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Contact the DDU

UK
Advisory 0800 374 626
Membership 0800 085 0614
From a mobile or overseas +44 (0)20 7022 2209
Email membership@theddu.com
Website theddu.com

Ireland
Advisory 1800 535 935
Membership 1800 509 132

Feedback
Managing editor
The DDU
230 Blackfriars Road
London SE1 8PJ

Or post on our website: theddu.com/feedback
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This month, the GDC’s new ethical guidance, *Standards for the Dental Team*, comes into effect and by now you will all have received a copy.

The new guidance is more specific than *Standards for Dental Professionals* and affects areas of dental practice that it did not reach. This is a positive step because in our experience dental professionals want to do the right thing, so they appreciate more information about what is expected of them by the regulator. Indeed, when the GDC reviewed the previous guidance it was criticised in the online questionnaire for being ‘too vague in parts, ambiguous and [lacking] detail’.

*Standards for the Dental Team* takes a more prescriptive approach, setting out the core principles of dental practice, what patients expect from the dental team, the standards that all dental professionals must reach, and providing guidance on how this should be achieved. It warns that failure to meet the standards and ‘serious or persistent failure’ to follow the guidance could see you removed from the register.

In my experience, most dental professionals strive to work in accordance with established practice and guidance but this should not prevent you from applying your own experience, skill or judgment; nor can guidance be expected to cover every eventuality in dental practice.

While you have an ethical duty to ‘provide good quality care based on current evidence and authoritative guidance’, the GDC accepts there may be exceptional situations where it is necessary to deviate from this. This is not a decision to be taken lightly and ignorance of guidelines would be difficult to defend but a reasoned decision to depart from them *in the best interests of a patient*, backed by detailed, contemporaneous records, may be justified. However, we would strongly advise you to discuss the matter with a colleague or seek our advice before taking such a step.

Equally, there will always be finely balanced situations in dental practice, such as when assessing someone’s mental capacity, when even the most experienced practitioner may be unsure of the most ethical path to tread. Again, if you are in doubt about how to proceed in the patient’s best interests, it’s worth remembering that our experienced dento-legal advisers are always available to discuss your concerns and to provide you with guidance, advice and support.

You can read more about *Standards for the Dental Team* and what it means for you in our main feature on pages 4-7. Elsewhere in this issue we have an illuminating analysis of recent complaints reported by members (pages 18-20) and of course we have our usual mix of case studies and dilemmas which draw on the experiences of members.

I hope you enjoy reading this edition of your *Journal*. 
New guidance from the GDC

Standards for the Dental Team

Head of the DDU, Rupert Hoppenbrouwers, reviews the GDC’s new standards, which come into effect on 30 September, and looks at what it means for dental professionals.

Standards for the Dental Team is more comprehensive and prescriptive than the separate guidance booklets which the GDC published some years ago. The new guidance also reflects changes in the profession since then, such as the registration of all dental care professionals and wider developments, for example the growing influence of social media and the Francis Report into Mid-Staffordshire NHS Trust.

Copies of the new document will be sent to all registered dental professionals. The GDC has revised its supplementary guidance on advertising, dental appliances, indemnity requirements and prescribing and there will be two new online guidance documents covering social media and reporting criminal convictions. The supplementary guidance is only available online. This will allow it to be updated easily so that the GDC can make any necessary changes without having to reprint the main standards document. Registrants will not receive paper copies of the supplementary guidance so you will need to familiarise yourself with it online and check regularly for updates. The supplementary guidance has the same status as Standards for the Dental Team and registrants are expected to follow it. Publication will coincide with the implementation of Standards for the Dental Team on 30 September 2013. The GDC is also updating its Scope of Practice guidance following the introduction of direct access for some groups of DCP’s.

Interpreting the guidance

The format of Standards for the Dental Team differs from the GDC’s previous guidance. It is divided into nine parts, each covering one of the GDC’s core ethical principles. Within each principle, the GDC includes a new section setting out what patients expect. While not part of the ethical guidance, these points are worth reviewing because they came from the GDC’s own research and may themselves raise expectations among patients who read the guidance. The document then sets out the standards that dental professionals must attain or risk removal from the register, and goes on to provide further guidance on how these standards can be met. Dental professionals are expected to follow the guidance or be able to justify any decision which is not in line with it. The GDC warns that ‘serious or persistent failure to follow the guidance’ could result in removal from the register.

Throughout the document, the GDC uses the terms ‘you must’ and ‘you should’. The former applies to ‘an overriding duty or principle’, such as standard 1.1 ‘You
must listen to your patients’. The GDC uses ‘you should’ in two ways: to explain how you will meet an overriding duty e.g. ‘you should be aware of how your tone of voice and body language might be perceived’ (in relation to standard 1.2.1); and where a duty does not apply in all circumstances or there are factors outside your control that may prevent you from complying e.g. ‘where possible, you should raise concerns first with your employer or manager’ (paragraph 8.2.3).

Be aware that the term ‘you must’ appears frequently within the guidance sections of the document, implying that the GDC considers compliance with this aspect of the guidance mandatory rather than discretionary. For example, ‘You must discuss treatment options with patients and listen carefully to what they say’ (paragraph 1.1.1, in relation to standard 1.1).

**What's new?**

In our experience, most dental professionals already work in accordance with the GDC’s guidance, especially principles such as putting patients first which have long been central to ethical practice. However, we want to draw members’ attention to some aspects which are new and other themes which are worth exploring in more detail.

**Communication**

The new standards are more detailed about the importance of effective communication in dental practice. Paragraph 2.1.2 says ‘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 UK’.

For the first time the GDC sets out in detail how you should give patients the information they need, in a way they can understand. This includes ‘not using professional jargon and acronyms’ and ‘using an interpreter for patients whose first language is not English’ (paragraph 2.3.3). It also says ‘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’ (paragraph 2.3.4).

If you haven’t already, consider a patient noticeboard for your reception area or waiting room as the GDC now expects you to display more information in an area where it can be ‘easily seen by patients’. This includes the GDC’s nine ethical principles; information about the dental team and their GDC registration (paragraph 6.6.10); a simple price list (paragraph 2.4.1); and your complaints procedure (paragraph 5.1.5).

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**The GDC’s core ethical principles**

1. Put patients’ interests first.
2. Communicate effectively with patients.
3. Obtain valid consent.
4. Maintain and protect patients’ information.
5. Have a clear and effective complaints procedure.
6. Work with colleagues in a way that is in patients’ best interests.
7. Maintain, develop and work within your professional knowledge and skills.
8. Raise concerns if patients are at risk.
9. Make sure your personal behaviour maintains patients’ confidence in you and the dental profession.
Dental charges
Last year, the Office of Fair Trading investigated the dental market and found that ‘dental patients commonly have insufficient information with which to make informed decisions about their choice of dentist and the treatments they receive’ and that many patients ‘may be provided with inaccurate information by their dentist regarding their entitlement to receive particular dental treatments on the NHS and, as a result, may pay more to receive private dental treatment’.

In response, the GDC’s new guidance covers the issue of fees and charges in greater depth under standard 1.7: ‘You must put patients’ interests before your own or those of any colleague, business or organisation’ and under standard 2.4 which states that ‘You must give patients clear information about costs’.

In particular, dental professionals:
• must make it clear which treatments can be provided under the NHS and which privately
• must not mislead patients into believing treatments which are available on the NHS can only be provided privately
• should ensure patients are aware if you work in a purely private practice before they attend for treatment
• must not pressurise patients into having private treatment if it is available under the NHS and they would prefer to have it under the NHS
• must include a realistic indication of cost and whether the treatment is being provided under the NHS or privately in their treatment plan
• must seek patients’ consent to any changes to their agreed treatment or estimated costs
• must ensure that there is clear information on prices in practice literature and on your website, and
• should tell patients whether treatment is guaranteed, under what circumstances and for how long.

Social media
In 2013 the GDC has included new guidance on the ethical use of social media as well as establishing its own presence in social media. Its message for dental professionals is not to post any information about patients on any forum which is identifiable or could be considered derogatory.

Paragraph 4.2.3 states: ‘you must not post any information or comments about patients on social networking or blogging sites. If you use professional social media to discuss anonymised cases for the purpose of discussing best practice you must be careful that the patient or patients cannot be identified.’

The GDC is recognising that users of social media sometimes forget it is a public forum just like any other. If you would not publish something in a journal or tell it to a journalist it is a safe bet that it would also be inappropriate to publish in social media.

Team working
The introduction of direct access means it is no longer necessary for patients to see a dentist before they can be treated by a hygienist or therapist. Detailed guidance about how the dental team should work together is provided under principle 6.

Most significant is the guidance under standard 6.2: ‘you must be appropriately supported when treating patients’ which is stricter than that in Principles of Dental Team working (2006). Standard 6.2 specifically states that ‘you should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting’ and sets out the limited circumstances when this doesn’t apply: out-of-hours emergency, treatment as part of a public health problem, or exceptional circumstances which could not have been foreseen. In a break from its previous guidance, paragraph 6.2.5 makes clear that dental professionals should also be supported by a GDC registrant or appropriately trained professional when providing treatment in a care or domiciliary setting.

The GDC says that if exceptional circumstances do arise, you must assess the possible risk to the patient of continuing treatment. In our opinion, this also means you should explain the risks to the patient, obtain their consent and make a note of this in the patient’s record.
In its previous team working guidance, the GDC said that those who employ, manage or lead a team ‘should make sure that there are arrangements for at least two people available to deal with medical emergencies when treatment is planned to take place’ (paragraph 5.7). The latest guidance is more prescriptive, stating that all dental professionals ‘must make sure that there is at least one other person available within the working environment to deal with medical emergencies when you are treating patients. In exceptional circumstances the second person could be a receptionist or a person accompanying the patient’ (paragraph 6.2.6).

A further point concerning medical emergencies is that the GDC expects you to follow the guidance on medical emergencies and training issued by the Resuscitation Council (UK) (paragraph 1.5.3). This includes a requirement for practices to be equipped with an Automated External Defibrillator.

Finally, in direct response to the recommendations in the Francis Report, the GDC has included a new standard under principle 8 which states that those who employ, manage or lead a team must ‘encourage and support a culture where staff can raise concerns openly and without fear of reprisal’. It also makes clear that ‘gagging clauses’ which prevent staff from raising concerns about patient safety must not feature in employment contracts.

**Patient records**

In its Care Update on dental services, the Care Quality Commission (CQC) found that dental practices were providing very good care. However, it highlighted record-keeping as an area for improvement after 19% of inspections showed that providers had not met the standard for keeping patient records up to date, safe and confidential.

**Reporting criminal proceedings**

Since 2010, dental professionals applying to join the GDC Register have been asked to declare whether they have ever ‘been convicted of a criminal offence and/or cautioned and/or are currently the subject of any police investigations which might lead to a conviction or a caution in the UK or any other country’, and to inform the GDC of any such conviction or caution in the future. The police in the UK will also report to the GDC criminal convictions and cautions against dental professionals.

Now Standards for the Dental Team makes reporting this an ethical requirement: ‘You must inform the GDC if you are subject to criminal proceedings or a regulatory finding is made against you, anywhere in the world.’

**Understanding and complying with the GDC’s new standards**

We have created a new course to look at what the new standards mean for dental professionals. This course provides expert guidance on commonly seen GDC complaints and reviews the benefits of remediation if you are faced with an investigation.

To book, or for more details, visit theddu.com/learn

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**Reference**

1. CQC, Care Update (Issue 2), March (2013)
Practical advice and reassurance are just a call away

Thousands of you call us each year for expert help and support. In most cases, members call us from their workplace, as soon as they encounter a difficult situation. This is ideal because the sooner we get involved, the more likely it is that we can help resolve the matter quickly. We know it’s not always possible or practical to contact us during our usual Monday - Friday hours of 8.30am - 6pm, which is why we’re available 24/7 for members who need urgent advice and assistance.

0800 374 626

Character reference

One of my patients has confided that he is facing a criminal charge and asked me whether I will provide a character reference for his solicitor to use. I have treated the patient for many years and feel I can make some positive comments about him. Should I oblige?

You are under no legal obligation to provide a reference, unless ordered by a court. The GDC might though take the view that every registered dental professional has an ethical obligation to assist in the administration of justice by providing a reference to a patient or the court. It is an entirely personal decision whether you provide a reference or not.

If you decide to provide a reference, it should be on your practice letterhead and include your name, address, profession, professional qualifications and your relationship with the patient, including how long you have known him.

Bear in mind that you could be called to court to give evidence under oath, so ensure the factual information you provide about the patient is correct and consistent with your records, and, where you are only expressing an opinion, make this absolutely clear.

Sign and date the reference and confirm the patient’s agreement by sending him a copy before forwarding it to his solicitor or any other third party. Remember to keep a copy for your records.

The patient’s solicitor may be able to offer further general guidance, but it would not be appropriate for them or the patient to tell you what to include in the reference.

Advice line dilemmas are fictional cases compiled from actual cases in the DDU files and are anonymised to protect confidentiality.
**Joint venture**

A nurse practitioner has approached me about renting a room in my practice to provide cosmetic treatments. I think it could be a good business opportunity for my practice but are there any ethical reasons why I shouldn’t go ahead?

In principle, the GDC would not disapprove of a dentist practising alongside another registered healthcare professional. However, you do need to be confident in the training, skills and professionalism of the nurse practitioner because any problems, such as a poorly-managed complaint, could reflect badly on your practice.

As botulinum toxin is a prescription only medicine (although dermal fillers are not) you need to check whether the nurse has prescribing rights or if she expects you to prescribe the drugs for her to administer, which may present practical difficulties in a busy dental practice. Unlike other prescription only medicines such as local anaesthetic, botulinum toxin is not considered suitable for prescription under a patient group direction and the prescriber would generally need to make a full assessment of the patient and accept responsibility for them.

Even if the nurse has prescribing rights, the Medicines and Healthcare products Regulatory Agency (MHRA) says that they cannot legally order and receive wholesale supplies of botulinum toxin. The MHRA says you would be prohibited from providing advance stocks to a self-employed nurse prescriber as this would be seen as wholesale dealing. You can only supply the drug to the nurse for administration on the basis of a patient specific direction.

We advise you to seek expert legal advice and draw up a written contract with the nurse practitioner says that they cannot legally order and receive wholesale supplies of botulinum toxin. The MHRA says you would be prohibited from providing advance stocks to a self-employed nurse prescriber as this would be seen as wholesale dealing. You can only supply the drug to the nurse for administration on the basis of a patient specific direction. We advise you to seek expert legal advice and draw up a written contract with the nurse practitioner, covering her specific areas of responsibility such as maintaining appropriate registration, professional indemnity, infection control procedures and data protection.

You might want to consider doing everything possible to separate your practice from that of the nurse prescriber. Such separation might include separate practice signs and professional plates, telephone numbers, practice promotion/advertising, entrances, reception and waiting room areas, finances, fee collection, records, and complaints systems.

Injectable cosmetic treatments such as botulinum toxin and dermal fillers are not regulated by the Care Quality Commission so in this instance, there is no requirement to notify them if you decide to go ahead.

Reference 1 MHRA website - www.mhra.gov.uk

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**Non-stop CPD cycle**

I took a career break from dentistry for three years when I had a family and removed myself from the GDC Register. I now want to return to practice part-time as my former practice has a vacancy. However, I am worried that my CPD is very out of date. Will this matter?

Your five-year CPD cycle is fixed and the clock continues, whether or not you are on the register. In applying for restoration, you will need to satisfy the GDC that your skills and knowledge are up to date by showing evidence of the required CPD.

On its website, the GDC says that in this situation, the evidence it requires of CPD will depend on how long you have been off the register and whether your CPD cycle ended during this time. Although you have not been registered for more than a year, if your CPD cycle has not ended, you will need to provide evidence of 50 hours CPD for each year that has elapsed since the start of your cycle, of which 15 hours per year should be verifiable.

If your CPD cycle has ended, you will need to show evidence of 250 hours of CPD, of which 75 must be verifiable, in the last five years. That is the five years immediately prior to your application to re-join the register.

It is also important to keep a written record of your CPD for at least five years after your CPD cycle ends, in case you are later selected for audit.
Q Raising concerns

Last week, one of the other practice dental nurses was unwell and I agreed to work with another dentist. During one appointment, the dentist gave a patient a temporary filling but suggested to her it was a permanent one, and charged her a fee for a permanent filling. When I challenged him, he told me that he was my boss and I should do as I was told. I raised this with the practice manager who told the practice principal but nothing has happened. Now the dentist has let it be known that he won’t work with me because I am ‘difficult’. What should I do?

The dentist concerned was in breach of the GDC’s guidance as set out in its new publication ‘Standards for the Dental Team’. The GDC would strongly disapprove of any act of dishonesty towards a patient.

You acted entirely correctly in first raising your concern with the dentist concerned and then taking it up with the practice manager when the dentist’s response was negative. Your duty to patients overrides any professional loyalty to your colleagues and you were right to speak out. It was then your employer’s responsibility to inform you how they proposed to handle the concern, and set a timeframe in which they would respond to you.

As this has not yet happened, we recommend you approach the practice manager and ask her what steps have been taken to investigate and address the matter. Explain that you will need to escalate your concern if nothing is done.

Your duty to patients overrides any professional loyalty to your colleagues

Keep a record of relevant conversations, correspondence and the action you have taken for future reference.

If you are not satisfied with your employer’s response, the GDC expects you to escalate your concern to a higher level. You could consider approaching the local primary care organisation if the treatment was NHS, the national healthcare regulator, or the GDC itself. In the case of the GDC, you could be called as a witness if the matter progresses to a fitness to practise hearing.

If you are worried that you are being victimised by the dentist involved, speak to the practice manager. The Public Interest Disclosure Act 1998 protects employees who raise genuine concerns about potentially illegal or dangerous practices, provided you are acting in good faith; honestly and reasonably believe the information is substantially true; are not motivated by personal gain; and have taken steps to raise concerns first with your employer.

Q Working alone

I’m a dental hygienist and I am about to begin work at a new practice, but there is a problem. The practice owner has told me that I will need to see patients alone. What should I do?

We have long advised dental professionals that it is a good idea to have nurse support, particularly when carrying out complex treatments. As well as providing practical assistance, the dental nurse can also act as a chaperone and is a potential witness if there is an allegation of misconduct or negligence.

In its new ethical guidance, Standards for the Dental Team, the GDC is more prescriptive. It states that you should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting. The only exceptions are if you are participating in public health programmes, dealing with out-of-hours emergencies or in unavoidable circumstances which could not have been foreseen. This doesn’t include absences due to staff leave or training (paragraph 6.2.2).

Apart from potential GDC disciplinary action, it could be considered a negligent breach of your duty of care to go against the GDC’s professional standards and work alone. The patient might be entitled to compensation if they successfully claim they have suffered avoidable harm as a result.

If no one from the team is available, the GDC expects you to assess the possible risk to the patient of continuing treatment. Most importantly, you must still ensure there is one other person available within the working environment to help deal with medical emergencies. In exceptional circumstances, the GDC says this might be a receptionist or the person accompanying the patient (paragraph 6.2.6).
Eating disorder

When a 14-year-old patient attended for a check-up, I noticed erosion of the enamel on the palatal surfaces of her anterior teeth. Although she denied it, I believe she has been making herself sick on a regular basis. I want to speak to her parents about my concerns. Can I do this without her consent?

First, speak to your patient and suggest she talks to her parents or her GP so she can get the appropriate support and treatment. If the patient is adamant that she does not want her parents to know, you need to consider whether she has capacity to make this decision and then whether you would be justified in talking to her parents without her consent.

Although the patient is under the legal age of consent, she may still have the capacity to weigh up the options and make an informed decision to refuse consent for the disclosure of confidential information to her parents. However, be aware that patients with eating disorders can lack insight about their condition. She might not even accept there is a problem.

If you believe that the risk to the patient outweighs the possible damage to her trust in you and the profession, you may be justified in raising your concerns with somebody who can help her. It would be sensible to find out if she would allow you to raise your concerns with another healthcare professional, for example her GP or the local safeguarding children lead, rather than her parents.

If she refuses and you decide it is in her best interests to share information with her parents or another healthcare professional about her without her consent, you would need to tell the patient of your intention to do so, unless this is not practicable, for example you are worried that she might come to further harm.

You should keep a record of your decision-making process in the patient’s notes.
Working with overseas dentists

A patient who has attended for an extraction has now told me she would like to travel to Poland to have an implant inserted because she cannot afford to have the treatment carried out in the UK. She has asked whether I would be prepared to assess and refer her to the clinic and provide the post-operative care.

When you refer a patient to any colleague, at home or abroad, you have a professional and legal duty of care to the patient and there are obvious practical obstacles in this case.

To ensure any referral is appropriate and in the patient’s best interests, you would ordinarily need to do the following.

- Research the clinic and clinician concerned and reasonably satisfy yourself that they have the necessary facilities, training, and experience to safely and satisfactorily treat the patient.
- Be confident that the clinic and dentists are appropriately regulated and are indemnified by an established indemnity provider.
- Seek to establish written agreement with the clinic and dentist concerned, clearly setting out all aspects of the patient’s treatment, including clinical liaison and the exchange of information at appropriate junctures.
- Give the patient verbal and written explanations of the arrangements, so she understands who will be responsible for each aspect of her care, and what action she can take in the event of complications or dissatisfaction with her treatment.
- Ensure the patient understands the benefits, risks, and likely outcome of the treatment and has consented to the referral.
- Maintain full records of all discussions, consultations and treatment, and copies of all communications with the patient and the clinic/dentist concerned.

However, it would be difficult, if not impossible to do all of this if the treatment is to take place in another country.

As the referring dentist you could also be putting yourself in a vulnerable position should the treatment go wrong because it would be relatively difficult for a patient to bring a complaint or claim for negligence against an overseas dentist. Were you to refer the patient to the clinic in Poland, and the patient was not happy with the care she has received there, she could choose to complain or claim against you and/or your practice, with all the time, trouble and worry that would involve.

Extraction

I’ve just finished my second year post-qualification as a Senior House Officer in two different oral surgery departments. During this time I carried out a number of minor oral surgery procedures, including the removal of many wisdom teeth. I want to offer this service at the dental practice where I am about to start working. What pitfalls should I consider?

Dento-alveolar surgery procedures are part of the practice of dentistry, so as a registered dentist there is nothing to prevent you from carrying them out in a general dental practice, provided you are trained and competent to do so, and have the necessary equipment and facilities.

If you are not on the GDC’s oral surgery specialist list, you must not suggest to patients of the practice, or in practice promotional material, that you are a specialist. However, you can inform patients that you have a particular interest in minor oral surgery and can provide treatments such as wisdom tooth extraction, and that you have hospital training and experience in this area.

Be aware of your limitations and be prepared to refer a patient whose treatment is beyond your capabilities, for example if they have a particularly complex medical history or the tooth is severely impacted. Remember that you might not have the same back-up facilities in a practice that are available in a hospital setting so do not attempt an extraction unless you are confident that you can complete the procedure.

It’s also advisable to maintain a record of the training and courses you have attended, as you may be asked to provide evidence of your experience if your treatment is ever questioned.

Although extraction of wisdom teeth is included in our subscriptions for dentists, in general, whenever you consider providing a new service, it’s a good idea to check that you are indemnified for the work.
Health and safety guidance on sharps

The Health and Safety Executive has produced guidance about practitioners’ obligations under the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 which build on existing law. Focusing on the need to assess the risks, provide appropriate information and training, and consult with employees, the guidance includes practical advice on the safe use and disposal of sharps, staff training and procedures for responding to a sharps injury. It is available on the HSE website hse.gov.uk

Legal ruling on tooth whitening

The High Court has ruled it is unlawful for anyone not registered with the GDC to carry out tooth whitening. Lorna Jamous, who had a tooth whitening business, was convicted in May of practising dentistry and unlawfully carrying on the business of dentistry when not regulated by the GDC.

CQC report

The CQC’s Care Update Report (Issue 2, March 2013) praised dental practices, saying their performance in areas such as respect and involvement of patients and infection control is ‘very good compared to other parts of the health and social care system’.

Of the 3,021 practices inspected, 92% were meeting the national standards. However, the report highlighted two areas for improvement.

- Recruiting staff effectively and carrying out thorough checks.
- Making sure patient records are up to date and kept safe and confidential.

HIV positive dental professionals allowed to practise

Restrictions on UK dental professionals and other healthcare workers with HIV are to be relaxed from April 2014 in response to scientific advice.

The Department of Health in England is to lift the ban on dental professionals carrying out exposure prone procedures, provided they are on effective combination antiretroviral drug therapy, have a very low or undetectable viral load, and are regularly monitored by both their treating and occupational health physicians. Public Health England will now set up a confidential register and monitor healthcare workers with HIV.

The changes will bring England into line with most other Western countries and were recommended by a tripartite working group of the Expert Advisory Group on AIDS (EAGA), the UK Advisory Panel for Healthcare Workers infected with Bloodborne Viruses (UKAP) and the Advisory Group on Hepatitis (AGH). They were the subject of a consultation to which the MDU responded positively on behalf of our dental and medical members.

The Scottish and Welsh governments consulted on the changes at the same time but at the time of going to press their decisions are not known.

Duty of candour

A ‘duty of candour’ now features in the new standard contract for the provision of NHS healthcare from 1 April 2013, with the exception of services commissioned under primary care contracts. It means hospitals must provide information and support to patients and their families if a ‘reportable patient safety incident occurs or is suspected to have occurred’. The duty only applies in cases of moderate or severe harm or death whereas dental professionals already have an ethical duty to be open and honest with patients whenever something goes wrong, irrespective of the degree/level of harm. If something goes wrong hospital dentists can be guided by their ethical duty but will also need to follow their organisation’s duty of candour guidance and procedures.

Membership

Make tax less taxing

Visit theddu.com/learn and take a look at our e-learning tutorial about tax. Developed in collaboration with HM Revenue & Customs, it includes modules on tax allowances, business expenses and National Insurance.

BSDHT exhibition

ICC Birmingham, 15-16 November

Visit us on Stand 19

Dento-legal adviser Leo Briggs and others will be on hand to discuss any dento-legal and/or membership questions you may have.

For more information about the event visit bit.ly/bsdht
A dentist had been treating a young patient for two years. The patient had shown evidence of decay from as early as three years of age and had a high incidence of caries. The child had refused much of the treatment the dentist had wanted to provide and cried at the prospect of receiving treatment.

The member had discussed her concerns about the levels of decay with the child’s parents and suggested possible dietary changes. She also advised them about the use of fluoride toothpaste although the parents told her they were opposed to the use of fluoride because they believed it was harmful. They didn’t allow her to take radiographs either.

When the child was five, the dentist carried out a temporary restoration of the child’s LLE and LRD because of recurrent caries. Believing the patient’s level of co-operation and his ability to cope with treatment were deteriorating, she also decided to refer him to the specialist Community Dental Service.

The patient was later admitted to hospital where a panoramic x-ray revealed deep decay, extending to the pulp in all eight of his primary molar teeth. He received extensive treatment: large fillings in three molars and a pulpotomy and stainless steel crown on another four.

Claim
A year later the member received a letter of claim alleging she had failed to provide preventive treatment, had allowed the patient’s teeth to develop extensive decay, and had failed to provide preventive advice to the parents. The patient’s claim was publicly funded. The dentist contacted the DDU for assistance.

We instructed an expert who was supportive of the member’s management.

The DDU wrote to the patient’s solicitors denying liability.

A costly victory

We successfully defended a dentist in a case which lasted over 10 years.

A dentist had been treating a young patient for two years. The patient had shown evidence of decay from as early as three years of age and had a high incidence of caries. The child had refused much of the treatment the dentist had wanted to provide and cried at the prospect of receiving treatment.

The member had discussed her concerns about the levels of decay with the child’s parents and suggested possible dietary changes. She also advised them about the use of fluoride toothpaste although the parents told her they were opposed to the use of fluoride because they believed it was harmful. They didn’t allow her to take radiographs either.

When the child was five, the dentist carried out a temporary restoration of the child’s LLE and LRD because of recurrent caries. Believing the patient’s level of co-operation and his ability to cope with treatment were deteriorating, she also decided to refer him to the specialist Community Dental Service.

The patient was later admitted to hospital where a panoramic x-ray revealed deep decay, extending to the pulp in all eight of his primary molar teeth. He received extensive treatment: large fillings in three molars and a pulpotomy and stainless steel crown on another four.

Claim
A year later the member received a letter of claim alleging she had failed to provide preventive treatment, had allowed the patient’s teeth to develop extensive decay, and had failed to provide preventive advice to the parents. The patient’s claim was publicly funded. The dentist contacted the DDU for assistance.

We instructed an expert who was supportive of the member’s management.

The DDU wrote to the patient’s solicitors denying liability.
Over the next few years, the patient’s solicitors made two offers to settle the case out of court, the first for £7,000 plus costs and the second for £4,500 plus costs.

After ten years, the DDU made representations to discharge the patient’s funding certificate because the patient’s case did not have a better than 80% chance of success and did not meet the public funding criteria.

The process was lengthy but the representations were eventually unsuccessful and public funding was continued. Proceedings were finally served against the member and a trial date was set.

From the outset, the DDU made numerous invitations to the patient’s solicitors to discontinue the claim but all were rejected. However, a few months before the trial and over 10 years after the letter of claim, the solicitors confirmed they were discontinuing the case.

By the time the claim was withdrawn, the DDU’s costs were £26,000. However, as the claim was pursued with public funding, the DDU was unable to recover its costs, making this an expensive but important success.

Chris Craig
Claims team manager

Points to consider

• From 1 April 2013 successful defendants are no longer able to recover costs from the losing party under Lord Justice Jackson’s reforms of Civil Funding, a principle known as Qualified One Way Cost Shifting (QOCS). As this case shows, even a claim without merit can consume significant amounts of a member’s time and significant DDU costs to defend, but the DDU will never settle a case for the sake of expediency.

• The expert could see that the dentist in this case had maintained careful records of the difficulties she had faced in treating the patient and the advice she had given. This made it much easier to challenge the version of events given by the patient’s family.
An abandoned extraction

A patient made a claim against her dentist after he made an unsuccessful attempt to extract a troublesome molar

A woman in her twenties visited her dentist after suffering toothache which had prevented her from sleeping for several months. After taking a periapical x-ray, which gave him a partial view of the tooth, the dentist agreed with the patient that the best option was to extract the LR7. Because the tooth was infected, the dentist applied a steroid dressing and a temporary glass ionomer filling and prescribed antibiotics. He then asked the patient to make an appointment in two weeks so the extraction could be carried out.

The dentist tried to extract the tooth but it fractured and he abandoned the attempt.
At the next appointment, the dentist took an OPG which revealed a distal radiolucency in the LR7 under a large amalgam filling which was characteristic of a carious lesion. The image also showed that the patient’s wisdom tooth was mesially impacted. The dentist decided not to proceed with the extraction at this appointment because the patient was still in pain. Instead he prescribed a further course of antibiotics and the appointment was rescheduled for a week later. He did not record this in the patient’s record.

When the patient returned, the dentist tried to extract the tooth but it fractured and he abandoned the attempt. Realising that the patient was not fully anaesthetised, he dressed the tooth to allow the pain and swelling to subside and prescribed more antibiotics. No record was made of the appointment.

The patient failed to return for her next appointment, later saying that she had lost confidence in her dentist. Unable to find another practitioner to carry out the extraction, she was eventually referred by her GP to hospital where an x-ray was taken. It was agreed that the tooth couldn’t be saved and it was surgically extracted.

**Claim**

The patient made a claim, alleging the dentist had fallen short of the standard expected of a competent dentist. Specifically, he had failed to extract her tooth; had not provided a reasonable explanation; and had failed to arrange follow-up treatment within 24 hours of the unsuccessful extraction. The patient said his actions had caused her unnecessary pain and suffering and left her with dental anxiety.

The dentist, a DDU member, requested our assistance with the claim. The expert instructed said that in his opinion, the member’s initial treatment and his original treatment plan of extracting the tooth under local anaesthetic were reasonable. He was also supportive of the member’s decision to abandon the extraction when it was clear that full anaesthesia could not be achieved and that surgical extraction was required because the crown of the tooth was already weakened.

However, the expert was critical of our member’s failure to keep adequate records of the patient’s second and third appointments. He felt that his decision not to extract the tooth at the patient’s second appointment because the area was still painful was incorrect. Rather than just prescribing antibiotics, he said our member should have extracted the tooth or drained the abscess by opening the pulp chamber. Finally he was critical of his treatment after the unsuccessful extraction: in dressing the tooth without draining the abscess and prescribing antibiotics, the third course in under a month, the expert felt he had not met the standards expected.

The DDU expert found that our member’s treatment at the patient’s second and third appointments had prolonged the infection and caused the patient unnecessary pain. She had also been given two unnecessary courses of antibiotics. However, there was no evidence she had developed a psychological fear of the dentist, as alleged. By her own account the patient had sought another dentist to carry out the extraction and did not need additional treatment for anxiety before she received treatment in hospital.

With our member’s agreement, we settled the claim for £1,500 plus legal costs.

**Ian McLaren**

Lead claims handler

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**Points to consider**

- **Claim**

  - Clear, contemporaneous and complete notes are essential for patient care. Falling to keep a proper record of appointments makes it difficult or sometimes impossible to defend your actions successfully in the event of a claim.
  - The patient felt she had not been given an adequate explanation after the extraction failed and it is possible this breakdown in communication caused her to lose confidence in her dentist. If anything goes wrong during a procedure, tell the patient what has happened, how you propose to manage the situation and answer any questions they may have.
  - The expert was critical of the dentist’s decision to prescribe three courses of antibiotics in such a short space of time. If your treatment plan does not appear to be working, be prepared to reconsider and if necessary seek a second opinion.
Complainants in England are able to take their case to the Parliamentary and Health Service Ombudsman if they believe their concerns about NHS services have not been addressed locally, but until recently cases were only formally investigated if they met certain criteria.

Now any complaint which meets certain basic criteria will trigger an investigation and the Ombudsman will be formally investigating thousands of complaints each year, across the NHS and public organisations in England.

Of course the aim of dental professionals, and a GDC requirement, is to try to resolve complaints satisfactorily at a local level and, ideally, to avoid complaints being made at all.

Any complaint which meets certain basic criteria will trigger an investigation

To help, we have analysed the 415 patient complaints notified by members in the first quarter of 2013. See Figure 1. While not every complaint was justified, we want to draw your attention to some common factors.

Who received complaints
The vast majority of complaints (405) were against dentists, with only 10 complaints against other members of the practice team (most commonly dental hygienists).

Of the complaints against dentists, 149 were practice principals, 172 were associates, six worked in NHS hospitals or community dentistry and 70 (almost one-fifth of the total) were newly-qualified dentists. The most common complaints against this group concerned allegations that treatment had been unsatisfactory or that something had gone wrong during a procedure, such as fillings, extractions, the provision of dentures or a bridge. In two cases, the dentist had been carrying out root canal treatment.

We strongly advise newly-qualified dentists not to attempt treatments which are outside their competence.

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Unsatisfactory treatment
Patients who complained their treatment was ‘unsatisfactory’ were generally dissatisfied because the outcome did not meet their expectations. The most common treatment involved was the fitting of a crown (35 cases) with several complainants aggrieved that the crown had fractured, while others were unhappy with the shade. Other unsatisfactory treatments to attract complaints were fillings (30 cases), ill-fitting or broken dentures (22 cases), root canal work (17 cases) and orthodontic treatment and bridges (both 13 cases).

Unsuccessful treatment may have been the result of a technical failure of the treatment provided by the dental professional, although other factors might be the treatment provided by another dentist or DCP, or the condition of the patient’s teeth and gums. However, such complaints could also indicate that the patient had unrealistic expectations. This highlights the need to explore the expected outcome and associated risks of treatment with the patient before embarking on treatment, and to make detailed notes of any such discussions in the clinical records.

Any complaint which meets certain basic criteria will trigger an investigation

Communication was an underlying factor in many of the complaints

Patient complaints: January - March 2013

- Unsatisfactory treatment: 174
- Failed/delayed diagnosis and treatment: 60
- Communication/rudeness: 50
- Fees/charges: 18
- Adverse incident during treatment: 14
- Adverse reaction: 10
- Pain: 9
- Refusal to treat the patient: 7
- Infection: 7
- Appointment delayed/cancelled: 6
- Wrong tooth treated: 6
- Other: 26
- Multiple grievances: 28

Figure 1
Communication
Communication was an underlying factor in many of the complaints, as noted previously, but allegations of rudeness and other communication problems, including alleged failure to properly obtain consent, were the principal causes for complaint in 43 cases. Of course, patients who are upset, anxious or in pain can make communication more challenging but dental care is increasingly dependent on a good rapport between practitioner and patient and this demands effective communication skills. Good communication with patients is also one of the nine ethical principles in the GDC’s new guidance Standards for the Dental Team.

Diagnosis
Dental decay was the most common condition in which diagnosis was allegedly delayed or missed, with some patients complaining they had been obliged to have root canal treatment or an extraction after undiagnosed decay progressed. Long-term failure to diagnose or treat periodontal disease was another allegation which featured several times in this category, as was failure to diagnose a fractured tooth.

Of course, failure to diagnose or treat a condition does not necessarily mean a dental professional has been incompetent. However, allegations that a dental professional did not listen to the patient’s concerns or that their care amounted to long-term supervised neglect may be hard to explain, particularly if the records do not indicate to what extent the dental professional undertook appropriate investigations and special tests in order to reach a diagnosis, provided a justifiable treatment plan, and reviewed this with the patient at each appointment.

Fees
As we highlighted in the April 2013 issue of the Journal, dental fees are a factor in many complaints and we published advice on how to avoid them. In this analysis, fees were the principal reason for the complaint in 18 cases but were a factor in 64 complaints, while many more members sought our advice about offering a refund to the complainant.

Adverse incidents and reactions
Adverse events during treatment included injuries to soft and hard tissues from dental instruments and incidents where the patient swallowed material during treatment. There were also several cases where patients experienced an allergic reaction, most commonly to the local anaesthetic used.

If something goes wrong during treatment, dental professionals have a duty to inform the patient immediately, apologise and explain what action they need to take to manage the situation. All patient safety incidents should be recorded, using the practice adverse incident recording system, and those resulting in more serious and/or prolonged harm need to be reported to CQC.

Unfortunately 25 complainants in our analysis had already reported the dental professional to the GDC and two complainants had taken their case to the Ombudsman or the Dental Complaints Service. But even if a complainant does take things further, evidence that you have dealt with the complaint in line with the NHS complaints procedure and GDC guidance should help you avoid serious criticism.

Finally, remember, we are on hand to help you respond appropriately if you get a complaint of any sort, so call our advisory helpline if you need advice and support.
Public health dentistry

In the latest in our series on the career pathways for dental graduates, we focus on public health dentistry. These are interesting times for members of this non-clinical specialty, which focuses on improving the dental health of the population at large.

Public health dentistry is the science of preventing oral diseases and promoting oral health. There are 118 specialists on the register of public health dentists but according to the NHS Careers website, this is a relatively new and expanding dental specialty and there is currently a national shortage of consultants.

Specialty training
You can apply for specialty training in public health dentistry after completing two years’ dental foundation training but ideally you should have experience of other areas of dentistry. You need to show evidence of equivalent training and experience against each competency area specified in the UK Dental Foundation curriculum. However, it is not essential to be a member of one of the royal colleges of surgeons.

You would usually expect to complete full-time specialty training in Dental Public Health in four years, one year of which will be a period of academic study in a recognised course such as a Masters in Dental Public Health. You can also study flexibly if full-time training would not be practicable and academic training posts are also available.

Areas covered in the specialty training curriculum include: oral health surveillance; assessing evidence of oral health and dental programmes and services; health and public protection and developing and monitoring quality dental services.

Assessment and qualification
During your training you will take part in workplace assessments including direct observation and there will also be an annual examination which will involve discussion of project work and a critical appraisal assessment. The final stage is the Intercollegiate Specialty Fellowship Examination.

When your Postgraduate Dental Dean recommends the award of a Certificate of Completion of Speciality Training to the GDC, your name will be added to the specialist list.

Find out more
Speak to your local education and training board for more information on training as a public health dentist. The British Association for the Study of Community Dentistry (bascd.org) is the professional association for anyone with an interest in promoting the oral health of populations and groups in society.

A copy of the specialty training curriculum in public health dentistry can be downloaded from the GDC website.

Robert Witton is Director of Social Engagement and Community Based Dentistry at Peninsula Dental School and a consultant in dental public health.

“My interest in this area of dentistry was sparked when I was involved in a children’s oral health project while teaching periodontics and paediatric dentistry at Portsmouth Dental Academy. I was offered a university post leading the community-focused curriculum after completing my four-year specialist training last year.

Public health dentists look at the bigger picture of dental health in the population. At the heart of what I do is partnership and collaborative working. There are many stakeholders to engage with including local GDPs, community dental teams, hospitals, local authorities and charities on projects to improve the oral health of communities and in particular vulnerable patients, such as children living in poverty and the socially excluded.

A career in public health dentistry requires great self-motivation as you might be the only specialist within a large area. You need good analytical and writing skills to produce reports on dental services and trends in oral health. It’s also important to have the organisational ability to oversee various projects and the ability to advocate and negotiate for the necessary funding to address local oral health needs.

Finally, as a non-clinical speciality, I’d advise anyone considering public health dentistry to think hard about whether they are ready to give up treating patients and the camaraderie of clinical practice. However, it’s tremendously satisfying to make a real difference to the oral health of the wider community.”
Employment law

Since April 2013, practice principal members\(^1\) have been able to call the DDU’s free employment law advice service for expert advice from our partners, Peninsula Business Services. Nicola Mullineux, research co-ordinator at Peninsula Business Services, reveals the most common requests for help.

It has never been more important for employers to have access to objective advice about employment law. In the first three months of 2013, the Employment Tribunal Service received 57,737 claims, 36% more than in the same period of 2012\(^2\). With each claim taking an average of 80 weeks before a judgment is handed down, it’s clearly in everyone’s interest to avoid the kind of grievances that can lead to a tribunal.

Our 24-hour employment law advice service is intended to help practice principals manage complex employee relations effectively rather than allowing them to become a time-consuming distraction. Since the service began, we have had a steady stream of requests for advice about a range of issues. However, the top four reasons for calls were:

1. conduct and disciplinary issues
2. family-related leave
3. employee grievances
4. employee absence.
Conduct and disciplinary issues
While standards of employee behaviour are an issue in the vast majority of the workplaces in the country, they are especially significant in dental practices, where interaction with members of the public is part and parcel of the job.

Calls for advice on how best to manage staff who have been rude and aggressive to patients make up a large proportion of calls on conduct-related issues. Poor behaviour towards other practice staff is also a regular concern, along with more general conduct issues, such as refusal to carry out management instructions. Derogatory comments on social networking sites about a practice and general poor work performance have also been raised as concerns.

Where concerns are raised about an employee’s conduct, it is extremely important for practices to carry out thorough investigations to establish the facts. Unfair dismissal is among one of the most common allegations heard by the Employment Tribunal Service and you will be expected to show evidence of what happened, as well as demonstrate that your disciplinary procedures were fair and transparent.

Family-related leave
Calls about maternity leave entitlements are high, along with requests for advice about pregnancy risk assessments; contact with the employee during maternity leave; and subsequent requests for flexible working upon return.

Employee grievances
Many grievance procedures are instigated by employees because of their alleged treatment by other staff members and the way this was managed. Changes in hours of work and handling of overtime have been other common reasons for the raising of a grievance.

Our 24-hour employment law advice service is intended to help practice principals manage complex employee relations

Employee absence
This is another frequent cause for concern for DDU members, including how to manage sickness absence, jury service, and also extended annual leave.

Using the employment law advice service
It’s not always easy to predict where a particular issue may lead, so it makes sense for practice principals to call the free 24-hour advice service and speak to a Peninsula consultant with in-depth experience in employment legislation, contractual requirements and case law precedents. We can provide telephone coaching in managing employee issues, as well as help with drafting any follow-up letters. For more information about this service visit theddu.com/peninsula

Free seminar for employers
On Wednesday 23 October 2013, the DDU is holding a free seminar in London in partnership with Peninsula Business Services. Worth 2½ hours of verifiable CPD, the seminar will look at how to prepare and motivate staff for a CQC inspection; day-to-day relations with employees; and the dento-legal aspects of team working. The seminar is relevant for dentists and practice managers who are responsible for CQC or employment issues within the practice and is open to DDU members only. You can attend either the morning session between 9am and 12pm or the afternoon session which begins at 1.30pm and ends at 4.30pm. For more information or to book your place visit theddu.com/peninsulaseminar

References
1 A ‘principal’ is defined by the DDU as a dentist who is paying a principal subscription.
2 Ministry of Justice, Tribunals Statistics (Quarterly) - 1 January to 31 March 2013.20 June 2013

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