on ethical issues and decision making.

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APPENDIX A: CDHA Code of Ethics Committee

Paula Benbow DipDH	Paris, Ontario
Sandra Cobban DipDH, MDE, PhD	Edmonton, Alberta
Mandy Hayre DipDH, BSc, PID, MEd	Nanaimo, British Columbia
Pauline Imai DipDH, BSc, MSc	Vancouver, British Columbia
Nancy Johnston DipDH	Bradford, Ontario
Carol Kline DipDH, BSc. MA	Vancouver, British Columbia
Laura MacDonald DipDH, BSc, D (DH), MEd	Winnipeg, Manitoba
Nancy Neish BA, DipDH, MEd	Halifax, Nova Scotia
Laura Perri DipDH, B.Sc. BEd	Oakville, Ontario
Harriet Rosenbaum DipDH	Ontario
<u>CDHA Staff</u>	
Judy Lux BA, MSW Manager Health Policy and Advocacy	Ottawa, Ontario
Ann Wright DipDH, MBA Director of Dental Hygiene Practice	Ottawa, Ontario

APPENDIX B: Provincial/Territorial Regulatory Authorities for Dental Hygienists

British Columbia - College of Dental Hygienists of British Columbia: www.cdhbc.com

Alberta - College of Registered Dental Hygienists of Alberta: www.crdha.ca

Saskatchewan - Saskatchewan Dental Hygienists' Association: www.sdha.ca

Manitoba - College of Dental Hygienists of Manitoba: cdhm@cdhm.info

Ontario - College of Dental Hygienists of Ontario: www.cdho.org

Quebec - Ordre des hygiénistes dentaires du Québec: www.ohdq.com

New Brunswick - New Brunswick College of Dental Hygienists: www.ndhcb.ca/en/authorities.php

Nova Scotia - College of Dental Hygienists of Nova Scotia: www.cdhns.ca

Prince Edward Island - Dental Council of Prince Edward Island: dapei@pei.sympatico.ca

Newfoundland/Labrador - Newfoundland and Labrador Dental Board: nldb@nf.aibn.com

Yukon - Department of Community Services: www.community.gov.yk.ca

Northwest Territories - Dept. of Health and Social Services: www.hlthss.gov.nt.ca

Nunavut - Department of Health and Social Services: bharvey@gov.nu.ca

APPENDIX C: Key Informant Interview Questions (NOVEMBER, 2011)

Preamble: *CDHA has undertaken a review of its Code of Ethics developed in 2002. The Code governs the behaviour of members and assures the profession's accountability to the public. The review at this time is to determine that the content continues to be relevant, appropriate and in keeping with current standards of professional conduct and ethical practice.*

CDHA recently assumed responsibilities for the former organization of Dental Hygiene Educators Canada (DHEC) which approved a code of ethics for dental hygiene educators in 2005. The CDHA code applies to dental hygienists in all practice settings, including education, and there are sections with overlap between the two codes. This project, in addition to conducting the review of the CDHA code, will examine the DHEC code to determine the need to integrate the two.

The following questions are an integral part of the review process. They have been designed to encourage discussion and will provide valued input to the development of a revised Code of Ethics.

Before we begin, do you have any questions?

1. Have you had the opportunity to review the current CDHA Code of Ethics?
2. Do you use the CDHA Code in your role as a dental hygienist?
 - If yes, could you please describe an example of how the code was of assistance to you?
3. In your view, what are the main strengths and weaknesses in the current CDHA code?
4. Are there particular values, ethical issues or principles we need to focus on as we develop a revised code? (e.g., new social norms such as social networking that you would like to see reflected in the new Code?)
5. Is there other content that you would suggest in order to make a code more useful and relevant to dental hygienists?
6. Is there an alternative format that would make the code more user-friendly?
7. Have you had the opportunity to review the Educators' Code of Ethics?
8. What do you perceive as the similarities and differences between the 2 codes?
9. There are several other codes of ethics for dental hygienists (e.g., regulatory organizations, employers). Do you think dental hygienists need more than one code of ethics?
 - If yes, why?
 - If no, would you support consolidating them into one document?
10. Do you have any other thoughts or ideas that may be helpful in developing a revised CDHA Code of Ethics?
11. Are there other topics we haven't covered that you would like to raise and discuss?

APPENDIX D: Validation Survey Questionnaire

CDHA Code of Ethics - Validation

INTRODUCTION

The Canadian Dental Hygienists Association (CDHA) is revising the Code of Ethics for Dental Hygienists in Canada. The purpose of this questionnaire is to obtain your feedback on the revised Code of Ethics. Please read the draft of the Code of Ethics http://www.cdha.ca/pdfs/CodeOfEthics_2012.pdf and refer to it as you complete the questionnaire.

We would like to thank you in advance for taking the time to complete the questions. The questionnaire should take approximately 20 minutes to complete. Please complete on or before APRIL 30, 2012. The information gathered from this survey will be used to validate the draft Code of Ethics. The information you provide will be compiled and reported to the CDHA Code of Ethics Committee (CEC) which consists of representatives of the Dental Hygiene profession from across Canada. Your information will remain confidential and only aggregate information will be reported.

If you have any difficulty accessing the draft Code and/or the questionnaire, please contact Jody Layer at jody@hhrgroup.ca. Thank you again for your assistance.

SECTION 1: ABOUT THE PREAMBLE

Question 1

The preamble to the Code of Ethics clearly explains the purpose of the Code:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 2

The preamble to the Code of Ethics clarifies the complementary relationships between the CDHA Code of Ethics and the other Codes existing such as provincial regulatory codes:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 3

Please provide any additional comments regarding the PREAMBLE:

SECTION 2: ABOUT THE PRINCIPLES

Question 4

The descriptors of the principles are easy to understand:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Beneficence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Autonomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Integrity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accountability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confidentiality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question 5

The five principles encompass a broad range of ethical issues encountered in the Dental Hygiene practice:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 6

Do you feel there are any ethical principles missing?

- Yes
- No

Question 7

Please list the ethical principles that should be added to the CDHA Code of Ethics:

Question 8

Please provide any additional comments regarding the PRINCIPLES:

SECTION 3: ABOUT THE RESPONSIBILITIES

Question 9

Principle 1: BENEFICENCE

The responsibilities under BENEFICENCE are relevant to the Dental Hygiene practice:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. Put the needs, values, and interests of clients first.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Provide services to clients in a caring manner with respect for their individual needs, values, culture, safety, and life circumstances, and in recognition of their inherent dignity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Regard informed choice as a precondition of treatment, and honour a client's informed choice including refusal of treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Recommend or provide those services that they believe are necessary for promoting and maintaining a client's oral health and its effect on total body health and wellness, and which are consistent with the client's informed choice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Take appropriate action to ensure a client's safety and quality of care when they suspect unethical or incompetent care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Seek to improve the quality of care, and advance knowledge in the field of oral health through advocacy and interprofessional practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question 10

Please provide any additional comments regarding any of the responsibilities for Principle 1 - BENEFICENCE:

Question 11

PRINCIPLE 2 - AUTONOMY

The responsibilities under AUTONOMY are relevant to the Dental Hygiene practice:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. Actively involve clients in their oral health care and promote informed choice by communicating relevant information openly, truthfully, and sensitively in recognition of their needs, values, and capacity to understand.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Involve and promote informed choice by substitute decision-maker(s) in situations where clients lack the capacity for informed choice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In the event of a substitute decision maker, involve clients to the extent of their capacity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Recognize cultural differences, and assess and plan interventions with individuals and populations receiving their services relative to the cultural context.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question 12

Please provide any additional comments regarding any of the responsibilities for Principle 2 - AUTONOMY:

Question 13

Principle 3: INTEGRITY

The responsibilities under INTEGRITY are relevant to the Dental Hygiene practice:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. Uphold the principles and standards of the profession with clients, with colleagues, and with others with whom they are engaged in a professional relationship.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Maintain and advance their knowledge and skills in dental hygiene through lifelong learning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Provide quality of care through ongoing self-evaluation and quality assurance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Promote conditions that enable social, economic, and cultural values and institutions compatible with meeting basic human rights and dignity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Collaborate with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, fair and high quality care to individuals, families and communities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Communicate the nature and costs of professional services fairly and accurately, adhering to guidelines and/or regulations for advertising as outlined by their jurisdictional regulatory authority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question 14

Please provide any additional comments regarding any of the responsibilities for Principle 3 - INTEGRITY:

Question 15

Principle 4: ACCOUNTABILITY

The responsibilities under ACCOUNTABILITY are relevant to the Dental Hygiene practice:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Practice within the bounds of their competence, scope of practice, personal and/or professional limitations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Refer clients who require services outside their scope of practice to the appropriate professional.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Address issues in the practice environment that may hinder or impede the provision of care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Inform their employers about the principles, standards, laws and regulations to which dental hygienists are accountable and determine whether employment conditions facilitate safe professional practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Inform the appropriate regulatory authority in the event of becoming unable to practice safely and competently.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question 16

Please provide any additional comments regarding any of the responsibilities for Principle 4 - ACCOUNTABILITY:

Question 17

Principle 5: CONFIDENTIALITY

The responsibilities under CONFIDENTIALITY are relevant to the Dental Hygiene practice:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. Demonstrate respect for the privacy of clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Promote practices, policies and information systems that are designed to respect and protect clients' privacy and confidentiality.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Understand and respect the potential of compromising confidentiality when connecting with clients through social networks or other electronic media.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Hold confidential any information acquired in the professional relationship and do not use or disclose to others without a client's express consent. (Please see Code of Ethics for exceptions)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Inform clients in advance of treatment of how their information may be shared, in particular around any uses or sharing that may occur without the client's express consent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Obtain a client's consent to use or share information about his/her circumstances for the purpose of teaching or research.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question 18

Please provide any additional comments regarding any of the responsibilities for Principle 5 - CONFIDENTIALITY:

SECTION 4: APPENDICES

Question 19

Appendix A clearly differentiates the concepts of ethical dilemma, ethical distress and ethical violation:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 20

The definition for ethical distress in Appendix A is clear:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 21

The definition for ethical dilemma in Appendix A is clear:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 22

The definition for violation in Appendix A is clear:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 23

The eight steps described in Appendix B provide a useful tool for ethical decision making:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 24

Appendix C provides appropriate guidance for reporting unethical behaviour of others:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 25

Please provide any additional comments regarding the APPENDICES:

SECTION 5: GENERAL QUESTIONS

Question 26

Overall the Code of Ethics is easy to understand:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 27

Overall the Code of Ethics is comprehensive enough to address a broad variety of ethical situations encountered by Dental Hygienists:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Question 28

Do you have any further comments regarding the Code of Ethics?

SECTION 6: DEMOGRAPHICS

Question 29

Please indicate your area of practice or area that you represent:

- Administration
- Dental Hygiene Practice
- Dental Practice
- Education
- Professional Regulatory Authority
- Provincial Dental Hygiene Association
- Public Health
- Other (Please Specify) _____

Question 30

How many years have you been practicing?

- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 20 + years

Thank you for completing the survey.

If you would like your name entered into a draw for a \$100 gift certificate for HBC, please send an email to: jlux@cdha.ca with "Code of Ethics draw" in the subject line.