Legal Aspects of General Dental Practice

Len D’Cruz
BDS LLM LDSRCS(Eng) DipFOd MFGDP
General Dental Practitioner, Dento-legal Advisor, Dental Protection, London, UK

With contributions from
Simon Mills
MB BCh BAO (Dubl.) BCL (NUI) MSc (Lond.)
Barrister at Law, Medical Practitioner, Law Library, Four Courts, Dublin, Ireland

David Holmes
Shepherd and Wedderburn, Solicitors, Edinburgh, UK

Foreword by
Kevin Lewis
BDS LDS RCS
Dental Director, Dental Protection, London, UK

Series Editor
F. J. Trevor Burke
Professor of Dental Primary Care, University of Birmingham School of Dentistry, Birmingham, UK
Foreword

Life in a busy dental practice can be complicated enough without the additional impact of ever-increasing legislation and bureaucracy that practitioners and their staff must deal with.

Dentistry is of course not alone in facing this problem, as any restaurateur, teacher, policeman, factory owner or business person will tell you; but every business or profession must understand how essentially the same laws assume their meaning and application in their own individual circumstances. The English laws of tort and contract, or the legislation relating to data protection, were not of course written with dentists in mind.

It is not possible, in a work such as this, to throw light on every dark corner of dental practice, nor to examine the application of every piece of UK legislation to it. Len D’Cruz has therefore chosen to focus upon the main pillars of the legal aspects of dental practice in the UK, and mostly upon English law. He covers the legal basis for professional standards (including negligence and serious professional misconduct), and the ethical and legal aspects of consent and confidentiality. Against that background, he has provided detailed sections on record keeping (both manual and electronic), complaints systems and report writing. For good measure, he provides a brief overview of the UK legal system which provides a helpful introduction for the reader who is new to this subject.

His decision not to become deflected into the massive areas of Employment Law and Health & Safety Legislation is vindicated by the time and space it has allowed to explore the chosen areas, and Len D’Cruz’s passion for his subject is self-evident.

The law can seem very academic and distant from the interface between a patient and members of the dental team, but in fact it permeates most, if not all, of the everyday working procedures in the dental practice environment.

This is made clear by the regular practical illustrations of how the law would apply to familiar situations and dilemmas in modern dental practice, that are provided throughout the text. By the constructive use of such illustrations, Len D’Cruz has provided both pace and momentum as the reader discovers that the law really can be both interesting and relevant to those in dental practice.

Kevin Lewis
This book aims to provide the basic principles of law relating to general dental practice for final-year students, vocational dental practitioners as well as busy general dental practitioners. Working for Dental Protection, it became increasingly clear that whilst many dentists have a general understanding of such fundamental issues as consent, confidentiality and clinical negligence, there was no one place they could find more detail and practical guidance in the application of those principles. The defence organisations all produce risk management publications and in the case of Dental Protection this is quite extensive but I felt there was a need to locate these in one source.

The law is stimulating, challenging and sometimes provocatively odd, but keeping abreast of it all can be daunting. I have tried as far as possible to state these principles as simply as possible, mindful that new cases and statutes may change the interpretation of things even as fundamental as consent.

Some readers may have wished for other topics to have been covered but I have confined myself to those areas most often enquired about from my own work as a dento-legal advisor and speaker at various post-graduate meetings around the UK.

I would like to sincerely thank my wife Anne and sons for their patience, understanding and unconditional (well almost) support and especially to Simon, who was born whilst this book was being written, and who kept me company on many an early-morning writing session.

My apologies to Margaret Grew, who was looking for ‘some romance’ within the pages of this book. There is none but maybe next time…

I have endeavoured to state the law as at February 2005.

L. T. D’C.
2005
London
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSA</td>
<td>Business Services Authority</td>
</tr>
<tr>
<td>CFSMS</td>
<td>Counter Fraud and Security Management Service</td>
</tr>
<tr>
<td>CHAI</td>
<td>Commission of Healthcare Audit and Improvement</td>
</tr>
<tr>
<td>CHI</td>
<td>Commission for Health Improvement</td>
</tr>
<tr>
<td>CHRE</td>
<td>Council for Healthcare Regulatory Excellence</td>
</tr>
<tr>
<td>CPD</td>
<td>continuing professional development</td>
</tr>
<tr>
<td>CPR</td>
<td>Civil Procedure Rules</td>
</tr>
<tr>
<td>CRHP</td>
<td>Council for the Regulation of Health Care Professionals</td>
</tr>
<tr>
<td>EPR</td>
<td>electronic patient record</td>
</tr>
<tr>
<td>GA</td>
<td>general anaesthesia</td>
</tr>
<tr>
<td>GDC</td>
<td>General Dental Council</td>
</tr>
<tr>
<td>GMC</td>
<td>General Medical Council</td>
</tr>
<tr>
<td>HSC</td>
<td>Health Service Commissioner</td>
</tr>
<tr>
<td>IR[ME]R 2000</td>
<td>Ionising Radiation (Medical Exposure) Regulations 2000</td>
</tr>
<tr>
<td>NCAA</td>
<td>National Clinical Assessment Authority</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
</tr>
<tr>
<td>PACE</td>
<td>Police and Criminal Evidence Act 1984</td>
</tr>
<tr>
<td>PAERS</td>
<td>Patient Access Electronic Record System</td>
</tr>
<tr>
<td>PCC</td>
<td>Professional Conduct Committee</td>
</tr>
<tr>
<td>PCDs</td>
<td>professionals complementary to dentistry</td>
</tr>
<tr>
<td>PCT</td>
<td>primary care trust</td>
</tr>
<tr>
<td>SIDS</td>
<td>sudden infant death syndrome</td>
</tr>
<tr>
<td>TBBD</td>
<td>temporary brittle bone disease</td>
</tr>
<tr>
<td>TQM</td>
<td>total quality management</td>
</tr>
<tr>
<td>VDPs</td>
<td>vocational dental practitioners</td>
</tr>
</tbody>
</table>
Legal structures and processes that impact in general dental practice

The starting point of any book on dento-legal perspectives in general practice ought to be an overview of the legal system, as well as how healthcare fits into the regulatory framework.

Even before this it is important to provide an understanding of what dental law is and why it is important. In their opus *Medical Law*, Kennedy and Grubb describe medical law as being a subset of human rights. Law in its widest sense is a form of social control which is set down by the state in the form of rules and is enforced through the courts and the legal system.

Running through dental law are two key themes—the rights of patients and others, and the duties of the dentist. Much of a dentist’s relationship with patients is embodied by these two themes, which sometimes conflict and are underpinned both by statute and common law, as well as a set of guiding principles of ethical and professional behaviour.

**FOUR PRINCIPLES OF HEALTHCARE ETHICS**

Four principles of healthcare ethics have been identified and summarised by Hope et al (see further reading at end of chapter), and are useful tools for dentists facing ethical or moral dilemmas in practice.

1. **Respect for patient autonomy**
   Autonomy is the capacity to think and decide, and then act on the basis of such thought and decision, freely and independently. Respect for a patient’s autonomy means giving the information necessary to allow that patient to make informed decisions, and then to respect those decisions and follow them even when the professional may believe they are the wrong decisions. The flip side of this self-determination is paternalism, where a dentist makes a decision without necessarily taking the patient’s wishes into consideration.

2. **Beneficence: promotion of what is best for the patient**
   This is a fundamental aspect of dental care for patients and the duty of the dentist is to steer the patient into what is best for them. What is best is an objective assessment of that patient’s needs and this would in most cases chime with what the patient wants under the principle of autonomy. The two principles conflict when a competent patient makes a decision which is patently not in their best interests.

3. **Non-maleficence: avoiding harm**
   It is a well-recognised maxim in healthcare that firstly we should do no harm. Thus, treatment provided should have more benefits than harmful effects, and this is a significant consideration when elective cosmetic dentistry is involved.

4. **Justice**
   This is a broader, policy-based principle which attempts to distribute the finite resources of time and money in a fair and equitable manner. This means that patients in similar situations should have access to the same care, whilst also recognising that care for one type of patient will influence the resources available for others.

   These principles of practice have been incorporated in the General Dental Council’s guidance ‘Standards for dental professionals’:

   1. Putting patients first and acting to protect them.
   2. Respecting patients’ dignity and choices.
   3. Protecting the confidentiality of patients’ information.
   4. Cooperating with other members of the dental team and other healthcare colleagues in the interests of patients.
   5. Maintaining your professional knowledge and competence.
Thus dental law will encompass ethical and professional responsibilities as well as adherence to the law of the land. The sanctions for breaking these two different codes are sometimes quite different. For example, being found legally liable for civil negligence will result in the dentist, or more often their indemnity organisation, paying damages to the patient. Being found guilty of professional misconduct by the General Dental Council could result in the dentist’s erasure from the Register and perhaps an end to their career in dentistry.

**BRANCHES OF LAW**

The law (Fig. 1.1) can be divided up into public and private law (more commonly known as civil law). Public law involves the government or instruments of government, whilst private law is concerned with disputes between individuals or companies.

Administrative law controls how, for example, local health authorities should operate and how decisions they make may be challenged by a judicial review. Public law encompasses criminal law, where the state takes the role of prosecuting a law-breaker and enforcing punishments.

Private law has many branches, and the law of tort, contract law and employment law are of immediate relevance to dental practice.

A tort is a civil wrong which is actionable and occurs even when there is no contract between two people. It exists because in a civil society one person can owe someone else a duty of care, even if they are complete strangers. When that duty of care has been breached, damages can be obtained by the injured party.

Contract law is about the rules concerning the identification, regulation and enforcement of agreements. These agreements cover many aspects of everyday life, such as shopping, travelling on a train or buying a meal in a restaurant. In dentistry, contracts are drawn up between practice owners and associates. They also exist between dentists and laboratories, and between practices and suppliers. Many contracts are not written down, but when they are, contracts serve as important documents that protect each party and define the terms of a relationship.

Employment law for practice owners is an ever-developing field, and many changes have occurred in employment legislation that impact directly and very significantly on general practice. Any dentist who needs advice on a specific issue relating to the employment, conduct or dismissal of a member of staff should contact their professional organisation, their indemnity provider or a lawyer.

**SOURCES OF LAW**

The two main sources of law are statute law (which would include European legislation) and common or judge-made law.

**Statute law**

This encompasses Acts of Parliament introduced by the government in power, in response either to party policy, the media or pressure groups. The government may consult interested parties and
the public through ‘green’ and ‘white’ papers before drafting the legislation into a Bill. When parliamentary time allows, the Bill is introduced into the House of Commons and follows various stages—a first reading, a second reading, a committee stage, a third stage which follows the report stage and then (if there are no objections) a vote on whether the Bill should be accepted. The Bill is then sent to the House of Lords, which has no power to veto but only amend, although they can delay a Bill for up to a year. The Bill is then sent to the Queen for her assent, whereupon it becomes an Act and passes on to the statute books.

Common law
Common law is so-called in England because historically judges were sent by the King around the country from London to hear cases and pass judgement in disputes. The judges decided cases on local customs which varied around the country, but gradually, as the judges discussed their cases together back in Westminster, they formulated the best custom and practice to follow and these became ‘common’ to all parts of the country.

An essential part of today’s common law is the doctrine of precedent. This is where a decision of a court may be binding on future courts in a similar case. The circumstances which make it binding depend on the position of the court in the court hierarchy and whether the material facts are the same.

In terms of court hierarchy in England, the highest court in the land is the House of Lords, and all the decisions it makes bind all lower courts below—the Court of Appeal, the divisional courts, the Crown Court (in criminal cases) and the High Court (in civil cases), and magistrates and county courts.

The doctrine of precedent is important in clinical negligence claims, whilst in ethical and moral dilemmas it is useful to have a House of Lords decision. Such matters may include the right to live, as in the case of conjoined twins or consent issues of refusing life-saving treatment.

The doctrine of precedent allows a degree of certainty in the law, such that by following a previous decision a lawyer can advise a client properly in terms of the likely outcome of a case. Precedent also allows the law to reflect changes in society and thinking, which makes it quite a flexible way of changing the law. There are concomitant disadvantages, such as judges making apparently conflicting decisions even when the facts of a case are similar, or when precedent legally binds lower courts even when a decision was bad or harsh.

EQUITY
Historically, the law of equity (or fairness) arose out of dissatisfaction with the remedies available from the common law, which could only offer damages, normally money, to compensate a wronged party. In some cases it may be more appropriate to use different remedies. Today the main equitable remedies of injunctions, specific performance, rescission and rectification remain important. Injunctions can be ordered against a violent patient from attending the practice, forbidding them from entering or coming near the premises. They also can be used in employment law to maintain confidential information or trade secrets when employees leave the business.

THE GENERAL DENTAL COUNCIL
Parliament has allowed dentistry, through various Acts (the latest being the Dentists Act 1984), to regulate itself, primarily by maintaining a register of dental professionals who are competent and fit to practise. Self regulation is a cherished aspect of dentistry as a profession. However, this has come under severe pressure in recent years with scandals, such as the Shipman, Ledward and the Bristol heart babies cases, dominating the headlines and undermining public confidence and trust in the ability of healthcare professions to govern themselves. The remit of the General Dental Council (GDC) is primarily to protect patients and the professional status and reputation of the dental profession, and this is clear from the Act itself:

The Council shall, in exercise of its functions under this Act, have a general concern—

a) to promote, at all stages, high standards of education in all aspects of dentistry
b) to promote high standards of professional conduct, performance and practice amongst persons registered under the Act.

The Dentists Act 1984, Part 1, section 1 (2) as amended by Amendment Order 2005
It does this by maintaining a dental register and issuing guidance on standards of dental practice and conduct. It also quality assures dental undergraduate education through its Education Committee.

The actions normally taken by regulatory bodies are to protect members of the public from the professional activities of a dentist, hygienist or therapist who may either cause harm, or undertake treatment which falls short of the expected standards which would have been provided by their peers. If patients are looking for the quick resolution of complaints, an explanation or an apology, the GDC route is not the one to take. However, some patients feel the need to ‘punish’ the wrongdoer, and the removal of the dentist’s name from the register would be seen in that light. It is important to remember that the GDC does not aim to punish dentists, and when a dentist’s name is removed from the register following an inquiry, this action is taken solely to protect the public.

Protected title

The Dentists Act gives statutory protection to the title ‘dentist’, as well as the actual practice of dentistry. Unlike in medicine where there is no legislative restriction on who can treat patients or provide medical or health-related service, it is a criminal offence to carry out the practice of dentistry if not qualified or registered to do so, although a registered doctor can practise dentistry.

No person shall take or use any title or description implying that he is a registered dentist unless he is a registered dentist

The Dentists Act 1984, Part IV 39 (2)

Registration

Entry to the dental register is based on primary qualifications set out in the Dentists Act 1984, the commonest route being via a dental degree from a UK dental school. The United Kingdom’s membership of the European Union has brought the freedom of movement of workers across borders. Under EU legislation, EU nationals who have carried out their dental training in the new EU countries will be entitled to apply for full registration with the GDC.

Professions complementary to dentistry (PCDs) also have various routes on to the register, with hygienists and therapists currently on the register and other classes (such as dental technicians, dental nurses and orthodontic auxiliaries) to be included in 2006 when the Section 60 order is passed.

Reform

The GDC has jurisdiction over dentists in England, Scotland, Wales and Northern Ireland, and whilst the legal systems and NHS structures have continued to develop independently in the devolved administrations, Parliament still reserves power over the regulation of the professions.

The Kennedy Report, following the Bristol babies scandal, called for a system which ‘needs the widest involvement of professionals, of the principal employer and of the public…An effective system of professional regulation must be owned collectively. Further, it needs an independence from the professions and from government which allows it to act in the public’s interest’.

Reform is coming in the shape of a new organisation that will oversee the decisions made by the GDC — the Council for Healthcare Regulatory Excellence. It is also coming in the shape of reforms of the GDC itself. As the first step towards increased public involvement and a faster, more transparent operating system in the council, the Dentists Act 1984 Amended Order 2002 (SI 2002 No.3926) was made under section 60 of the Health Act 1992. This amended the GDC into a smaller Council with a higher proportion of lay members, made continuing professional development (CPD) compulsory and enabled the Council to set up a new independent ‘Fitness to Practise’ Panel to hear conduct and health cases.

Further changes to the regulation of the profession will occur through a second section 60 order in 2005. This was drafted in July 2004 and was intended to be put before the Privy Council by the government and signed by the Queen in January 2005. This was then delayed until July 2005 at the earliest, with the likelihood that its provisions will not enable the GDC to make any changes until 2006 and possibly 2007 for aspects relating to registration of PCDs (professionals complementary to dentistry).

This section 60 order is intended to modernise the GDC’s fitness-to-practise procedures for dealing
with misconduct and ill health amongst dental professionals, and to introduce new procedures to tackle problems of poor performance.

The structure and sanctions of the GDC have hitherto been a blunt instrument to tackle issues of poor performance. A dentist’s conduct may give rise to concerns, but if that conduct does not cross the threshold of serious professional misconduct, the GDC has no powers to address such shortcomings, which may be, for example, in terms of attitude, aptitude or communication skills.

Other changes that will occur in 2005 and beyond with the section 60 order are:
1. Removal of restrictions on dental body corporates.
2. Dental hygienists and therapists enabled to develop new skills within their training and competence.
3. Regulation of other PCDs, such as dental nurses, dental technicians, clinical dental technicians and orthodontic therapists.
4. Mandatory indemnity cover for all registrants.

**Private patients’ complaints scheme**

The reforms in the pipeline are quite wide-ranging and will also establish a private patients’ complaints scheme, funded by the GDC but separate from it. This has always been a cause for concern both for the dentist and the public. Private patient complaints often do not amount to the suggestion that the registrant’s conduct would amount to serious professional misconduct, and therefore the GDC would have no reason to consider it. The only other route for the patient was a civil claim in negligence.

For the dentists themselves, the GDC’s involvement was an unwelcome and unnecessary addition to the stress of receiving a complaint.

The impetus for a private patients’ complaints scheme came also from the Office of Fair Trading (OFT), which had looked at dentistry following a super-complaint from the Consumers Association in 2001.

The scheme will mirror the NHS complaints scheme, with emphasis on supporting practices to resolve complaints locally. Where this is not possible, the new body will investigate and resolve complaints. As part of this local structure, there will also be GDC-recognised Practitioner Advice and Support Schemes (PASS) which may also look at a broad range of concerns about a dental professional, with panel membership drawn locally from the Health Authority and local practitioners.

**Disciplinary function (see Appendix 1)**

In common with the General Medical Council, the GDC has been reviewing its procedures, primarily in response to concerns from the public that misconduct among dental professionals was going unpunished, with dentists ‘looking after their own’. The review is also in response to the introduction of the Human Rights Act 1998. The lack of transparency and the seeming injustice of the Council being the ‘prosecutor’ and ‘adjudicator’ in disciplinary matters has resulted in the establishment of a separate fitness-to-practise panel whose members are appointed and not members of the GDC.

**Initial stage of complaint receipt**

The first stage in the procedure is the receipt of a complaint in writing. This complaint or information may come from a wide range of sources, such as a patient, another registrant, an employer or health authority, or the police.

The Council is informed automatically by the police if a dentist has been convicted in the UK of a criminal offence. The Council can consider any criminal conviction, including offences not directly connected to the practice of dentistry or which occurred while the dentist was not registered.

This has two significant implications. Offences such as fraud, assault, drink-driving and theft, even if unconnected with dentistry, will be reported to the GDC if they result in a criminal conviction. This also means that dental students, convicted of an offence whilst undergraduates, have found themselves facing GDC disciplinary proceedings as soon as they apply to become registered following graduation.

As part of the registration procedure, a dentist will need to satisfy the Registrar that they are fit to be registered, both in terms of health and character. A number of dental students have fallen foul of this regulation. A criminal conviction, or even a caution, will come to the attention of the Dean of the dental school, and university authorities are obliged to reveal the details of such episodes in their statement of good character to the GDC.

In
any case, under regulations in force since 2002, a dentist wishing to work in the NHS (even as a vocational dental practitioner [VDP]) must declare any convictions or police cautions to the Health Authority, who may then decline to issue an NHS contract number depending on the circumstances.

Patients’ complaints no longer need to be supported by a statutory declaration or an affidavit—a legal process that in the past hindered patients’ access to the Council’s disciplinary procedures.

**NHS or private complaint**

On receipt of the complaint, the GDC’s professional standards officers will decide whether the complaint is one that they can deal with. The first consideration is whether treatment was provided under the NHS or private contract. If the treatment was provided under the NHS, the GDC will usually consider referring the patient back to the Health Authority/Primary Care Trust (England and Wales), Health Board (Scotland) or Health and Social Services Board (Northern Ireland). The aim would be to try and resolve the complaint at a local level. Whilst a private patients’ complaints scheme remains to be established, many more patients who have received private dental care will address their complaints directly to the GDC without using the practice-based complaints procedure.

**Serious professional misconduct**

In 1987, the Judicial Committee of the Privy Council decided that in establishing ‘serious professional misconduct’, the ‘Council should establish conduct connected with his profession in which the dentist concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists and that falling short, as is established, should be serious’.

Cases coming before the conduct committee vary widely in nature and circumstances. Some cases recently considered include Example 1–5.

The emphasis on the seriousness of the misconduct is one of the key changes to take place. The aim in the new system will be to look at what past behaviour (i.e. the incident or complaint that has been brought to the GDC’s attention) says about that professional’s current and future suitability to continue on the register, as part of an overall assessment of their fitness for continuing registration.

---

Example 1

A dentist, in a single case brought to the GDC, had placed implants and fixed prosthodontic restorations. Whilst the dentist concerned recognised his shortcomings and accepted responsibility for them in this single case, the GDC were nevertheless concerned about his departure from good practice by not adequately warning of the risks associated with the proposed treatment, not providing a written treatment plan with costings, inadequate clinical planning of the case, poor record keeping and a failure to refer to an appropriately qualified colleague for continuing care. The dentist was not found guilty of serious professional misconduct, but the committee expressed its disapproval of his management.

Example 2

A dentist made 20 claims to the Dental Practice Board for payment to which he knew he was not entitled. In a number of cases, he altered the forms in order to mislead the Dental Practice Board into believing that he was entitled to these payments. In an attempt to defend himself, he fabricated periodontal records for 18 patients. He was found guilty of serious professional misconduct and was erased from the register.

Example 3

A dentist was found not to have explained in advance the treatment he proposed to a patient’s tooth, and also failed to obtain consent and explain clearly the costs of the proposed treatment. The dentist also admitted that when treating the patient he did not wear surgical gloves and was not assisted by a dental nurse or other person. As a direct result, the committee believed that he increased the risk of cross infection and compromised his ability to provide cardiopulmonary resuscitation if necessary. He was found guilty of serious professional misconduct and admonished.

---

1 Anonymised cases taken from the GDC Gazette, Summer 2003–Spring 2004 issues
This more holistic approach offers greater flexibility and lends itself to looking at wider issues of professionalism, communication with patients and teamwork skills, as well as the technical ‘standards-of-care’ aspects that are the common feature of clinical cases.

**Fitness to practise**

Under the amendment of 2004, the fitness to practise of a registrant may be impaired because of:

- misconduct
- deficient physical performance
- adverse physical or mental health
- a conviction or caution in the UK for a criminal offence, or a conviction elsewhere for an act which if committed in the UK would be an offence
- the ruling of another regulatory body that the registrant’s fitness to practise is impaired—this could mean that in the case of a doubly qualified dentist on both the GMC and GDC register, a determination in one will be notified to the other
- an allegation referring to conduct which occurred outside the UK or before the person was registered.

**Investigating Committee**

Under the amendments envisaged in the section 60 order, an allegation will be referred in most cases to the registrar and then on to the Investigating Committee. This committee does not currently exist, as part of its function is now carried out by the Preliminary Proceeding Committee, which will be replaced.

The registrant will be notified and will be invited to put comments to the Investigating Committee for their consideration. Rules of evidence normally governing legal procedures will be observed in investigating any allegation made against a registrant, and they have two main options available to them. If the committee feels the allegation does not warrant further consideration by one of the fitness to practise committees, it will take no further action. It may also issue a warning to the registrant regarding their future conduct, performance or practice. This may also take the form of advising the registrant that the matter under consideration will remain on file and may be referred to if any further allegations are made of a similar nature.

If the committee decides the allegation should be considered further it can refer the matter to the Health Committee, the Professional Performance Committee, the Professional Conduct Committee or the Interim Orders Committee.

**Professional Conduct Committee (PCC)**

The Professional Conduct Committee for any particular case will be drawn from the Fitness to Practise Panel. This has 35 panel members (15 dentists, 15 lay members and 5 PCDs). The intention is that where a particular registrant is being investigated, their speciality (e.g. general dental practice, PCD, etc.) will be reflected in the
make-up of the PCC for that case. The PCC will investigate the allegations, and under strict rules of evidence will be required to prove each allegation on the criminal standard of proof, i.e. beyond reasonable doubt. The committee will sit with a legal assessor, who is a qualified lawyer and can give advice about the legal process.

The proceedings, open to public and press, are like standard court proceedings where the registrant respondent (the person answering to the complaint) would normally be present throughout and represented by a barrister (counsel-instructed and funded by the registrant’s defence organisation), will be cross-examined by a barrister instructed by the GDC who act as the ‘prosecutor’, and will also have to answer questions from the PCC. Witnesses can be called by both sides.

If the allegations are not proved, the committee is required to publish a statement to that effect, subject to the registrant’s consent. If the allegations are proven, the committee (in private) will decide whether the proven facts demonstrate the registrant’s fitness to practise is impaired. In that case they can either:

- erase the registrant
- suspend the registrant’s registration for up to 12 months
- impose conditions on the registrant’s registration for a maximum of 3 years, the continuing registration being therefore conditional on complying with certain requirements, for example not practising unsupervised, not providing certain treatments or to certain categories of patients
- reprimand the registrant.

The PCC has further powers to review cases it has made determinations on and would be free to either remove or extend those original sanctions, depending on the conduct and performance of the registrants in the meantime. The registrant has a right of appeal against any decision made by the GDC through a process called judicial review to the Privy Council, as does the Council for Healthcare Regulatory Excellence (CHRE; see below), who may appeal a decision if they believe the GDC has been unduly lenient.

Any dentist erased will have the opportunity to apply to be restored on to the list before the expiration of the minimum erasure time. At the time of writing, this minimum erasure time is 12 months but the Government is proposing a period of 5 years. Both the GDC and the British Dental Association oppose this on the grounds that such a sanction is more akin to punishment and a disciplinary regime than a system for the protection of the public, and that it could be regarded as unfair and disproportionate. If the period is extended to 5 years, the registrant will only have two attempts in that period of erasure to apply successfully to get back on the list.

Guidance to the Professional Conduct Committee about what action to take if a person’s fitness to practise is deemed impaired can be quite illuminating. Erasure is regarded as being merited when certain behaviours are considered so damaging to a registrant’s fitness to practise, and to public confidence in the dental profession, that this sanction is the only appropriate outcome. The list given below, whilst not exhaustive or intended to cover all situations, suggests also that not to erase in these situations would require careful justification:

- Serious abuse of the clinical relationship.
- Other serious abuse of the privileged position enjoyed by registered professionals, e.g. prescribing powers, patient trust in terms of ‘expert’ advice.
- Causing serious avoidable harm to patients deliberately or by reckless substandard care.
- Putting patients in the way of serious avoidable harm by failing to maintain safe standards in relation to premises, equipment and other aspects of the clinical environment—this would include radiation safety and infection control.
- Failure to maintain professional knowledge and competence in areas relevant to the registrant’s practice—thus failure to do CPD would result in erasure.
- Violence and unlawful indecent acts.
- Failure to maintain appropriate indemnity or otherwise ensure adequate protection for patients.

**Professional Performance Committee**

The Professional Performance Committee has the same sanctions open to it that the PCC has, except erasure. There is as yet (because this committee
had not come into existence at the time of writing) very little guidance on what matters relating to the registrant’s conduct will be brought before the committee.

**Health Committee**

The Health Committee will be entitled to consider a matter where a registrant’s fitness to practise may be impaired by health-related problems. Its method of operation is based in statute and is to be found in a detailed document—*The General Dental Council Health Committee (procedure) Rules Order of Council 1984*.

The committee sits in private and is not open to the press or public. It consists of five people, of whom at least two are registered dentists and at least two are lay persons. Notification to the GDC of a registrant’s fitness to practise on grounds of health may come from a colleague or from another GDC committee. The registrant, upon notification of the Health Committee’s involvement, will be invited to submit to examination by at least two medical examiners chosen by the GDC. The registrant can obtain an independent medical report.

The medical assessors will be asked to report on the fitness of the dentist to engage in practice, either generally or on limited basis, and on their recommended management of the case. The dentist or a representative will be invited to give oral evidence at a hearing, and witnesses can also be called and examined and cross-examined by both sides.

The Health Committee has the power to suspend the registrant for up to 12 months or impose conditions on continued practice if they judge the fitness-to-practise of the dentist to be seriously impaired by reason of physical or mental condition. In coming to this conclusion, the Committee can take into account the dentist’s current or continuing and episodic condition, or a condition which although currently in remission may be expected to cause recurrence of serious impairment.

These cases are often unfortunate tales of drug or drink addiction and inevitably involve a degree of psychiatric impairment, where issues of judgement and rational behaviour are considered. These may also encompass organic psychiatric disorders.

**COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE (CHRE)**

One major public concern is the dental profession’s ability to deal effectively with its own members. In order to oversee the regulatory functions of the General Dental Council (as well as nine other professional bodies including the General Medical Council, the General Optical Council, the General Osteopathic Council, the General Chiropractic Council, etc.) an overarching body was created—the Council for Healthcare Regulatory Excellence (CHRE).

The Act that brought this body into being was the National Health Service Reform and Healthcare Professions Act 2002 (Part 2, section 25). Originally designated the Council for the Regulation of Healthcare Professionals (CRHP), the body changed its name to the Council for Healthcare Regulatory Excellence in July, 2004. The CHRE is a UK-wide organisation and the Act gives it authority to:

- promote the interests of the public and patients in relation to the regulation of healthcare professions
- promote best practice in the regulation of healthcare professions
- develop principles for good, professionally led regulation of healthcare professions
- promote cooperation between regulators and other organisations.

The CHRE has 19 members—one representative from each of the nine regulators (who is usually the president) and 10 ‘lay’ members.

Its biggest impact on dental practitioners will be on those dentists who find themselves on the receiving end of a sanction from the General Dental Council’s Professional Conduct Committee. If the CHRE considers that this sanction has been ‘unduly lenient’ in respect of a finding of professional misconduct or fitness to practise, or lack of a finding or in regard to any penalty imposed, they can refer the case to the High Court or the Court of Session (in Scotland).

The CHRE has 4 weeks to respond from the date on which the dentist concerned received the decision from the PCC, and therefore the dentist could face the potential stress of yet another hearing if the GDC decision is appealed by the CHRE. The Court of Appeal has recognised that
there is an element of double jeopardy, with the dentist being tried twice, but concluded that this was of secondary importance to the need to protect the public.

There is an automatic notice of relevant decisions to the CHRE by the regulators, and in the period September 2003 to October 2004, 526 cases were notified to CHRE for consideration. Of these, only 42 were considered in more detail at case meetings, and 13 cases were referred to the High Court. One of these was from the General Dental Council. This is despite the fact that in the Commons Committee stage of the Bill establishing the CRHP, the Minister said that the need to refer cases to court would be only ‘as a last resort to deal with exceptionally grave cases in which there has been a perverse decision or the public interest has not been fully or properly served…we believe that there will be very few cases—perhaps one or two a year’.

NATIONAL CLINICAL ASSESSMENT AUTHORITY (NCAA)

The NCAA was a special health authority that was established in April 2001 following recommendations made in the Chief Medical Officer’s reports: ‘Supporting doctors, protecting patients’ and ‘Assuring the quality of medical practice: implementing supporting doctors, protecting patients’. The NCAA provides a service to support the NHS in dealing with doctors and dentists whose performance gives cause for concern. They are able to provide advice to PCTs and Trusts about the local handling of cases, and where necessary carry out clinical performance assessments to clarify areas of concern and make recommendations on how difficulties may be resolved.

In order to help doctors and dentists in difficulty, the NCAA provides advice, takes referrals and carries out targeted assessments where necessary. The NCAA’s assessment involves trained medical and lay assessors. This is a full clinical performance assessment of the dentist, which considers clinical capability, health, behaviour and job context.

Once an objective assessment has been carried out, the NCAA will advise on the appropriate course of action. The NCAA does not take over the role of an employer, nor does it function as a regulator. The NCAA is established as an advisory body, and the NHS employer organisation remains responsible for resolving the problem once the NCAA has produced its assessment. As part of the development of systems and processes, the NCAA has liaised with regulatory and investigatory bodies such as the General Medical Council (GMC), Commission for Health Improvement (CHI) and the National Patient Safety Agency (NPSA), with whom it has developed memoranda of understanding. These are designed to ensure easy and swift cooperation, recognise each other’s distinct areas of operation and allow for fast-track referral of cases between the organisations to ensure that cases are responded to by the appropriate body.

As part of the DoH’s review of its arm’s length bodies in June 2004, the NCAA was brought together with the National Patient Safety Agency (NPSA), and established as a separate, self-contained division within the new agency, known as the National Clinical Assessment Service (NCAS).

The authority also conducts research and development into how performance problems can be identified and addressed, and runs an external education programme to support NHS managers in dealing with performance issues.

PATIENT COMPLAINTS IN DENTAL PRACTICE

A dissatisfied patient in general dental practice has a number of options open to them. They can simply vote with their feet and find themselves another practice. They may wish to complain to the practice themselves, or the health authority if the complaint is to do with the provision of services under an NHS contract. Or they may complain to the General Dental Council.

This section gives a broad outline of the three stages of the NHS system of complaints. It then goes on to describe briefly what happens at the GDC if a patient writes directly to complain about a dentist. This may be the only avenue open to them if treatment was carried out under private contract. Some general practitioners treat patients either under an insurance type scheme such as Denplan or as part of a quality assurance scheme such as the BDA Good Practice Scheme. Both these schemes have procedures in operation if a
patient should make a complaint about the services they have received.

From the introduction of the National Health Service in 1948 up until 1990, there was no official separate procedure for complaints, and these were dealt with under the service committee procedures as set out in the regulations. Thus, complaints and discipline cases were inextricably linked, to the detriment of both patients and practitioners.

Fundamental to the progress of the complaint was the identification of a breach of one or more of the practitioner’s Terms of Service. Without this, there was no complaint to answer and the patient was left with no further options under the NHS.

**Pre-1996: the ‘old system’**

Criticism of the NHS complaints system in the 1980s and 1990s centred on three issues: a) it was biased towards dentists, b) the procedures were opaque and c) it focussed too much on disciplining rather than resolution of the patient’s complaint. In 1993, in response to the disquiet amongst professionals, academics and patient interest groups, the Wilson Committee was asked by the Government to review the NHS complaints procedure. They reported their findings in ‘Being heard—the report of the committee on NHS complaints procedures’ (1994). The committee identified nine principles that should be introduced into any NHS complaints procedure: responsiveness, quality enhancement, cost effectiveness, accessibility, impartiality, simplicity, speed, confidentiality and accountability.

Their conclusions ran to over 60 recommendations but fundamental was:

- introduction of a single procedure applicable throughout the NHS
- a three-stage process involving ‘local resolution’, ‘independent review’ and the Health Service Commissioner (HSC)
- an extension of the HSC’s jurisdiction to GDPs (and other Part II practitioners) so as to cover ‘clinical judgement’ complaints.

The government accepted the Wilson Committee’s recommendations in ‘Acting on complaints’ in March 1995, and on April 1, 1996 the ‘new complaints’ procedure was introduced into the NHS for doctors and dentists. The most significant change was the separation of the complaints procedure from disciplinary procedures, thus allowing a wider range of issues to be addressed within the complaints procedure. It also meant that practitioners would be more likely to engage fully with the process knowing that disciplinary issues were not the usual endpoint to the investigations.

**Post-1996: the ‘new system’ and future reforms of the complaints system**

For dentists, the need to have a practice-based complaints procedure and to publicise it became an NHS Terms of Service requirement.

(1) Subject to sub-paragraph (2) a dentist shall establish, and operate in accordance with this paragraph, a procedure (in this paragraph and in paragraph 31B referred to as a ‘practice based complaints procedure’) to deal with any complaints made by or on behalf of his patients and former patients.

In terms of scope, the complaints procedure applies:

…to complaints made in relation to any matter reasonably connected with the dentist’s provision of general dental services and within the responsibility or control of

- a) the dentist
- b) any other dentist either employed by him or engaged as a deputy
- c) a former partner of the dentist
- d) any employee of the dentist other than one falling within paragraph (b)

The paragraph goes on to outline who should be responsible for receiving and investigating complaints, who can make a complaint, the time limits for an acknowledgement (3 days) and full response (10 days), and the need to inform patients about the existence of the complaints procedure and the named complaints manager.

There is a further requirement to provide the health authority with an annual return, specifying the number of complaints received by the practice where all other dentists are included on the dental list and are working together.

In addition to there being a terms of service requirement for NHS practitioners, the GDC expects that ‘if a patient has cause to complain
about the service provided, every effort should be made to resolve the matter at practice level’ and that the Council ‘endorses the detailed guidance on handling complaints which has been issued by the NHS Executive and the British Dental Association and would expect compliance’.

The details of the current complaints procedure are to be found in the NHS Executive document: Complaints: listening, acting, improving: guidance pack for general dental practitioners (1996).

Complaints manager

The intention of having a complaints manager is to ensure one person has an overview of the whole complaints system and will assume the task of coordinating the correspondence and replies. The person nominated to administer the complaints procedure should be identified as such to patients. In a small practice it is usually the dentist who acts as the complaints manager, but this would be inappropriate if the complaint was about that particular dentist. In this case another member of staff should act as the coordinator.

Complaints and disciplinary procedures to be separated

4.28 Policy remains firm on the need for the new complaints procedure to be concerned only with resolving complaints and not with investigating disciplinary matters. The purpose of the complaints procedure is not to apportion blame amongst staff. It is to investigate complaints with the aim of satisfying the complainant (while being scrupulously fair to staff) and to learn any lessons for improvement in service delivery.

Because of the previous intertwining of the complaints procedure with discipline, unless the complaint could be framed in such a way as to fall within a dentist’s terms of service, it could not be considered. The aim of separation was therefore to widen the scope of the complaints procedure but at the same time remove the threat of disciplinary action from the dentist.

Information gathered in the complaints process by the practitioner as part of local resolution, belongs to the practice and is kept separate from the patient’s records. The Health Authority therefore has no right of access to it and, it could be argued, neither does the patient. It was felt by the Wilson committee that this guidance was necessary to avoid repercussions for the patient later if it is known they have made a complaint about the practice in the past, especially as the notes will be transferred on to any new doctor who sees the patient. In the case of general dental practice the notes remain with the practice and are seldom transferred to other practices.

A practitioner must consent to its release and it cannot be made available automatically for use in disciplinary investigations, although the Ombudsman has powers to require the production of information and documents.

Possible claims for negligence

4.37 The complaints procedure should cease if the complainant explicitly indicates an intention to take legal action in respect of a complaint.

The guidance in relation to this issue makes it clear that responding to the complaint openly may be sufficient to satisfy the complainant, even if the initial contact is via a solicitor’s letter. The reality is that communication has already broken down between the patients and dentist, and it would be hard to reconcile differences through the mediation of a ‘no win no fee’ solicitor. A dentist would be unwise to make admissions in these circumstances despite the guidance that ‘a hostile, or defensive, reaction to the complaint is more likely to encourage the complainant to seek information and a remedy through the courts’ (para 4.38).

4.39 In all prima facie cases of negligence, or where the complainant has indicated the intention to start legal proceedings, the principles of good claims management and risk management should be applied. There should be a full and thorough investigation of the events.

Where it is appropriate, defence organisations may advise a dentist to settle the matter by a reimbursement of fees or an ex gratia payment.

Local resolution—stage one

Local resolution is the first part of a three-stage process that is common to all sectors of the NHS.
The intention is to make this part of the process responsive enough to deal with the majority of the complaints received by a general dental practitioner, the aim being that the practice itself deals with the problem quickly and efficiently.

A complaint can come either verbally, in person or on the phone, or in writing. It may be directed to the practice or to the health authority. In the latter case, the health authority advises in the first instance that the complainant writes or contacts the dental practice concerned to make their complaint. Complaints may be made about virtually any aspect of healthcare and are not confined to the treatment provided.

The response times for general practices are expected to be an acknowledgement within two days and a full response within ten working days. These are for guidance only but it is generally accepted that the longer the delay in responding, the more entrenched both parties may become. However, staff may be on holiday, have moved to another practice or are awaiting advice and draft letters from their defence organisations and therefore these guidelines are often overlooked.

**Conciliation**

As part of the local resolution stage, conciliation should be offered where, following an investigation, an immediate oral response seems inappropriate or where the complainant remains dissatisfied following an earlier response. The health authority may already have become involved if the complainant has written directly to them. In this case the health authority normally writes to the dentist, enclosing a copy of the complaint with an offer to use the services of their lay conciliator. This is provided free of charge to both parties, but both parties need to agree to it.

Conciliation is used when a person wishes to complain under a practice-based procedure, and it would (in the opinion of the health authority) be unreasonable to expect the complaint to be made directly to the dentist concerned, or where the complainant is dissatisfied with the investigation carried out in the practice-based procedure.

The complainant should be advised of the complaints procedure and that they have a right to seek an independent review if they remain unhappy with the practice-based response.

**Independent review—stage two**

Complainants who are not happy with the practice-based response may seek an independent review of the matter. They may do this only in relation to NHS services. Where private dental treatment has been provided, and that is the source of complaint, they do not normally have access to this system.

Up until 2004, the independent review stage was carried out by the health authority who, via a screener, reviewed the complainant’s request to establish an Independent Review Panel (IRP). There was no absolute right to an independent review, and it was a matter for the convenor’s discretion. This stage (most of all) was criticised as lacking any real independence, and the decision-making process by the panels was inconsistent, primarily because they sat so infrequently.

In response to these and other concerns, the 1996 complaints procedure underwent an independent evaluation during 1999–2000. The evaluation report (NHS complaints procedure national evaluation) and a listening document (Reforming the NHS complaints procedure—a listening document) were published in 2001. In 2003, the Department of Health published NHS complaints reform—making things right, which described proposals to reform the NHS complaints procedure. This resulted in further legislative changes and came into force in July 2004 as the ‘National Health Service (Complaints) Regulations 2004’. These regulations do not cover the local resolution stage of complaints in general dental practice, as these remain regulated by The National Health Service (General Dental Services) Amendment Regulations 1996.

The original intention was to implement the reformed complaints in procedure in full from June 2004, but Ministers decided to phase it in after the 5th report from the Shipman Inquiry, which published in December 2004. The reports from the Neale and Ayling inquiries will also influence the direction of the complaints procedures.

The new arrangements do apply to general dental practitioners for independent review, as set out in part III of the complaints regulations.

**Healthcare Commission**

The Healthcare Commission (formerly known as the Commission for Healthcare Audit and
Inspection) took over the second stage of the NHS procedure in England and Wales in July 2004. They cannot consider a complaint where the complainant has stated in writing an intention to take legal proceedings.

All requests for an independent review will be acknowledged within two days. The requests to involve the Healthcare Commission can come from the patient, or trusts with the patient’s consent. There will then be an initial review during which a member of the Healthcare Commissioners Complaints Team will review the case, with the help of expert advice if necessary, to determine whether further investigation is needed. A letter with the decision and any recommendations will be sent to the complainant and the practitioner about whom the complaint is made, within 20 days. The Healthcare Commission at this point can refer the complainant to the GDC or the Health Service Commissioner.

If the Healthcare Commission decides to carry out a further investigation itself, the terms of reference will be sent to the complainant and the practitioner they are complaining about for comment, and both parties will receive a full report of their findings at the end of the investigation. The Healthcare Commission has wide discretion to conduct its investigation in any manner it sees fit and may take any advice it deems to be required.

If the complainant is unhappy with the outcome of the investigation, they have a right to request an independent panel to hear their concerns. The panel will consist of three members of the panel who are unconnected to the NHS but are trained in dealing with complaints. The panel will hear from both sides of the complaint, and a participant before a panel may be accompanied or represented by a friend or advocate but not by a legal representative acting as such. The panel will then make recommendations for resolution and/or for improving the services where appropriate.

**Health Service Commissioner (Ombudsman) (HSC)—stage three**

The Health Service Ombudsman is the third tier of the complaints system in the NHS. The Health Service Commissioners for England and Wales came into existence as a result of the National Health Service Reorganisation Act 1973 (subsequently Part V of the National Health Service Act 1977) but their jurisdiction is now defined by the Health Service Commissioners Act 1993 (as amended).

In accepting the recommendations from the Wilson Committee, the government extended the jurisdiction of the Health Service Commissioners to complaints against dentists (and other Part II practitioners) and to those involving clinical judgement in section 6 of the Health Service Commissioners (Amendment) Act 1996. This was a new step but recognised by the Health Service Commissioner at the time, William Reid, as being another burden: ‘I well understand the concern of professionals about the potential multiple jeopardy they face—from the courts, the regulatory bodies and now the Ombudsman—when encountering complaints about their practice’.

The HSC can only investigate a dentist where it has received a complaint by or on behalf of a person if they have sustained injustice or hardship in consequence of action taken by the family health service provider. Action includes inaction and a failure to provide a service.

Any complaint about a dentist to the HSC must be about action related to NHS services the provider has undertaken to deliver. This means that dental treatment provided under private contract falls outside the remit of the HSC, although there have been investigations conducted where the patient believed they were having NHS treatment when in fact it was private. The HSC can also investigate, amongst other bodies: health authorities, primary care trusts and the Dental Practice Board.

Before the HSC can investigate a complaint, it must be demonstrated that the complainant pursued the matter under the local resolution phase. An investigation cannot be instigated until those procedures have been ‘invoked and exhausted’, unless in the particular circumstance of a case it is reasonable for this to happen.

There are statutory limits to what can be investigated by the HSC. These include complaints about personnel issues, actions taken by health authorities in connection with disciplinary cases (the old service committees) and commercial or contractual matters.

**Legal remedy**

The HSC cannot investigate complaints about matters where the complainant has or had: