Outline

Many complaints about dental care can be traced back to communication problems both in the surgery and at reception. Drawing from examples of actual complaints, this presentation will look in detail at the role of each and every team member in three of those key conversations, which have been impacted by recent changes in UK law. They are:

- The discussions of ‘material risks’ that take place as part of the consent process – we will examine the background to, and practical implications of, the 2015 Supreme Court decision in the “Montgomery” case which now applies throughout the UK.
- The communication that must take place regarding adverse events and outcomes – we will examine the ethical (professional) and legal (statutory) duty of candour in the light of the 2014/15 changes in the law in England (2016 in Scotland), and the GDC’s own guidance.
- Discussions regarding the cost of treatment – in relation to which both ethical and legal obligations need to be satisfied. This will touch upon the 2015 reforms of relevant consumer law and also the concerns raised by the Consumers Association (Which?) and the Office of Fair Trading in recent years.

Learning objectives:

1. To explain the difference between ethics and laws of various kinds, and which members of the dental team are accountable for adhering to their requirements. Saying that you didn’t know or fully understand is no defence.
2. To explain the “Montgomery” decision and its practical implications for the information that patients need to be given before seeking their consent to dental treatment
3. To explain the legal and ethical aspects of the duty of candour, and to help each individual participant to understand which aspect(s) apply to them now and in the future.
4. To enable participants to understand how to avoid complaints and other dento-legal problems relating to the management of the financial aspects of dental care.

About the speaker

Kevin Lewis qualified from The London Hospital in 1971. He spent 20 years in full time general dental practice and 10 further years practising part time. He was the Dental Director of Dental Protection for 16 years up to June 2016 and also an Executive member of the Council (Board of Directors) and senior management team of the Medical Protection Society.

Kevin has been writing a regular column in the dental press since 1981 – originally as the Associate Editor of Dental Practice and since 2006 as the Consultant Editor of Dentistry magazine. He still writes and lectures regularly all over the world, and has been awarded honorary membership of the British, Irish and New Zealand Dental Associations.
Introduction

The three “essential conversations” that are discussed in this presentation will involve most (if not all) members of the dental team, directly or indirectly.

Unless these conversations happen as they are intended to, we will see that in some cases a dentist or practice owner can face criminal charges, in others a potential GDC Fitness to Practice investigation (for anyone who is GDC-registered) because the GDC guidance makes it clear that these conversations must take place. In all cases a failure to have these conversations can affect the practice’s reputation and lead to patient dissatisfaction and sometimes angry patients who are determined to take things further. Increasingly, patients enlist the support of newspapers, and digital media of all kinds (including social media) to share their bad experiences and this can do enormous damage to your practice and its reputation.

On the other hand, if a practice makes a real effort to make these three conversations as effective as possible, and every member of the practice team understands their importance, they can act as a springboard to happy patients who respect and value the practice and the practice team more than ever. This in turn can help you to retain satisfied, appreciative patients, who recommend their families and friends to come along.

These three conversations have a particular importance not only because the law has changed in the last couple of years in relation to all of them, but also because they have a particular tendency to generate strong feelings on the part of patients. Strong enough to lead to complaints, and by drawing from some actual complaints we will get a glimpse into how the patient is feeling and what has made them so angry. Complaints that suggest that these crucial conversations have not taken place, are more likely to be brought to the attention of the GDC and when they get there, are more likely to be viewed seriously.

Law and Ethics

Although the terms are often lumped together, there are important differences between law and ethics. It is important to understand these differences in order to properly understand the three conversations which are the subject of this presentation, as well as how things like professionalism, professional guidelines and standards fit in, and where and how the GDC sits within the overall picture.

The law is necessarily prescriptive and often very tightly drafted and detailed. It deals with specific issues for a specific range of purposes, usually with a particular aim in mind. On the other hand, ethics tends to consist of much broader, higher level guiding principles which can help us to choose the right path and make proper decisions in situations where the law itself doesn’t provide us with the answers we need.
However, as illustrated in the above diagram, there are areas of overlap between law and ethics. And in the middle (where the two circles overlap above) there are many things we do that simultaneously satisfy both ethical and legal requirements – and knowing how to reach that safe ground is what this presentation aims to achieve.

The Law takes many forms. Firstly, ‘statutory’ law like

- Acts of Parliament – either in Westminster or in Holyrood
- Regulations (which draw their power from an Act of Parliament)
- Statutory Instruments which update and amend Acts and Regulations.

We will discuss several examples of these. But the English and Scottish legal systems, while separate and distinct, share similar roots in “common law” and principles of fairness and equity in the dealings within society between people and organisations, in situations where no Act or Regulations have been broken. Some of these basic principles stretch back many centuries. Civil law is partly based on these principles and consistency is achieved by referring to previous (“precedent”) cases and how they dealt with similar issues and situations, while also allowing this kind of law to respond to changes in society and evolve appropriately. In this way, a series of cases has gradually changed the law relating to consent in this country, up to and including the “Montgomery” decision of the UK Supreme Court early in 2015 (which we will discuss shortly).

‘Tort law’ in England and ‘Delict’ in Scots Law have their roots in common law and clinical negligence is an example of this kind of law. It is a civil (as opposed to a criminal) “wrong” that one party (or parties) does to another. The offence committed by the wrongdoer is harm caused against one or more people or an organisation rather than against the State or society as a whole. There is a pre-requisite that the wrongdoer owes a “duty of care” (see below) to the other party.

Ethics is different, and is essentially a voluntary framework of guiding principles which helps to bring order and purpose into what would otherwise be a gap between the fine detail of very precisely written laws, on the one hand, and a complete free-for-all on the other. Because they lack the obvious statutory power of laws and regulations, ethics have been described as “allegiance to the unenforceable”. In the case of dentistry, this is not strictly true because the General Dental Council (GDC) has the power to suspend or remove a dentist from the Dentists’ Register in a variety of situations where no law has been broken.

Laws will sometimes specify who is responsible for complying with them, and in some cases the range of penalties for not doing so. But it can also be an offence to assist someone else when they are breaking the law. The GDC’s legal authority stems from the Dentists Act 1984 and various Amendment Orders (Statutory Instruments) passed by Parliament since then to amend that original Act. This is the legal framework that gives the GDC powers to make and
apply Rules (eg for Fitness to Practice or CPD) and to publish Guidance. Failing to follow that Guidance is not in itself a criminal offence, but it allows the GDC to use its statutory powers and agreed procedures to apply an appropriate sanction, the aim being to maintain professional standards and thereby keep the public safe. The legal framework makes provision for different levels of departure from the standards deemed acceptable by the GDC, such as “misconduct” which means a gross or serious departure from the reasonable professional standards expected by the GDC. In Fitness to Practise cases, the GDC can take certain actions (such as issuing advice, or a formal warning and perhaps publishing this openly) if it has concerns, but it cannot apply a sanction which interferes with your continued registration and/or right to practise, without a Professional Conduct Committee first making a finding of misconduct. The only exception to this is when an Interim Orders Committee decides, when it believes that public safety might be at risk, to suspend an individual’s registration as a precautionary step while the allegations are being investigated.

Dishonesty in its various forms, is generally regarded as “misconduct”. In recent years the GDC has interpreted many kinds of misleading/deceptive behaviour, as demonstrating dishonesty. This is even more likely when coupled with showing a lack of respect for patients and/or their rights, as can be the case if the three “essential conversations” don’t take place. All the more reason to understand what the GDC (and the law) expects of us where these important conversations are concerned.

Warning patients about MATERIAL RISKS as part of the consent process

“I start with the proposition that the law which imposed a duty to warn on a doctor has, at its heart, the right of a patient to make an informed choice as to whether, and if so when and by whom, to be operated on”

Sir Denis Henry - Court of Appeal decision (UK) Chester v Afshar [2004] UKHL 41 Paragraph 86

This ground-breaking case happened to arise in the UK (in England), and happened to involve a medical practitioner. But in country after country around the world, the courts are stepping in to swing the pendulum very much in favour of the patient when matters of consent are under discussion. In the above case, the panel of Judges sitting in the House of Lords concluded that the normal application of the well-established principles of tort law would result in the clinician being found not guilty of negligence – so they departed from traditional principles in order to find him guilty (food for thought?) because they wanted to emphasise that the patient’s right to self-determination and autonomy is a fundamental principle and an important point of ‘public policy’.
When dental professionals are trained, consent is usually taught as part of a law and ethics curriculum. The background of the personnel providing this training will largely determine where the emphasis is placed; sometimes the legal aspects of consent tend to dominate discussions, while on other occasions the teaching is left to someone with no formal legal training, and here the emphasis is often very clinically and practically focused and simplistic in nature. At both extremes, but for different reasons, the process of obtaining consent from individuals can soon become more concerned with getting a signature on a form or protecting an individual or an institution.

A signature on a ‘consent form’ is not in itself a reliable indication that a patient has actually understood any of the issues involved – even if they state that they have or indeed have given consent for a procedure to take place. The reason is for this is that consent is not about the legal protection of those providing treatment. It is actually a communication process and a reflection of patient autonomy. Consequently, any consent form used should simply be regarded as one small part of the overall record of the communication that has taken place between patient and clinician in advance of treatment. It is worth noting that Ms Chester, the patient in the Chester v Afshar case, had signed the hospital’s “approved” consent form.

**What is consent?**

Many definitions have been suggested, but the one reproduced below is a useful starting point and contains all the necessary ingredients that we need to consider for our present purposes:

“The voluntary and continuing permission of the patient to receive a particular treatment. It must be based upon adequate knowledge of the purpose, nature and likely effects and risks of that treatment including the likelihood of its success and any alternatives.”

The eight key points to consider in this definition are:-

a) Voluntary - a free choice made in the absence of any kind of undue influence  
b) Continuing - a consent given for each occasion when treatment is proposed  
c) Particular – a specific consent for a clearly specified procedure, to be carried out by a specific person on a specific occasion  
d) Purpose (why is it needed?) and Nature (what does it involve?)  
e) Likely effects (what can I expect/how will I feel if things go to plan?)  
f) Potential Risks (what else might happen and how might this affect me?)  
g) Likelihood of success (what would qualify as “success?”)  
h) Alternatives (what if we did nothing at all, or something different?)

In order to obtain a valid consent there are some essential first steps

i) in relation to satisfying yourself as to the person’s authority to give consent (most commonly in relation to treating minors/children but also relevant when someone other than the patient is giving consent on behalf of an adult patient who is not able to give a valid consent in person at the relevant time).

ii) in relation to the person’s competence to understand the above considerations and give a valid consent – this involves all the issues covered by the Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act in England.
These issues are beyond the scope of this presentation. Here we are concerned specifically with the information that is given to the patient when seeking their consent – covering points (d)-(h) incl in the above list – and particularly (e) and (f). An effect or risk that a clinician might consider trivial, remote or routine, may be viewed very differently (and with much more concern) by a patient.

For many years, clinicians were on safe ground if they warned the patient about the likely effects and risks of a procedure, to the extent that would be considered reasonable by other clinicians in the same position (in latter years this would have been informed by the evidence base).

This position flowed from a landmark Scottish judgement back in 1955 in the case of Hunter v Hanley. In order to establish liability (delict in Scotland, which is equivalent to negligence under English law) in circumstances where deviation from normal practice is alleged, three facts have to be established in order for a breach in a clinician’s duty of care to have occurred:

1. It must be proved that there is a usual and normal practice;
2. It must be proved that the defender has not adopted that practice; and
3. It must be established that the course the professional had adopted is one which no professional person of ordinary skill would have taken if he/she had been acting with ordinary care.

While different in its detail, it is broadly equivalent to another landmark (English) judgement two years later (1957), in the much-quoted case of Bolam v Friern Hospital Management Committee. The Judge (McNair J) said of the clinician in that case: “I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art”.

This ‘Bolam principle’ (as it came to be known in countries following British law) may seem a little too cosy and paternalistic in today’s world, and weighted very much in favour of the medical (and dental) profession. Looked at through the eyes of the patient it feels like the profession was being given carte blanche to close ranks to protect each other. For precisely that reason, and reflecting the rise of consumerism and patients’ rights around the world, one country after another has since taken the opportunity to swing the pendulum back towards the patient, when suitable cases have arisen to make that possible. The diagram below helps to illustrate this progressive shift:-
The first stage in the shift from the Hunter or Bolam standard or “reasonable clinician” position(1) was to require clinicians to give the warnings that any “reasonable person” in the patient’s position would want and expect to be given (2) - a Canadian consent case was the first to reject ‘the Bolam Principle’ and move to this very different position. But at the higher level of expectation (3) that was first defined in 1992 in the important Australian High Court decision in the case of Rogers v Whitaker, even this is not sufficient – here the clinician must consider the specific, individual patient and their particular circumstances rather than routinely giving them the same warnings that they might give to any other patient. Herein lies the danger of “standard” warnings and “one size fits all” consent forms, even though NHS employees (for example) are even today required to use standard consent forms issued by their employing Trust/Health Board. In the absence of a meaningful understanding by the patient, even a signed consent form may not be worth the paper it is written on (so to speak) as evidenced by the case of Chester v Afshar.

In a series of decisions over the intervening years, UK law has chipped away at the “Bolam” principle in relation to consent, mostly by finding ways to question or challenge the “reasonableness” of the “body of opinion”. But in the case of Montgomery v Lanarkshire Health Board [2015] UKSC 11 the UK Supreme Court made a decision that is binding across the whole of the UK, even though this was of course a Scottish case which was determined under Scots Law. The court ruled as follows:-

A patient must be warned of all material risks. The test of materiality is whether,

“In the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or

the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”

The first half of this statement takes us to step (2) in the above diagram, and the rest continues the journey up to step (3). In fact the wording is identical to that used in the 1992 Australian case. In practical terms, what is expected of you is only taken all the way to step (3) when you are treating a patient whose situation is in some way different from any other “reasonable person in the patient’s position”. But how well do you know the patient, and how confident are you that you know which risks each particular patient would attach significance to? This creates particular challenges (and dangers) when you are treating patients that you don’t know very well. In the post-Montgomery era, the law now expects you to invest more time and effort in understanding the patient and considering the risks individually in the context of what you know (or should reasonably be able to find out if you spend the time and ask the right questions) about the patient. Of course, “attaching significance” to a risk does not automatically mean that it would lead the patient to decline the procedure in question – but they are entitled to have the information so that they can weigh the risks against any benefits they hope to achieve by undergoing the procedure.

What the GDC expects

Ironically perhaps, the Montgomery decision simply brings the law into line with the GDC’s longstanding guidance as currently published in Standards for the Dental Team and consistent with previous guidance stretching back many years. All registrants should be familiar with this guidance, but by way of illustration, here are just a few extracted paragraphs (please note that the sections quoted below have been chosen for the purpose of these handouts and are not comprehensive) :-
1.7.1 You must always put your patients’ interests before any financial, personal or other gain.

- avoid any suggestion that you have failed to warn a patient about a material risk, because you did not want them to decline treatment or go elsewhere.

2.1 Communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account

2.1.1 You must treat patients as individuals. You should take their specific communication needs and preferences into account where possible and respect any cultural values and differences.

2.1.2 You must be sufficiently fluent in written and spoken English to communicate effectively with patients, their relatives, the dental team and other healthcare professionals in the United Kingdom.

2.2 Recognise and promote patients’ rights to and responsibilities for making decisions about their health priorities and care.

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each.

2.2.2 You should encourage patients to ask questions about their options or any aspect of their treatment.

2.2.3 You must give full and honest answers to any questions patients have about their options or treatment.

2.3 Give patients the information they need, in a way they can understand, so that they can make informed decisions

2.3.1 You should introduce yourself to patients and explain your role so that they know how you will be involved in their care.

2.3.2 Other members of your team may have valuable knowledge about the patients’ backgrounds or concerns so you should involve them (and the patients’ carers if relevant) in discussion with patients where appropriate.

2.3.3 You should recognise patients’ communication difficulties and try to meet the patients’ particular communication needs by, for example not using professional jargon and acronyms;

2.3.4 You should satisfy yourself that patients have understood the information you have given them, for example by asking questions and summarising the main points of your discussion.
2.3.5 You should make sure that patients have enough information and enough time to ask questions and make a decision.

3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs

3.1.1 You must make sure you have valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members have already seen them. Do not assume that someone else has obtained the patient’s consent.

3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

- options for treatment, the risks and the potential benefits;
- why you think a particular treatment is necessary and appropriate for them;
- the consequences, risks and benefits of the treatment you propose;
- the likely prognosis;
- your recommended option;
- the cost of the proposed treatment;
- what might happen if the proposed treatment is not carried out; and
- whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.

3.1.4 You must check and document that patients have understood the information you have given.

3.1.5 Patients can withdraw their consent at any time, refuse treatment or ask for it to be stopped after it has started. You must acknowledge their right to do this and follow their wishes.

You should explain the consequences or risks of not continuing the treatment and ensure that the patient knows that they are responsible for any future problems which arise as a result of not completing the treatment. You must record all this in the patient’s notes.

3.1.6 You must obtain written consent where treatment involves conscious sedation or general anaesthetic.

3.2 Make sure that patients (or their representatives) understand the decisions they are being asked to make

3.2.1 You must provide patients with sufficient information and give them a reasonable amount of time to consider that information in order to make a decision.
3.2.2 You must tailor the way you obtain consent to each patient’s needs. You should help them to make informed decisions about their care by giving them information in a format they can easily understand.

3.2.3 When obtaining consent, you should encourage patients who have communication difficulties to have a friend, relative or carer with them to help them ask questions or understand your answers.

3.2.4 You must always consider whether patients are able to make decisions about their care themselves, and avoid making assumptions about a patient’s ability to give consent.

3.2.5 You must check and document that patients have understood the information you have given them.

3.3 Make sure that the patient’s consent remains valid at each stage of investigation or treatment

3.3.1 Giving and obtaining consent is a process, not a one-off event. It should be part of ongoing communication between patients and all members of the dental team involved in their care. You should keep patients informed about the progress of their care.

3.3.2 When carrying out an on-going course of treatment, you must make sure you have specific consent for what you are going to do during that appointment.

3.3.3 You must tailor the way you confirm ongoing consent to each patient’s needs and check that patients have understood the information you have given them.

3.3.4 You must document the discussions you have with patients in the process of confirming their ongoing consent.

Practical suggestions

1. Review the way in which your practice collects, holds and updates personal information about a patient, especially in areas which may impact upon how they might view material risks – for example, their occupation (and hobbies/personal interests) or any important events in the patient’s life. Involve every member of the practice team to make this process as effective as possible.

2. Any discussion of the purpose, nature and likely effects and risks of that treatment, the likelihood of its success and any alternatives, should ideally take the form of a two-way dialogue with the patient, asking them at each stage whether anything you are telling them is causing them any worry or concern and if so, seeking to understand the personal reasons behind those concerns.

3. The treating clinician should lead and take responsibility for these consent discussions, but he/she can be helped by other team members – for example
   • a reception/admin staff member might give the patient an information sheet (and hopefully note this fact in a dated entry in the patient’s records)
   • a dental nurse who is present in the surgery when the risks of treatment are being discussed, can either record those discussions as they are taking place (leaving the clinician free to concentrate on the communication itself), or can act as a backup to help the clinician to ensure that all the key aspects of those discussions have been fully recorded.
4. Information sheets and consent forms can be helpful - but do not fall into the trap of assuming that simply giving patients the information means that they will always have understood it. This is precisely why the term “informed consent” is increasingly viewed as being unhelpful because consent is not just about passing on information. Some patients are helped by having written as well as verbal explanations, but the key to obtaining a legally valid consent is tailoring the information to the individual needs of the patient. This satisfies both the GDC’s requirements and complies with the expectations of the post-Montgomery era.

A standard information sheet and/or consent form may well cover off the general risks of a procedure and satisfy the “reasonable patient” expectation. But it will not always be sufficient to satisfy the “specific patient” expectation because of its inherent generality. Your discussions should examine those risks in the context of the individual patient and their responses, and show that you are doing all you can to tailor the discussions to the individual patient. Your records of those discussions should demonstrate that this additional effort has been made.

5. Invest time in listening to the patient and finding out as much as possible about them, getting to know them and understanding their needs and wants, concerns and expectations. An added bonus of this careful communication is that it develops rapport and patient trust and confidence, minimises the potential for dissatisfaction - and builds your reputation and therefore, subsequent recommendations.

6. Be open and honest with patients about the training, qualifications, experience and expertise of the clinician who is treating the patient, and in terms of what can and cannot be realistically achieved. This honesty must flow through all of the practice’s marketing and promotional material, and include one-to-one conversations and other forms of communication, including written and electronic communication in all its forms (email, practice website, social media etc).

A clinician’s relative inexperience in a procedure may well be viewed as a ‘material risk’ that a patient might well attach significance to - especially if the risks could be significantly reduced if the treatment were to be carried out by a more experienced clinician or specialist. No claims should ever be made about the practice, its people or its services that cannot be substantiated.

Candour is the quality of being open and honest in your dealings with other people. It embraces similar qualities such as frankness, truthfulness, sincerity, directness, straightforwardness and the avoidance of deception and covert (secretive) behaviour. Transparency is another word used to capture the values embodied in candidness/candour, meaning that nothing is hidden from view.

Background
The recent damning HIS criticism of care standards for the elderly at the Queen Elizabeth University Hospital in Glasgow was one of the latest of many scandals in health and social care across the UK. Going back a more few years, the Francis Report following the Mid-Staffs tragedy in England may have been the trigger for political action, but this was hardly the only scandal in health and social care where patients had suffered avoidable harm and lack of care. The events at the Winterbourne View care home, and cases such as “Baby P”, had created a heated and impatient climate in which the government wanted to be seen to have taken radical action. Against this background, the
government of the day in Westminster sensed the public exasperation at the appearance that lessons were not being learned, and its response was to introduce further legislation, although many expressed the view that legislation was not necessary because so much existed already, and it was also a clumsy and usually ineffective way to achieve a change in organisational culture — which was clearly at the heart of what was required. Because every individual registered healthcare professional already had professional conduct guidance to follow, as set by their professional regulator, the Government felt that there were three significant areas of weakness that needed to be addressed:

- The need for organisational accountability, especially in bodies that were owned and managed by people who were not themselves registered health professionals and therefore sat outside the existing professional regulatory environment (GMC/GDC/NMC etc)
- The fact that these organisations employed many people who were not (and who were not required to be) registered with the relevant regulator. A way needed to be found to make somebody responsible and accountable for their acts and omissions other than through the civil courts.
- The government wished to be seen to respond to the public desire that “heads should roll” in terms of criminal accountability for some of the things that had been turned a blind eye to at Mid-Stiffs and Winterbourne View.

It was to some extent a public flexing of government muscle and legislation affecting England and Wales was introduced in 2014 in response to the Francis Report, in particular. This took effect later that year for hospitals, the final roll out (including to primary care dental practices) taking place in April 2015. However, health and social care is a devolved power and the Scottish government made its own legislative changes much later, through Part 2 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016. The stated aim is to implement the changes in order to introduce the Duty of Candour in Scotland with effect from April 2018 but the fine detail is still being worked out.

It is important to note that the detail of the Duty of Candour in Scotland differs in some important respects from the equivalent arrangements in England and Wales. Some of these differences were necessitated by separate legislation which was either already in existence or in the process of being implemented when the Duty of Candour was formally introduced in England – a good example of this is The Apologies (Scotland) Act 2016 (“The Apologies Act”) which came into force on 24 February 2016 and for which there is no direct equivalent in England.

In England the Care Quality Commission (CQC) was quickly identified as a convenient vehicle for implementing and monitoring compliance, and the implementation of the Duty of Candour required little more than some minor amendments to pre-existing Regulations made under an existing Act. Heath Improvement Scotland (HIS) is different in many ways to CQC, and this required more thought in terms of how best to introduce and oversee the Duty of Candour in Scotland. The wording of Part 2 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 is deliberately vague in a number of places, to allow for the fine detail to be worked out in consultation with relevant parties, but there are many sections which are identical or very similar to the wording of the English Regulations.

Things are not made any easier by the fact that all members of the dental profession, whether based in Scotland, England or elsewhere in the UK, have a single professional regulator, the General Dental Council (GDC). The legislation may be different in the various parts of the UK, but the GDC’s
guidance is common to all and is fundamental to the Fitness to Practise procedures. The GDC’s guidance on matters covered by the Duty of Candour (as well as that of the GMC and other healthcare regulators) was reinforced after the new Duty was introduced in England, and already applies to registrants in Scotland even though the statutory (legal) duty is not yet in force.

The duty of candour
This could be seen as having three separate but related elements, not all of which apply to the same people or bodies. These elements are:
- A statutory (legal) duty
- A professional (ethical) duty
- A contractual duty

By way of a simple overview, the table below summarises how these three elements impact upon different types of individual and/or organisation.

<table>
<thead>
<tr>
<th></th>
<th>Statutory (Legal) Duty</th>
<th>Professional (Ethical) Duty</th>
<th>Contractual Duty</th>
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<tbody>
<tr>
<td>NHS Organisations eg Hospitals Health Centres and Clinics</td>
<td>Yes since November 2014 in England. No in Scotland - until the new Duty is implemented (?April 2018)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Other NHS organisations such as NHS Health Scotland, NES</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Responsible Persons (usually an organisation or those owning/operating it - see text for current provisional definition of this term – powers granted to Scottish Ministers to modify this definition as they deem necessary)</td>
<td>Only when the new Duty is formally implemented (?April 2018)</td>
<td>Yes if registrant Otherwise No</td>
<td>Generally no - but some of them will have an NHS contract to this effect</td>
</tr>
<tr>
<td>People who are not owners but who are managing dental practices and the delivery of dental care/treatment services</td>
<td>Only if they are the responsible person (see above) once the new Duty is formally implemented (?April 2018)</td>
<td>Yes if registrant Otherwise No</td>
<td>Possibly</td>
</tr>
<tr>
<td>Other Registrants (eg with GMC, GDC etc) not covered above</td>
<td>No</td>
<td>Yes</td>
<td>Possibly</td>
</tr>
<tr>
<td>Other Individuals who are not registered with GMC, GDC etc</td>
<td>No</td>
<td>No</td>
<td>Probably not</td>
</tr>
</tbody>
</table>
A professional (ethical) duty of candour has long existed for all kinds of healthcare professionals, and this embraced additional members of the dental health team when dental nurses and others became registered with the GDC a decade ago. The ethical requirement is embodied in the professional guidance issued by the various healthcare regulators, and although they use different words and phrases to describe it, and the words also change over time, they amount to more or less the same thing. Indeed, to underline this concerted effort, eight of the healthcare regulators (incl the GDC) even issued a joint statement in October 2015 after the statutory duty of candour had been extended to all health professionals in England.

Many of the paragraphs contained within the GDC’s Guidance Standards for the Dental Team deal with aspects of this honesty, openness and necessary trust between patients and the dental health professionals with whom they interact. At first sight the introduction of a new (legal/statutory) duty of candour was superfluous and simply caught up with what the GDC already expected, but nevertheless the GDC was keen to show its support for the Government’s intended message to healthcare workers and it quickly released the following statement:

“Openness and honesty is vital to ensuring a successful relationship between dental professionals and their patients. GDC guidance already very clearly sets out what’s expected of dental professionals, but we will be working to strengthen this through new guidance.”

This ‘strengthening’ took the form of publishing a new guidance document “Being open and honest with patients when something goes wrong” the latest version of which is downloadable from the GDC’s website www.gdc-uk.org

The statutory duty in Scotland

The necessary powers for the legal duty were introduced by the Scottish government through Part 2 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 which became law in April 2016. Regulations and formal Guidance will follow and the intention is to have all of this in place so that the Duty of Candour can be implemented right across healthcare, social services and other forms of care in Scotland at the same time, the target date being April 2018 or earlier in 2018 if this proves possible. In England there had been a staged roll out starting with hospitals and ambulance services in November 2014 and continuing in April 2015 to include primary care and social care in all is forms. Regular updates and a list of Frequently Asked Questions are downloadable from the Scottish government at www.gov.scot/Topics/Health/Policy/Duty-of-Candour

Under the terms of this new statutory duty, the ‘responsible person’ –see below - needs to make sure that the practice acts in an open and transparent way:

- With relevant people
- In relation to care and treatment provided
- To service users

The English Regulations imposed what is described as a general duty of candour and the hope was that it will change organisational culture. If you are a practice owner, it is your job to use your management influence to create and support such a culture and through your personal leadership, to embed it within the team and that you control and its working practices. The Health (Tobacco,
Nicotine etc and Care) (Scotland) Act deals only (as far as dentistry is concerned) with the legal requirements for the process to be followed in the event of “an unintended or unexpected incident occurring in the provision of a health service” which could lead to one or more of a specified list of “outcomes” which are not an intended or expected consequence of the treatment. The “outcomes” are defined and are broadly similar to those applicable in England, but the detail of the required “Duty of Candour Procedure” in Scotland will be set out in the Regulations when they are published.

It will include a requirement to offer an apology to the patient or relevant person, but in Scotland such an apology cannot be construed as an admission of negligence (delict) or a breach of a statutory duty. This reflects the useful protection bestowed by The Apologies (Scotland) Act 2016 for which there is no direct equivalent in England.

Subject to what any subsequent Regulations might include, there is not yet any indication that the accountability for a “responsible person” who does not comply with the new legal requirements, would include the possibility of a criminal prosecution in Scotland. If that proves to be the case, this would be a highly significant difference from the Duty of Candour in England, where the relevant section is one of seven standards defined within the new Regulations that carry risk of a criminal prosecution with no prior notice being required to be given by the overseeing body (the CQC). Any conviction would carry a modest fine but also an automatic referral to the GDC as well as the associated adverse media attention. Standard 6.6.3 of The GDC guidance makes it clear (see below) that it will hold those in management positions responsible if they obstruct the principle of candour.

The diagram below conveniently summarises the required process as it currently exists in England. The final shape of the required procedures in Scotland may differ in key respects and terminology but it is already clear from the wording of Part 2 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 that most of the same ingredients will be used – even if the final recipe is different!
Who would the “responsible person” be in a typical dental practice?

The Act defines eight possible “persons” including—somewhat confusingly:

“a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service”, or

“a person (other than an individual) providing an independent health care service mentioned in section 10F(1) of the 1978 Act” (in turn meaning the National Health Service (Scotland) Act 1978).

However, the FAQs provided by the Scottish Government on its website states that in a GP (medical) practice, for example, it will be for the GP practice itself to determine who should be the responsible person. It goes on to explain that “Discussions with Scottish Government Primary Care Division and stakeholders will inform guidance about approaches to be taken in respect of GP practices and NHS Boards.

Elsewhere in the same FAQ resource, discussing primary care settings, it states that “It will be up to the responsible person (the organisation) to develop and implement processes and systems that support the activation of the procedure and to report on it effectively”. All of this suggests that, as in England, a framework will be provided by means of the wording of Regulations, supplemented by Guidance, and then each individual practice/organisation will work out how best to satisfy these basic requirements within the context of its own particular setting and resources.

What kind of incident triggers the “Duty of Candour” procedures in dentistry?

Any unintended or unexpected incident that in the opinion of a registered dentist or relevant dental health professional, results in or could result in one of outcomes listed below. The outcome would only be ‘notifiable’ thereby triggering the procedure if it relates directly to the incident rather than to the natural course of the illness/condition for which treatment is being provided.

The outcomes are (subject to any further modification deemed necessary by Scottish Ministers when producing Regulations for this purpose)

- The death of the person
- “Severe harm” (defined as a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions).
- Harm which is not “severe” but which results in
  - An increase in the person’s treatment
  - Changes to the structure of the person’s body
  - The shortening of the person’s life expectancy
  - An impairment of the person’s bodily, sensory, motor, physiologic or intellectual functions which has lasted or likely to last for a continuous period of 28 days or more.
  - The person experiencing pain or psychological harm which has lasted or likely to last for a continuous period of 28 days or more.
- The person requiring treatment by a registered health professional in order to prevent
  - The death of the person
  - Any injury to the person which if left untreated would lead to one or more of the outcomes mentioned above
**Reporting**

One section of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 which differs slightly from the equivalent provisions in England relates to Reporting. The responsible person is required to produce an annual report on the duty of candour incidents and how they were dealt with. The emphasis is on learning and implementing changes and improvements where indicated and evidence of that would be expected.

Such a report must not mention any individual by name or otherwise identify them, and can be in whatever form the responsible person deems appropriate, but is required to be submitted to HIS in the case of an independent health care service such as a primary care dental practice.

**As ever, the devil is in the detail and you should make sure that you familiarise yourself with both the Regulations and Guidance that the Scottish Government will be publishing in due course.**

If it is self evident that the wrong tooth has been treated, or the wrong tooth extracted, it is perverse to suggest that an apology offered at the time and an acceptance of the error by the clinician could be construed as anything other than a good thing. Assuming of course that the clinician realised at the time what has happened – which is not always the case.

On other occasions a clinician may have extracted a tooth as indicated by a referring dentist, but always wondering why the tooth was being extracted at all. Here there is clearly an element of vulnerability on the part of both clinicians if an incorrect tooth has ended up being extracted, and the error may not be immediately apparent on the day of the extraction. But as soon as it comes to light, the statutory duty is triggered for the owner of one or both practices.

There is an abundance of evidence that people sue primarily because they are angry or feel let down. The risks of complaints and litigation initiated by patients and family members are strongly influenced by

- whether or not they like you
- whether or not they think you like them
- whether or not they think you care (enough) about them and / or are (sufficiently) interested in them
- whether or not they trust and respect you and believe that you have their best interests at heart
- how important / special / valued / respected you make them feel

Many of the elements that make people angry are not related to the adverse event directly, but things like:

- Information being withheld from them by people they had respected and trusted
- No one telling them what happened – and what is going to happen.
- No one acknowledging their distress and apologising – the magic “Sorry” word.
- No one telling them what has been learned from what happened to them, so that the same thing is less likely to happen to somebody else.

Professor Lucian Leape, of Harvard School of Public Health and previously Professor of Surgery and Chief of Pediatric Surgery at Tufts University School of Medicine in the USA is an acknowledged
leader in the field of patient safety and the management of medical error. He has commented: “Pretending that nothing happened, or telling about it in incomplete ways, is lying. Apologise when you make a mistake and accept the consequences. If we did it more, they would be fewer.”

It is important that a patient is told quickly that something has gone wrong, with no attempt to deceive them or keep relevant facts from them. You want them to hear about it first from you, rather than from someone else, and for them to be in no doubt that you genuinely care for them and for their well-being and are concerned for them and want to help them through the event. Similarly, when something has gone wrong from the patient’s point of view, it is important to see the patient quickly to discuss their concerns. This may be why patients react so angrily when they find out about a buried root or a fractured and retained endodontic instrument from a subsequent treating clinician. There is then the compounding effect of the adverse outcome and the feeling of not being told, or possibly even lied to.

Having said that time is of the essence, you still should take the time needed to prepare yourself for the conversation. It is often said that there are always TWO direct victims to an adverse medical event - the patient and the clinician involved. So you need to give yourself time to settle yourself, gather such information as is immediately available and think about what you are going to say, how you are going to say it, where you’re going to say it, who you are going to say it to (especially if the patient is not in a state to receive the information) and who you think should be with you when you’re saying it.

After the initial explanation of the situation, the conversation could continue along the lines of: “I can appreciate how distressing this is for you. This is not the outcome that either of us hoped for or expected. I’m terribly sorry this happened to you.” The next sentence should be to ask, “What’s your understanding so far about what happened?” This enables you to find out what the patient knows or may have been told already.

If what they have been told is wrong, you can gently correct it. (“I can understand why s/he thought that, but since then we’ve been able to establish that...”). But if you don’t ask that question, they may be confused – and angry – that different people seem to be telling them different stories. The sooner you and the patient are “on the same page” in understanding what has happened, the better.

It’s important that the information you provide is factual. Don’t assume or guess. If you don’t know what happened or how it came to happen, just say so, and then tell the patient that you will find out, and as soon as you know you’ll let them know.

**In Summary**

- Most patients realise that accident do happen. They want and expect honesty and respect, not perfection.
- Wrong is wrong even if everyone is doing it. But right is right even if nobody is doing it.
- Treat patients as you would want other health professionals to treat you and members of your own family.
- Studies have shown that as many as 97% of families that are hurt by medical errors and know who was responsible for the injury, don’t sue. There is a wealth of evidence to support the premise that patients tend not to sue or complain about health professionals that they like, and who show respect, compassion and care for them. So the very thing that most people worry most about in terms of candour and open disclosure, is itself founded on a myth.
**Background**  This issue is hardly a new one. It keeps re-surfacing partly because most NHS patients have to pay charges when they see a dentist, but not when they see a doctor or visit a hospital. This immediately makes dental treatment feel more like a ‘commercial’ transaction. Add to this the fact that (since 1990) the mixing of NHS and Private treatment is commonplace in primary care dentistry, which also happens in an optical and pharmaceutical setting but much less so in a medical GP practice and very rarely at your local hospital. With the commissioning and contracting system placing an artificial ceiling on NHS earnings, and clawbacks being more draconian than in the early days, practices may look more towards private income to make their practice sums work and to grow their practices.

Every NHS dental (patients) charges system devised since charges were first introduced 65 years ago, has created winners and losers. For the losers, the natural target for their disaffection and desire for redress is not the government of the day, but the person who is asking them for the money. Given that patients charges are effectively income collected free of charge by dental practices on behalf of the government, it seems doubly unfair that dentists always get the blame when costs disputes arise.

The current percentage system is at least simpler in one sense than some of the previous arrangements but it is a high percentage of the total NHS fee and this, plus the fact that the slightest change in the treatment changes the total fee and the patient’s charge, leads to some difficult conversations, some disgruntled patients and (inevitably) some complaints.

Way back in November 2001 the Consumers Association (CA) took advantage of its newly-granted powers to make its first-ever “super-complaint” to what was then the Office of Fair Trading (OFT) (this no longer exists and its functions have been split across several agencies, including the new Competition and Markets Authority-CMA). The subject of the “super-complaint” was their serious concerns over a lack of transparency in the pricing of dental treatment, and a lack of clarity over NHS vs Private treatment. The (then) Prime Minister Tony Blair had famously promised – at the height of the NHS dentistry access crisis – that every patient who wanted an NHS dentist would have one by October 2001. When that deadline arrived it was clear that this hadn’t happened but yet again much of the blame was conveniently deflected towards the “greedy” dental profession.

The OFT investigated the CA’s super-complaint the following year and reported (amongst other things)

- A lack of pricing transparency in the provision of private dental treatment (in particular, it criticised the lack of signage/posters/price lists and other sources of information displayed at dental practice premises)
- A lack of clarity and openness by dentists regarding the likely cost of treatment, in advance of that treatment – in connection with both NHS and Private treatment.
- Confusion on the part of patients as to whether treatment was being provided on the NHS, or privately
Concerns that the lack of NHS treatment availability, especially in some parts of the country, was having an adverse impact on competition in the provision of private dental treatment (ie patients/consumers had little option but to have treatment done privately despite the fact that they felt “entitled” to NHS treatment)

The GDC took the opportunity to strengthen its guidance when “Standards for Dental Professionals” replaced “Maintaining Standards” in May 2005. Throughout this decade, there was much media attention with the Daily Mail, The Times and the Guardian leading the way – invariably critical of the dental profession. Stories of “rip-off” and “greedy” dentists abounded, often using the well-tried formula of an investigative journalist visiting a number of practices and comparing their widely different treatment plans and estimated costs, and occasionally using covert recording devices.

Meanwhile, there were other developments taking place.

The Consumer Protection from Unfair Trading Regulations 2008

These Regulations (sometimes known rather confusingly for healthcare professionals as “the CPRs”) came into force in May 2008 and they implemented an EC Directive (the Unfair Commercial Practices Directive). They were introduced under the Consumer Protection Act 2008 which was designed “To promote a fair, accessible and sustainable marketplace for consumer products and services and for that purpose to establish national norms and standards relating to consumer protection, to provide for improved standards of consumer information, to prohibit certain unfair marketing and business practices, to promote responsible consumer behaviour, to promote a consistent legislative and enforcement framework relating to consumer transactions and agreements.”

The stated aim of the CPRs 2008 was to prohibit unfair and misleading trading practices – both by act (what you do and say) and omission (what you fail to do and say) which cause or are likely to cause “the average consumer” to take a different decision to that which they might otherwise have done. Included here are acts and omissions which are deceptive and misleading due to some aspect of how information has been presented to the consumer. It includes

- Any kind of misleading information
- Any action which creates confusion with competitors’ products or services
- Failing to honour firm and verifiable commitments (including those set out in any Code of Practice or recognised standards to which you claim to adhere – in the case of the dental profession this would include the GDC guidance)

In September 2011, Which? magazine (the public mouthpiece of the Consumers Association) published the results of research it had carried out in 2010 on private and mixed NHS dentistry. Its reported findings were as follows:-

This research showed that patients don't shop around and lack a comparable source of information they can trust on private dental pricing. In addition, prices are rarely on show in surgeries – only 7 out of 40 visited by our undercover researchers had costs on display. And not enough patients knew about the treatment and cost of dental work in advance of it getting started.
Fewer than half of those questioned (46% of those receiving more than a checkup on a private or mixed private / NHS visit) remembered being given a treatment plan and cost estimate. Only 13% of 1,821 members of the public surveyed, who had private or mixed treatment, recalled getting information about complaining - so we're pleased that the system of redress will be looked at in the OFT study. This study will also focus on how dentistry services are sold and whether patients are given appropriate information to help them choose between dental practices. Our research found that the majority of private patients would switch to the NHS if they could find a good NHS dentist - we know access has improved in recent years so clearer communication on this is required.

In 2001, Which? submitted a super complaint on the private dental market, which was accepted. Positive changes in its aftermath included the setting up of the Dental Complaints Service for private patients in 2006, but many issues, such as lack of clear pricing, still exist.

In May 2012 the OFT published the findings of its comprehensive market study into what it termed “the dentistry market”. The key findings relevant to this presentation (alongside many other findings about direct access, barriers to competitive entry into the market etc) were ;-)

Overview of key findings

1.6 Insufficient information for patients: Dental patients often do not benefit from timely, clear and accurate information to make active, informed decisions regarding their choice of dentist and dental treatment. In particular:

• 39 per cent of NHS dental patients who had been to the dentist in the last two years reported that there were no leaflets or posters providing information on NHS charges at their dentist

• 56 per cent of dental practices that provide some private dental services do not display private fee information at the dental practice reception

• 82 per cent of dental patients who recently received a course of dental treatment that incurred a charge did not receive a written treatment plan.

1.7 We are concerned that effective, timely, sufficient enforcement action against dentists and dental practices is not being prioritised and pursued by NHS commissioning bodies, the Care Quality Commission (CQC) and the General Dental Council (GDC), where dentists and dental practices have breached relevant regulations and/or standards which those bodies each have powers to enforce.

1.8 We are particularly concerned to find that around 500,000 patients each year may be provided with inaccurate information by their dentist regarding their entitlement to receive particular dental treatments on the NHS, and as a result be required to pay more to receive private dental treatment unnecessarily. Evidence gathered by the OFT suggests that NHS commissioning bodies and the GDC need to be far more proactive in identifying and pursuing formal, robust and timely enforcement action against such instances of misconduct where appropriate.

1.9 Sale of dental payment plans: Twenty per cent of dental patients who have joined a dental payment plan as a means of paying for private dental treatment stated that they felt that they were put under pressure by their dentist to sign up to the plan. As a result, such patients are denied the
opportunity to make active, informed decisions regarding how they pay for their dental treatment and may receive poorer outcomes and value for money.

Extracted from Executive Summary OFT Market Study, Dentistry. May 2012

Which? Magazine then launched its “Clean up Dental Costs” campaign, calling for greater proactivity by bodies such as the Government, the Department of Health, CQC, the GDC and the BDA to address the issues and concerns that still appeared to exist despite all the attention drawn to them. By this stage the GDC guidance was already very clear and unambiguous, but it was strengthened even further in October 2013 when Standards for the Dental Team replaced Standards for Dental Professionals.

Most of the reports from OFT, the Consumers Association and groups like the Patients Association have tended to be very England-centric in their terminology but the underlying principles are equally applicable in Scotland.

Once again, by way of illustration, here are just a few extracted paragraphs (please note that the sections quoted below have been chosen for the purpose of these handouts and are not comprehensive):

1.7: You must put patients’ interests before your own or those of any colleague, business or organisation

1.7.1 You must always put your patients’ interests before any financial, personal or other gain.

1.7.2 If you work in a practice that provides both NHS (or equivalent health service) and private treatment (a mixed practice), you must make clear to your patients which treatments can be provided under the NHS (or equivalent health service) and which can only be provided on a private basis.

1.7.3 You must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately. If you work in a purely private practice, you should make sure that patients know this before they attend for treatment.

1.7.4 If you work in a mixed practice, you must not pressurise patients into having private treatment if it is available to them under the NHS (or equivalent health service) and they would prefer to have it under the NHS (or equivalent health service).

2.1 Communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account

2.2 Recognise and promote patients’ rights to and responsibilities for making decisions about their health priorities and care

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must: explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and give full information on the treatment you propose and the possible costs.
2.2.2 You should encourage patients to ask questions about their options or any aspect of their treatment.

2.2.3 You must give full and honest answers to any questions patients have about their options or treatment.

2.3 Give patients the information they need, in a way they can understand, so that they can make informed decisions

2.3.6 You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

2.3.7 Whenever you provide a treatment plan you must include:
- the proposed treatment;
- a realistic indication of the cost;
- whether the treatment is being provided under the NHS (or equivalent health service) or privately (if mixed, the treatment plan should clearly indicate which elements are being provided under which arrangement).

2.3.8 You should keep the treatment plan and estimated costs under review during treatment. You must inform your patients immediately if the treatment plan changes and provide them with an updated version in writing.

2.3.9 You must provide patients with clear information about your arrangements for emergency care including the out of hours arrangements.

2.3.10 You should make sure patients have the details they need to allow them to contact you by their preferred method.

2.3.11 You should provide patients with clear information about any referral arrangements related to their treatment.

2.4: You must give patients clear information about costs

2.4.1 You must make sure that a simple price list is clearly displayed in your reception or waiting area. This should include a list of basic items including a consultation, a single-surface filling, an extraction, radiographs (bitewing or pan-oral) and treatment provided by the hygienist. For items which may vary in cost, a ‘from — to’ price range can be shown.

2.4.2 You must give clear information on prices in your practice literature and on your websites - patients should not have to ask for this information.

2.4.3 You should tell your patients whether treatment is guaranteed, under what circumstances and for how long. You should make clear any circumstances under which treatment is not guaranteed (for example, a lack of care on their part which leads to recurring problems).

2.4.5 If you think that you need to change a patient’s agreed treatment or the estimated cost, you must obtain your patient’s consent to the changes and document that you have done so.
6.6.3 You should encourage all team members, including those not registered with the GDC, to follow the guidance in this document, as well as following it yourself.

9.1 Ensure that your conduct, both at work and in your personal life, justifies patients’ trust in you and the public’s trust in the dental profession.

9.1.1 You must treat all team members, other colleagues and members of the public fairly, with dignity and in line with the law.

Selected paragraphs extracted from Standards for the Dental Team, General Dental Council

This is both detailed and comprehensive guidance, designed to ensure that the GDC is seen to have acted upon the concerns of the CA and OFT. The concern of the GDC tends to get particularly aroused when a complaint includes any allegations that suggest that a member of the public has been misled, misinformed or dealt with in a deceptive or dishonest fashion. Any criminal prosecution involving issues of this nature would similarly be likely to be acted upon and viewed seriously by the GDC.

With this in mind, it is worth noting that yet another legal development took place towards the end of 2015, in the shape of the Consumer Rights Act 2015.

The Consumer Rights Act 2015

This came into effect on 1st October 2015, replacing three major pieces of consumer legislation - the Sale of Goods Act, Unfair Terms in Consumer Contracts Regulations and the Supply of Goods and Services Act. Dentistry is generally acknowledged to be mostly the provision of services, but including a few instances of the provision of goods - either alongside services or otherwise.

Just as with the previous Sale of Goods Act, all products must be of satisfactory quality, fit for purpose and “as described”. The test in each case is what “the reasonable person” would consider satisfactory, given the terms on which the product or service was presented to the consumer. If “high quality” is promised or claimed at the time of sale or supply, then “high quality” is what must be delivered.

Aspects of “satisfactory quality” (in the eyes of “the reasonable person”) also include appearance, durability and freedom from minor defects.

All goods must be fit for the purpose for which they are supplied. They must also be consistent with any description given or implied at the time of purchase. The latter may be important if (for example) a fixed restoration or appliance is not constructed of the material that the contract for services specified, or if a bridge is priced on a “per unit” basis and the fitted bridge comprises fewer units than had been agreed and priced for.

In practice, the Consumer Rights Act 2015 is unlikely to be a heavily-used mechanism for redress by dental patients because they already have access to both NHS and Private complaints mechanisms through which they can seek a full refund – which is the best financial outcome they can expect through the Consumer Rights Act. Under this consumer legislation and in a claim based on an alleged breach of the implied terms of a contract assuming these terms, any claim is less attractive to a patient than a Civil claim alleging clinical negligence (delict), which if successful enables damages to be claimed over and above a simple refund of the sum paid, and for (at least some) legal costs to be recovered. On a ‘belt and braces’ approach, such a claim might include one or more allegations of a breach of contract, the terms of the Consumer Rights Act being automatically implied into every consumer contract. However, one potentially interesting aspect of the 2015 Consumer Rights Act is to make it easier to challenge hidden fees and charges. Now the key terms of a contract for dental services, including price, may be
assessed for fairness unless they are both prominent and transparent. Terms which are not fair or which have not been made sufficiently clear are not automatically binding on the consumer.

Some examples of terms that may be unfair under the Consumer Rights Act include:

- fees and charges hidden in the small print
- something that tries to limit a consumer’s legal rights
- disproportionate default/penalty charges

Ultimately, if agreement is not reached, a court will decide whether or not a term is unfair. If the court decides that a term is unfair the patient may be able to disregard that term and thereby not be liable for the associated cost.

Summary and Practical Tips

1. Quite apart from keeping you on the right side of the law and avoiding the wrath of the GDC, establishing and maintaining a reputation for being open, honest and straightforward in your financial dealings with patients makes good business sense. It takes time and effort to build up trust and patient confidence but this reputation can be alarmingly fragile – time pressures, misunderstandings and assumptions (that somebody else has explained something, or that the patient understood something that they had been told about, when they did not) can undermine trust and confidence at a stroke.

2. Never tell patients anything that is not true, or instruct/allow any member of your team to do so.

3. Do not mislead patients either deliberately or by failing to make something clear accidentally.

4. Have a clear policy in your practice that you are committed to making sure that patients understand their options, know what they need to pay (and when, and how payment can be made). If it is not possible to be precise, as is often the case at the start of treatment, you can

   a) give patients a range of expected costs (from £x to £y)

   b) give them an upper limit, and where appropriate explain that if for any reason as treatment develops this limit might be exceeded, you will update them at that stage. Once you have made this commitment, make sure that you honour it – use your team members to check that this happens.

5. Try to ensure that patients get no surprises where the cost of their treatment is concerned. Knowing in advance when payment will be expected, how much will be due and what payment methods you accept, can sometimes be as important to patients as the total amount involved.

6. Make sure that patients know whether treatment is being carried out on the NHS, or Privately. This is really important when NHS and Private treatment is being mixed, or if a patient may reasonably be expecting to be treated on the NHS (maybe because they have always been an NHS patient or have requested NHS treatment). They may have chosen to attend your practice specifically because you have stated or advertised the fact that you are accepting NHS patients and/or offering NHS treatment. If any part of the treatment is being carried out under the NHS (with certain exceptions other than for new patients) there is a requirement under the NHS Regulations that a Form GP17DC or equivalent is completed and given to the patient whenever treatment is being mixed in this way (and in a number of
other situations). The failure to provide a completed GP17DC is not only a breach of NHS Regulations – it has often been cited in the past as one of the charges in GDC Fitness to Practise hearings, so it is hardly an “optional extra”.

7. Financial disputes are unpleasant, and they sit uneasily alongside the provision of health care. When dentists are involved they make attractive stories for certain parts of the media and are readily seized upon by patient and consumer groups. Make sure that your communication with the patient about treatment costs is consistent, whether in the surgery or at reception, whether face-to-face or on the telephone (or via other channels of communication). Take a pride in managing this aspect of your patient relationships outstandingly well – the key to this is transparency and good communication.

In this presentation we have looked at just three of the many “essential conversations” we need to be having with our patients. We have seen that a lot of legal and ethical/professional conduct developments took place in 2014-2016 which have made these three conversations particularly crucial.

They also share another feature in common - the GDC considers these conversations to be very important, as reflected in the level of detail that the GDC has chosen to provide in its various guidance documents including Standards for the Dental Team. This is because they are ultimately all about demonstrating respect for patients and their right to autonomous decision making. Without good information that they can understand, they are not really being given a fair choice.

Much of the adverse media attention, and campaigning by patient/consumer groups in recent years has been about issues such as this. Publicity about shortfalls in any of these respects - whether in the newspapers, social media or elsewhere – can be extremely damaging. On the other hand, if you are getting things consistently right in these respects, all this media publicity simply serves to make your own patients appreciate you all the more and less likely to go elsewhere.

Every member of the dental team needs to understand the issues we have covered, because they can help to keep every member of the team safe, keeping patients happy and satisfied, and building the reputation and success of the practice.