**Dental ethics case 24**

Non-therapeutic cosmetic treatments including Botox

**CASE SCENARIO**

Since my practice has not been very busy recently, I completed a week-end course on how to administer cosmetic and dermal fillers including onabotulinum toxin A (Botox) injections. Are there any regulations related to my scope of practice as a dentist on which I am infringing, and, if it is outside my scope of practice, am I being unethical?

**COMMENTARY**

A fundamental principle of professional ethics in dental care is that the best interests of patients should always take precedence over any consideration of profit or personal gain.¹ Yet for dentistry this poses an obvious problem. Where are we to draw a line between what patients need and what they want? Dentists are in business for themselves and their livelihood, and their ability to meet the needs and wants of patients will depend on a variety of issues and becomes particularly important with regard to elective treatments where there is no dental dysfunction.

This dilemma will be discussed from both a legal and an ethical standpoint. Our legal obligation is defined by the HPCSA and the regulations defining the Scope of the Professions of Dentistry under the Health Professions Act, 1974.² The HPCSA guidance is set out in the following Ethical Rule 21 Performance of Professional Acts:³ “A practitioner shall only perform, except in an emergency, a professional act for which he or she is adequately qualified and sufficiently experienced”. In cases where a practitioner is not adequately qualified and sufficiently experienced, the practitioner “shall not fail to communicate and co-operate with appropriately qualified health practitioners in the treatment of a patient.” The onus is, therefore, on the practitioner to ensure that he or she has had adequate education, training and experience in the performance of any procedure.

Botox is the brand name for a commercially available product that contains botulinum toxin, but is often used as a generic noun for all products intended for cosmetic use containing botulinum toxin. It is a prescription-only medicine and therefore has to be prescribed by a doctor for an individual patient. Botox is a neurotoxin, which can cause problems if not used correctly. Facial paralysis is not unknown and there is concern when Botox therapy is used on young people, in particular, teenagers. Dermal fillers, however, are quite different and do not require a prescription. Theoretically, dermal fillers can be provided by any unqualified member of the public (beauty therapists, etc.). It is generally considered that the current situation is unsatisfactory.

Many dental practices, often as a result of patient enquiries, have started to consider the possibility of providing this type of ‘treatment’ and in some cases deem that the procedures may be something a suitably qualified oral hygienist or dental therapist could undertake. However, it is debatable as to whether the provision of such non-therapeutic cosmetic treatments is actually within the scope of the practice of dentistry. Opinions are varied. If a procedure is unrelated to dentistry and beyond the scope of practice, it cannot be performed by a dentist, no matter what training or certification they have received, and would clearly be illegal and unethical. There is a grey area, then, as to how and under what circumstances the use of onabotulinum toxin A and similar treatments are related to the practice and scope of dentistry.

It may be argued that cosmetic dental procedures involving peri-oral regions such as the lips, cheeks or jaw would be related, but procedures beyond those designated areas would not be considered within the scope of dentistry. In the United Kingdom, the General Dental Council in 2008 ruled that the provision of non-surgical cosmetic procedures, such as Botox and dermal fillers, away from the peri-oral or immediate perioral area, does not constitute the practice of dentistry. The Council is also of the view that ‘alternative or complementary’ therapies that are not provided in conjunction with, or linked to, a patient’s dental treatment, must be provided separately from the dentist’s practice of dentistry.

Furthermore, there has been concern related to the need for formal education and training in cosmetic surgery, the period and full-time nature of the training which should be satisfied if he or she wished to perform cosmetic or plastic surgery, and/or wanted to carry out non-therapeutic cosmetic treatments. The HPCSA October 2009 Statement includes under Cosmetic Procedures the following:

a. “Cosmetic Surgery” be defined as an operative procedure in which the principal purpose is to improve the appearance, usually within the connotation that the improvement sought is beyond normal appearance, and it’s acceptable variations, for the age and the ethnic origin of the patient;
b. cosmetic surgery was always an elective procedure;
c. cosmetic surgery was performed in the main by spe-
cialists in plastic and reconstructive surgery, but may
also be performed by other specialists who have for-
mal structured training, assessment and ongoing pro-
essional development in certain aspects of cosmetic
surgery relevant to those particular specialties;
d. assessment of competence of any such registered
specialist in any particular cosmetic surgical proce-
dure which has not formed part of specialist training
shall be by a training/examination body accredited by
the Board by such training.

Others have argued that suitably qualified and indemni-
fied practitioners may carry out non-therapeutic cosmetic
procedures, but that they should think carefully before
offering them to patients. Dentists need to ensure that
they have appropriate indemnity before providing elec-
tive treatment to improve facial aesthetics.6 Open
the techniques used are almost entirely on an elective base.
The patients who request such treatment tend to be a
self-selecting group with high and sometimes unrealistic
esthetic expectations. Any of these factors may contrib-
ut to these techniques having a higher risk potential for
litigation and malpractice.

The ethical principles of patient autonomy, beneficence,
non-maleficence, justice and veracity are essential to this
debate and should provide practitioners with a basis on
which to make and take professional decisions.5

**Patient autonomy:** patients requesting elective, aesthetic
dental treatment often have a vision of or goal for their care,
and although a patient’s aesthetic goals are important in
treatment planning, a dentist has an ethical responsibility
to evaluate the patient’s needs and to educate the patient
regarding realistic goals and appropriate treatment options.
Patient autonomy, by itself, is not a rationale for treatment.
If a patient has expressed a desire for a particular proce-
dure, there is no ethical violation as long as the procedure
lies within the realm of accepted treatment and the dentist’s
scope of practice. In addition, the patient must understand
the risks, limitations and potential benefits of the proce-
dure.

**Beneficence** is the principle that expresses the concept
that all dentists have the responsibility to provide benefi-
tial treatment, to benefit patients by not inflicting harm, and by
preventing and removing harm. Provision of beneficial treat-
ment requires rigorous and effective education. Clinical
competence is therefore an ethical requirement.6

**Non-maleficence:** The dentist has an obligation to main-
tain an up-to-date level of knowledge and to know when
referral to an appropriate specialist is warranted. The credo
“first do no harm” is even more critical when providing non-
therapeutic cosmetic treatments, since the treatment offers
no direct health benefit.

**Veracity and informed consent:** Veracity requires that
the dentist presents a treatment plan and delivers care in
a truthful manner without false, misleading or deceptive
information. Valid informed consent requires full disclosure
of risks and benefits. Furthermore, the patient’s oral health
care needs, and the clinician’s ability to adequately and le-
gally deliver the care must be discussed in a truthful manner.
The coercion of patients to undergo procedures by misrep-
resenting their value or necessity, or performance of certain
procedures for financial gain in a time of economic downturn
when such procedures are not in the best interest of the pa-
ient, will result in the breakdown of the trust that is inherent
in the dentist-patient relationship.

The HPCSA has cautioned the public against misleading
advertising for cosmetic surgery, and warns practitioners
guilty of misleading advertising that they will be disciplined
by the Council. “We are greatly concerned about the
flurry of advertisements in the print and electronic media
on cosmetic surgery and elective procedures. In some
circumstances, these advertisements are not entirely ac-
curate in that they are based only on these procedures
being successful. Yet, evidence abounds that there are
serious failures at times which are often downplayed or
never mentioned.7 “These advertisements also ignore the
fact that the success of such procedures differ from one
patient to the other based on many individual factors and
prognosis. Some clinical benefits and conclusions that are
normally advertised therefore cannot be said to be accu-
rate without an individual diagnosis and prognosis. These
adverts could then be said to be misleading and deceptive
and therefore against the HPCSA ethical rules.”

The Council has often expressed concern about the increas-
ing involvement of practitioners in procedures for which they
are inadequately trained or qualified to perform. “We are is-
suing a stern warning to all health care practitioners regis-
tered with the HPCSA to refrain from performing procedures
without the required training, qualifications or experience.
This can only compromise patient care and lead to litiga-
tion and professional misconduct processes. Mostly, these
cosmetic procedures should be performed by specialists in
the respective fields”.

Ethical principles justify a dental practitioner’s decision-mak-
ing within the bounds of accepted treatment and their scope
of practice. Their primary responsibility is to respect the
patient’s rights, do no harm, do good, be fair and be truthful in
the management of their patients.

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Readers are invited to submit ethical queries or dilemmas to
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