

# Special Care Dentistry

for the General Practice Resident:  
Practical Training Modules

## Contributing Authors:

Miriam Robbins, DDS, MPH  
Maureen Romer, DDS, MPA  
Steven Krauss, DDS, MPH  
Evan Spivack, DDS  
Nancy Dougherty, DMD, MPH  
Robert Marion, MD  
Koshi Cherian, MD

## Editor:

Charlotte Connick Mabry, RDH, MS, FADPD

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***Special Care Dentistry  
For the General Practice Resident  
Practical Training Modules***

- **This educational modular series consists of eight evidence based Power Point presentations designed to give the general practice resident a global view of dental treatment for people with special needs. Approximately 300 references are listed throughout this work. The eight modules address the most important aspects of clinical medicine and dentistry required for treating a patient with special needs. Discussion of access and barriers to dental care, the need for special care dentistry in the pre and post doctoral dental curricula, along with assessment of the competency of participants are included in the modules. Upon completion of the modules, the participant should have the knowledge to assess a patient with special needs.**
- **The educational package is a previously piloted pre and post test exam. The modules are accompanied by “teacher’s notes” which are visible in each Power Point presentation. This format alternately allows the instructor to assign the series as a self-study project.**

**continued**



## **Special Care Dentistry For the General Practice Resident Practical Training Modules**

- A description of each module follows below:
- **Introduction to Special Patient Care:** discusses the definition of disability, the prevalence and incidence of disability, aspects of “normalization”, and the barriers to care. A list of resources is provided for the individual and family.
- **Special Care Dentistry/Legal and Ethical Issues:** discusses informed consent and various other types of consent, comprehensive medical history documentation, appropriate use of desensitization and restraint, communication/human rights issues, case law and detailed literature review of restraint.
- **Treatment Modalities/Treatment Planning for Patients with Special Needs:** discusses reasons for sedation, hospitalization OR cases, general anesthesia, pharmacological techniques, IV and enteral drugs.
- **Learning Disabilities/Mental Retardation and Down Syndrome:** discusses the causes and risk factors, diagnosis and intervention, physical findings and medical concerns, dental and craniofacial characteristics of people with learning disabilities, mental retardation and Down syndrome.
- **Neuromuscular Disorders/Cerebral Palsy and Muscular Dystrophy:** discusses types of cerebral palsy, risk factors, oral and dental findings, various forms of muscular dystrophy and treatment planning considerations.
- **Autistic Spectrum Disorders:** defines and describes the spectrum of autistic disorders including Pervasive Developmental Disorder and Asperger’s. A recent review of the literature regarding proposed etiologies (i.e.: genetic links, vaccines) is presented as well as suggestions for behavior management and treatment strategies.
- **Oral Manifestations/Genetic and Congenital Disorders:** discusses syndromology definitions, gene and chromosomal abnormalities, craniofacial disorders, dental and orthopedic conditions.
- **Seizure Disorders:** discusses definitions of seizures and epilepsy, risk, incidence and prevalence of seizures, classification and treatment of seizures, choice of medication therapies and practical considerations for dental treatment.
- Pre and post tests and the answer sheets are not included in the module series. Please contact Annette Shafer in the Office of Investigations and Internal Affairs at [annette.p.shafer@omr.state.ny.us](mailto:annette.p.shafer@omr.state.ny.us) to request a copy and we will forward it to you electronically.



# Special Care Dentistry

## Legal and Ethical Issues

**Dr. Maureen M. Romer**

Associate Professor,

Director of Special Care Dentistry,

Arizona School of Dentistry and Oral Health

[mromer@atsu.edu](mailto:mromer@atsu.edu)



# Informed Consent

- Grounded in the principle of patient autonomy
  - ADA Principles, Code of Professional Conduct and Advisory Opinions:
    - “The dentist has a duty to respect the patient’s rights to self-determination and confidentiality.”
    - “...professionals have a duty to treat the patient according to the patient’s desires, within the bounds of accepted treatment...the dentist’s primary obligations include involving the patient in treatment decisions in a meaningful way, with due consideration being given to the patient’s needs, desires and abilities...”<sup>1</sup>



# Informed Consent

***Informed consent:*** the process of communication between a doctor and patient in which a patient grants permission for the proposed treatment based on a realistic understanding of the nature of the illness, description of the procedure, risks and benefits and treatment alternatives, including no treatment at all.<sup>2,3,4</sup>



# Types of Consent

- **Explicit consent**
  - is the patient's stated decision to undergo treatment
- **Implied consent**
  - when it appears that the patient has voluntarily submitted him/herself for treatment
  - it arises from the signs, actions or conduct of an individual<sup>5</sup>



# “Specific” Consent

- **removal of body parts, other surgical procedures and anesthesia**
- **behavior management techniques, especially for restraint**



# Exceptions

- **Emergency Medical Treatment**
  - situations that would otherwise lead to serious disability or death do not require informed consent, although an effort to obtain consent should be made as long as it does not unnecessarily delay the treatment of the patient<sup>4</sup>
  - “Reasonable man”



# Exceptions

- **Simple and Common Exclusions**
  - the risk is so remote or commonly known as to not warrant disclosure (i.e. blood drawing)
- **Exceptions to the duty to disclose**
  - doctor's privilege to withhold information for therapeutic reasons



# Exceptions

- **Some states require written consent for certain procedures or diagnoses.<sup>6</sup>**



# Who May Consent?

- Patient 18 or older
- Parent, if patient is a minor child<sup>7</sup>
- Guardian or Other Authorized Surrogate
  - individuals with MR/DD over 18, parent may not be guardian, may need to seek legal guardianship
  - some states: patient advocates may consent *OR* involved adult family member <sup>8</sup> (i.e.; New York State)



# Who May Consent?

- **Adult patients with temporary loss of capacity *OR* who once had capacity**
  - **advance directives (living wills, health care proxies, durable powers of attorney)**
  - **if patient not adjudicated to be incompetent, retain right to make own treatment decisions (including refusal of treatment)<sup>5</sup>**
    - **Exceptions for treatment in life threatening situations<sup>9</sup>**



# Questionable Capacity

- **Mental capacity**
- **Legal competency**
  - **consult risk management**



# Witnessing the Consent

- **Attests to the fact that the informed consent process took place**
  - **patient/guardian/authorized surrogate had opportunity to ask questions and get answers**



# Failure to Obtain Informed Consent

- **Criminal charge of battery**
  - (an unwanted touching)
- **Claim of negligence**
  - (malpractice)<sup>2</sup>



# Patients in Residential Settings

- **For patients who lack capacity:**
  - Obtain an explicit consent for treatment from the legal guardian/authorized surrogate.
  - Document with an original signature
- **Ascertain from group home manager or staff nurse who the patient's legal guardian/authorized surrogate is.**
- **Consent forms can be given to patient's escort to be signed at the residence by the guardian/authorized surrogate .<sup>10</sup>**



# Patients in Residential Settings

- **Put your name and phone number on consent, so that guardian/authorized surrogate can contact you directly.**
- **For specific consents (i.e. extraction, sedation, apicoectomy, biopsy, etc.) speak with the guardian/authorized surrogate either by phone or in person.<sup>10</sup>**



# Obtaining a Medical History

- If patient lives with parent or other family member, obtain history from them.
- For patients in group homes, the dentist may have little or no contact with a family member.
- Patient's ***“Big Book”***
  - binder that contains guardian information, a record of past medical and dental visits, annual physical, dietary restrictions, and behavioral and social information.<sup>10</sup>



# Obtaining a Medical History

- **Consult sheets**
  - to be completed and returned by the dentist often have vital medical information on them
  - also a good place to write a request to the agency for further patient information.<sup>10</sup>



# Obtaining a Medical History

- **Staff Nurse**
  - oversees the general medical care of the group home residents.
  - coordinates care among specialties.<sup>10</sup>



# Restraint

- **Recurring theme in the literature on restraint: the balance of**
  - **autonomy**
  - **patient safety**
  - **quality of life<sup>9, 11-17</sup>**



# Definition

- **The U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (CMS)**
  - **“Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident’s body that the individual cannot remove easily which restricts movement of normal access to one’s body. Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms.”** <sup>18</sup>



# The Joint Commission

- **Hospitals are subject to The Joint Commission (formerly JCAHO) regulations**
  - **Acute Medical and Surgical (Non-psychiatric) Care restraint standards**
  - **Behavioral Health Care Restraint and Seclusion Standards<sup>19</sup>**



## **Children's Health Act of 2000 (Public Law 106-310)**

- **Interpretive Guidelines for Intermediate Care Facilities (ICFs) for Persons with Mental Retardation**
  - **“a health-related protection, prescribed only by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.” (Tag w297)<sup>20</sup>**
  - **should only be employed when no other option is available or when other options have proven ineffective**



# Human Rights Committees

## Tag w261

- **“Specially Constituted Committee”** consisting of “facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.”<sup>20</sup>



# Human Rights Committees

- **Must review and monitor individual programs to manage inappropriate behavior and that involve risks to clients' rights and protection (Tag w262)**
- **Written consent (Tag w263)**
- **Monitor and review practices and programs as related to drug usage and physical restraint among other client right issues (Tag w264)<sup>20</sup>**



# Interpretive Guidelines on Dental Services

- Annual exam and diagnosis (Tag W 354)
- “Comprehensive Dental Treatment”
  - including “dental care for the relief of pain and infection, restoration of teeth and maintenance of oral health.”  
(Tag w356)
  - exams should indicate that (dental) services were furnished, rather than that the individual was “unable to be examined” or “as best as can be determined” (§483.460(g)(2))
  - dentists may participate in Individual Program Plan (Tag w349)<sup>20</sup>



# Papoose Boards

- **New York State excludes**
  - “those devices customarily used in conjunction with medical, diagnostic, surgical procedures/treatments or movement/transfer of patients that are a regular or usual part of such treatment or procedure, e.g. body restraint during surgery.”<sup>21</sup>
  - “The use of mechanical supports necessary to keep an infirm or disabled patient in a safe or comfortable position or to provide stability necessary for...medically necessary procedures.”<sup>22</sup>

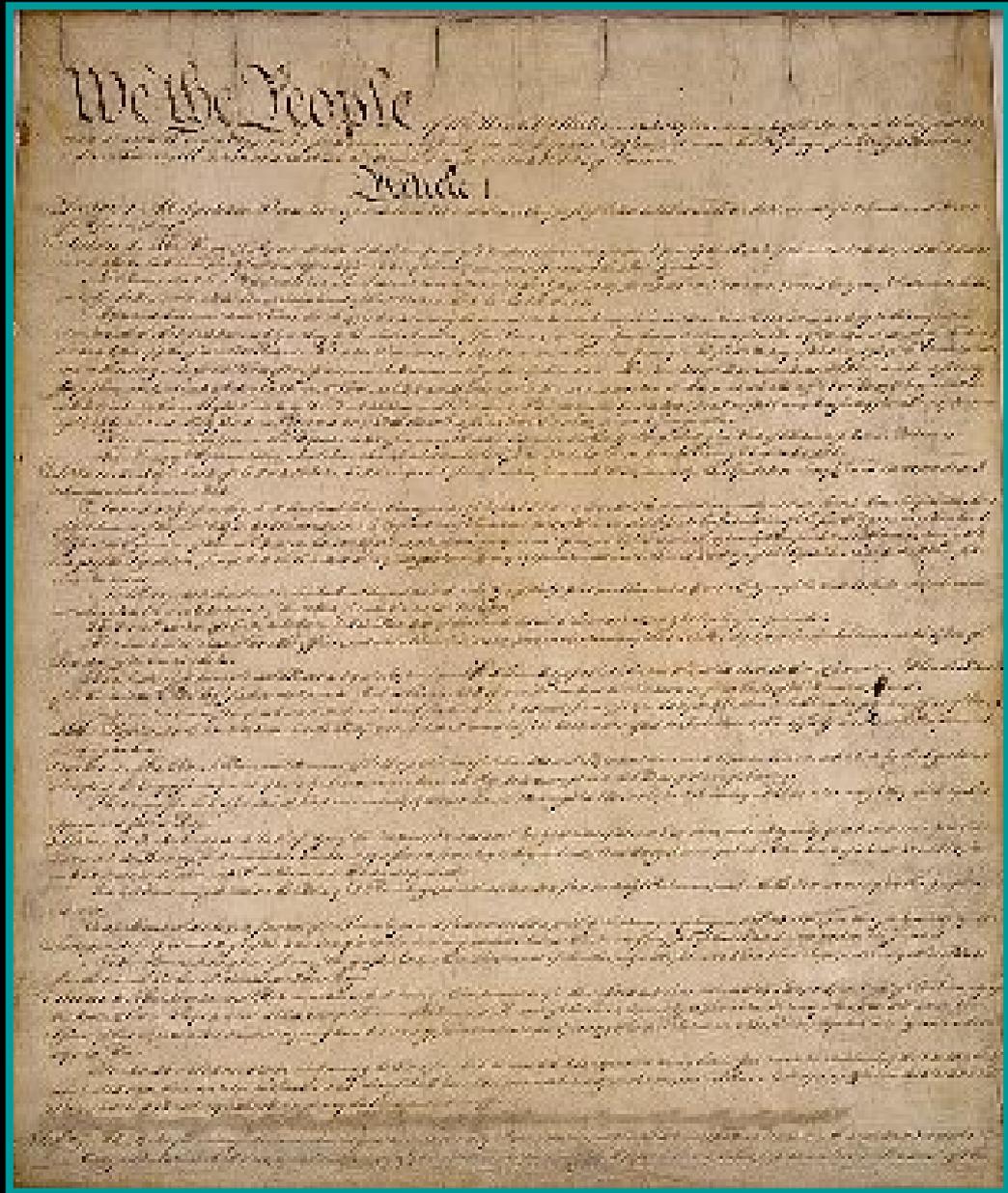




# Constitutional Law

## Due Process Clause of 14<sup>th</sup> Amendment

- Guarantees liberty interests
- Supreme Court acknowledges that the state has a duty to provide necessary medical care for patients in long-term care facilities
- *Youngberg v. Romeo*
  - U. S. Supreme Court established that committed individuals have constitutionally protected liberty interests under the Due Process Clause of the Fourteenth Amendment.<sup>23</sup>





Article XIV.  
All persons born or naturalized in the United States, were  
jurisdiction thereof, are citizens of the United States and,  
as they reside. No State shall make or enforce any law which  
shall abridge the privileges or immunities of citizens of the United States;  
nor shall any State deprive any person of life, liberty, or property, without due  
process of law; nor deny to any person within its jurisdiction the equal protection  
of the laws.

Section 2. Representatives shall be apportioned among the several  
States, according to their respective numbers, counting the whole number of  
free persons, including Indians not taxed. But when the right to vote in  
the choice of electors for President and Vice President of the United  
States shall be denied to any of the male inhabitants of such State, being  
twenty-one years of age, and citizens of  
the United States, or in any way abridged, except for participation in rebellion  
or other crime, the basis of representation therein shall be reduced in the proportion



# Case Law

- ***Reese v. Nelson*<sup>24</sup>**
  - safe use of restraint to complete a dental procedure versus the patient's liberty interests
- ***Wyatt v. Stickney*<sup>25</sup>**
  - restraints require doctor's orders
- ***New York State Association for Retarded Children v. Rockefeller (AKA Willowbrook)*<sup>26</sup>**
  - protection from harm (establishment of standards)



# Case Law

- ***Youngberg v. Romeo (U.S. Supreme Court)***
  - Liberty interests “are not absolute; indeed to some extent they are in conflict.”
  - Sometimes necessary in an institutional setting to restrain an individual for safety reasons
  - To address this conflict the court adopted the professional judgment standard, “that courts make certain that professional judgment was in fact exercised.”<sup>23</sup>



# Case Law

- ***Youngberg v. Romeo***
  - “the decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from the accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”<sup>23</sup>



# Case Law

- ***Society for Goodwill to Retarded Children v. Cuomo***
  - “lack of sufficient dental care caused (a patient’s) gums to deteriorate necessitating the surgical removal of nine of her teeth”
  - patient’s constitutional right to adequate care had been violated<sup>27</sup>



# Literature Review

- **Medline and Google Scholar**
- **The majority of the literature regarding restraint focuses on**
  - **mental health institutions**
  - **long-term care facilities (nursing homes)**
  - **restraint of suspects by law enforcement officials.**
- **Gap in the literature re: restraints and patients with developmental disabilities**



# Literature Review

- **Dental restraints are temporary and specific and not analogous to general behavior restraints<sup>28</sup>**
- **Purpose is to enable safe, efficient treatment and are only applied for the duration of a specific procedure**
- ***Medical immobilization, protective stabilization and physical intervention* have been proposed as substitutes for the term restraint<sup>29,30,31</sup>**



# Rationale for Use of Restraint

- **Connick<sup>9</sup>**
  - Patient safety, effective care, risk of neglect
- **Casamassimo<sup>32</sup>**
  - Positive ends, support
- **Evans & Strumpf<sup>11</sup>**
  - Goals of care must be weighed
- **Shuman & Bebeau<sup>13</sup>**
  - Assumption that in certain cases behavior needs to be controlled
- **Helgeson<sup>33</sup>**
  - Poor outcomes if dental neglect allowed



# Patients' Rights

- **O'Donnell<sup>12</sup>**
  - Pt's rights vs. obligation to ensure care
- **Klein<sup>15</sup>**
  - Constraint of liberty interest is minimal
- **Fenton<sup>34</sup>**
  - Restraint passes constitutional requirements
- **Ozar<sup>16</sup>**
  - Obligation to all patients
- **Burtner<sup>14</sup>**
  - Behavior management techniques not different, just more frequent



# Psychological Effects

- **Grandin<sup>35</sup>**
  - Relaxing, calming and comforting effect
- **Mion<sup>36</sup>**
  - Beneficial effects vs. deleterious effects
- **Wong<sup>37</sup>**
  - Study involving young medical patients



# American Academy of Pediatric Dentistry

## Consider:

- other behavior management techniques
- dental needs of the patient
- effect on the quality of care
- patient's emotional development
- patient's considerations
  - ALSO: documentation and informed consent<sup>30</sup>



# American Academy of Pediatric Dentistry

## Objectives

- reduce/eliminate untoward movement
- protect patient and staff
- facilitate treatment

## Indications

- require immediate tx & dx; cannot cooperate due to lack of maturity or mental or physical disability
- when the patient and/or dentist would be at risk without immobilization<sup>30</sup>



# Southern Association of Institutional Dentists

## Characteristics of a Dental Restraint

- short duration
- limits movement of head, body & extremities
- prevents injury to patient and staff
- generates enough physical control to allow treatment
- is usually well tolerated by the patient<sup>5</sup>



# Colorado State Board of Dental Examiners

- **Training requirement beyond dental school**
  - **may include a residency, graduate program or extensive continuing education course that involves both didactic and experiential mentored training**



# Shuman and Bebeau (1994)

1. The restraint is necessary for safe, effective treatment.\*
2. The restraint is not for punishment or the convenience of staff.\*
3. The least restrictive alternative is used.\*
4. The restraint should cause no physical trauma and minimal psychological trauma.\*
5. Reasonable benefits are expected as a result of the treatment.<sup>13</sup>

*\*(Shuman & Bebeau cite Fenton SJ. Revisiting the issue of physical restraint in dentistry. Spec Care Dent 1989;9:1863 for recommendations 1-4.)*



# Shuman and Bebeau

6. There is consent for the dental treatment.
7. There is consent for the use of the restraint.
8. The restraint is specifically selected based on the planned treatment.
9. The dental staff is trained in the safe use of the restraint.
10. Restraint use is clearly documented, including type, duration, and reason for use.<sup>13</sup>



# Fenton, et al (1987)

## ADH ad hoc committee report

- Physical or chemical restraint is a valid treatment modality for the non-compliant developmentally disabled patient.
- When using restraints, the least restrictive alternative should be employed.
- Physical or chemical restraint should not be used solely for the convenience of the dentist or as punishment for an uncooperative patient.<sup>38</sup>



# Fenton, et al (1987)

## ADH ad hoc committee report

- **The restraint must cause no physical injury and the least possible physical discomfort.**
- **The reason for use of the restraint, the type of restraint used, and the length of time administered must be documented in the treatment record.<sup>38</sup>**



# Summary of Guidelines

- **Other alternative behavior management techniques should be considered prior to use of restraint**
- **Restraints should not be used for punishment**
- **Restraints should not be used for the convenience of staff**
- **Restraints should not cause physical harm to a patient**
- **Restraints should protect the patient and staff from injury during treatment**



# Considerations:

- **Dental treatment needs (i.e. extent of protocol)**
- **Effect on quality of care (e.g. poor quality restoration on moving patient, standard of care)**
- **Patient's physical condition**
- **Patient's emotional/developmental status**
  - (i.e. level of cognitive function)
- **Avoidance of sedation/general anesthesia and associated risks**



# Documentation should include:

- **Informed consent**
- **Reason for use**
- **Type of restraint**
- **Length of time used**
- **Previous attempts with alternative management techniques**



# Desensitization

- may be considered for some patients with challenging behaviors
- for patients with more severe and profound cognitive deficits, may only serve to calm the patient and desensitize them to the restraint through repeat exposure<sup>39</sup>
- first visit to the dentist serving as introduction, (no actual dentistry is provided)
  - orientation to a new place, to decrease a patient's anxiety on subsequent visits<sup>40</sup>



# Other considerations may include:

- **More restrictive state statutes**
- **Voluntary agency guidelines**
- **Hospital or institutional regulations**



# Professional Attitudes

- **LACK OF TRAINING!**
- **Series of studies during the four years of dental education**
  - **more than half of U.S. dental schools less than 5 hours of classroom presentations**
  - **75% provided 0 to 5 percent of patient care time for the treatment of patients with special needs.<sup>41-45</sup>**



# Professional Attitudes

- Lack of financial reimbursement<sup>46</sup>
- Fear, apprehension <sup>46</sup>
- The Future?

**New CODA standard :**

**“Graduates *must be competent* in assessing the treatment needs of patients with special needs.”<sup>47</sup>**



# Summary

- **No single behavior management technique is appropriate for all patients with special needs**
- **Evaluate all the relative variables**
- **Least restrictive & most effective method**
- **Balance the perceived risk/benefit**
- **Consider patient's past behavior in the dental environment** <sup>48</sup>



# Resources for Professionals

- **Special Care Dentistry**
  - [www.scdonline.org](http://www.scdonline.org)
- **Southern Association for Institutional Dentists**
  - <http://saiddent.org>
- **American Academy of Developmental Medicine and Dentistry**
  - [www.aadmd.org](http://www.aadmd.org)



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