CHAPTER THREE

Professional duties of dentists

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Dentists, especially general dental practitioners (GDPs), are often eager to attend postgraduate courses to learn new techniques to enable them to offer advanced treatments or cosmetic work, including implants. These areas can be most remunerative. However, it is often forgotten that this is the very type of work that attracts complaints that may lead to litigation. The safety of patients is paramount and should over-ride personal and professional loyalties.[1]

The Lord Chancellor, writing in the *Medical Law Review*,[2] has said that medical litigation is increasing and awards made by courts are often startlingly high. As dental technology advances and new materials come to the market, expectations rise and the consumer can become over-optimistic. Dentists or doctors cannot and should not guarantee success for any treatment undertaken. Patients have the right of self-determination, the right to a treatment plan with costs anticipated and the right to refuse any treatment. It is the duty of a dentist to respect these rights.

This chapter will cover the following topics.

- Professions and professionals: history and development
- Standards of care: duty of care to protect the life and health of patients
- The importance of continuing education
- Unethical and unsafe practice in dentistry: ‘whistle blowing’
- Health and professional performance: risks, duties to disclose problems and sources of help
- Public expectations of dentistry; difficulties in dealing with uncertainty and conflict
- Ethical importance of good inter- and intraprofessional communication and teamwork

Professions and professionals: history and development

The history of dentistry dates back to almost the 5th century BC, with some forms of dental knowledge exhibited amongst the Phoenicians, Egyptians, Chinese, ancient Hebrews and Europeans.[3] In Europe those who practised dentistry in the 19th century were called 'surgeon-dentists'. They lacked any scientific knowledge and often inflicted harm on their patients.[3]

In England dental hospitals were established before dental schools. The first dental hospital opened its doors in 1858 in London. In 1860 the Royal College of Surgeons held the first examinations for the Licentiate in Dental Surgery, but it was not until 1878 that the first Dentists Act was passed authorising the General Medical Council to maintain a register of qualified dentists who could call themselves 'dental surgeons'. Unfortunately the Act did not prohibit those who were unqualified from practising dentistry, it only prevented them from calling themselves 'dental surgeons'. The untrained continued to practise without fear of prosecution.

In 1917 the government set up a committee to 'enquire into the extent and gravity of the evils of dental practice by persons not qualified under the 1878 Act'. On the basis of the report, the Dentists Act 1921 was passed. The stricter controls laid the foundations for the current system of regulation, with offenders liable to a £100 fine. The Act also prohibited corporate bodies from carrying on the business of dentistry unless certain conditions were met.

The 1921 Act gave the profession a measure of autonomy by setting up a Dental Board. Though under the control of the GMC, this was the forerunner of the General Dental Council. The 1921 Act permitted unqualified dentists to register if certain conditions were met, such as age over 23 years, being of good character and if dentistry was their principal means of livelihood in five of the seven preceding years.[3]

The 1956 Act granted the profession full self-government by establishing the General Dental Council, with powers to supervise dental education, maintain and publish the Dentist's Register and enforce standards of professional discipline. The 1956 Act was an amendment of the previous Acts. A consolidating Act was passed in 1957.

The European Dental Directives in 1978 required member states to adhere to common standards of training for primary and specialist qualifications and to permit migrant dentists with appropriate qualifications the freedom to work in the host state. Recognition of specialist qualifications was not implemented until 1998.

Then followed the Acts of 1983 and 1984. The Dentists Act of 1957 was improved and updated in 1983, including the establishment of the Health

Committee. The Act was consolidated in 1984, under which the profession still operates.

The Health Act 1999 received Royal Assent on 30 June 1999. Provisions of the Act enable the Secretary of State to make changes to the Dentists Act 1984 by Orders in Council. Hence primary legislation will no longer be required to amend the Dentists Act.[4]

Definition of a professional

A profession is an occupation requiring advanced education and involving intellectual skills, examples being medicine, dentistry, law, etc. It is a vocation or calling that involves some branch of learning or science.

A professional is a person doing something with great skill or one engaged in or worthy of the standards of a profession. The professional uses his or her knowledge by its practical application to the affairs of others, serving their interests or welfare.[5]

A successful professional is one who benefits mankind, has a fair degree of independence and is respected within his or her community.[5]

Standards of care: duty of care to protect the life and health of patients

In the ordinary law of negligence the conduct of the reasonable man is assessed. In medical or dental law the reasonable doctor or dentist is substituted for the reasonable man. The concept of duty is the key controlling feature of the modern law of negligence,[2] regardless of whether that duty arises in contract or tort. Reasonable conduct is not negligent,[6] unreasonable conduct can amount to negligence.

In Bolam v Friern Hospital Management Committee 1957,[7] Mr Justice McNair held that: 'The doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'. The Bolam test was affirmed in the House of Lords in 1980.[8]

In Sidaway v Board of Governors of Bethlem Royal Hospital and Others 1985,[9] the standard of care was on the issue of what information should be given to a patient to obtain valid consent to treatment. It was held that the Bolam test applied. Lord Diplock said: 'In matters of diagnosis and the carrying out of treatment the court is not tempted to put itself in the surgeon's shoes; it has to rely on expert evidence'.

In Australia it is the courts, and not the profession, that determine the standard of care. In Canada Bolam was never accepted, as it would allow 'doctors to legislate themselves out of liability'.[10] In Reibl v Hughes in 1980,[11] the Supreme Court of Canada held that the doctor's duty was to provide information that a reasonable patient would wish to know.

Bolam was revisited in the UK in 1997 in Bolitho,[12] where the House of Lords upheld the principles of Bolam but reserved the right to intervene if medical opinion was not reasonable, not responsible or if it was illogical.

Duty to protect the life and health of patients

No treatment should be undertaken if it is going to harm the patient even if the patient specifically asks for that particular treatment. The patient's best interest should be the primary concern of the practitioner. The practitioner should say 'no' where appropriate.

The GDC maintains a serious view on the taking of medical history. History taking, both dental and medical, is a special form of the art of communication.[13] It informs dentists of risks that they may encounter and precautions that may be necessary. Practitioners are advised to make themselves familiar with the Dental Practitioners' Formulary and, if necessary, to communicate with the patient's medical practitioner.

Unnecessary exposure of patients to radiation must be avoided. Practitioners should be familiar with the Department of Health's publications *Radiation Protection in Dental Practice* and *Radiological Protection July 1988* and the Report by the Royal College of Radiologists and the National Radiation Protection Board 1994.

General anaesthesia is a procedure which is never without risk.[1] The GDC has published very precise guidelines on the use of general anaesthesia. Every surgeon has a responsibility to abolish pain during surgery but this should not be at the risk of endangering the patient's life.

The importance of continuing education

In its ethical guidance *Maintaining Standards*, the GDC states:

> In the interest of patients, a dentist has a duty to continue professional education whilst continuing to practise. A dentist who fails to maintain and update professional knowledge and skills and who, as a result, provides treatment which falls short of the standards which the public and the profession have a right to expect, may be liable to a charge of serious professional misconduct. (para. 1.3)

Each generation of professionals may on occasion accuse its predecessors of ignorance as standards of competence steadily rise.[14] Practitioners must exercise such care as accords with the standards of reasonably competent medical professionals *at the time.* They must keep themselves up to date and cannot 'obstinately and pig-headedly carry on with the same old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion'.[14]

Lifelong learning: recertification for the dental profession

The GDC's Reaccreditation and Recertification scheme for the dental profession was launched at Dentistry 2000 in Birmingham. A preparatory scheme was introduced in October 2000. Dentists are expected to complete 250 hours of continuing professional development (CPD) activity over a five-year period. Not less than 75 hours must be 'verifiable' CPD while the remainder can be 'general' CPD. The scheme will become mandatory as soon as legislation permits.

The GDC's aim is to promote high standards to ensure the protection of the public through the profession's commitment to dental education. The concept of clinical governance was outlined in the government's White Paper, *A First Class Service: quality in the new NHS*. Recertification will ensure that all dentists update their knowledge and acquire new skills in order to benefit their patients and enhance the quality of their professional lives.

The scheme will operate in five-year cycles. At the end of five years dentists will have to declare the number of hours of verifiable and general CPD completed in the preceding five years. Registration will be conditional on completion of minimum hours specified in the scheme. The scheme will be widely publicised, monitored, scrutinised and, where necessary, dentists may be given additional time to comply. Non-compliance may lead to erasure. There will be a right of appeal to an independent review panel and a final right of appeal, perhaps to the Privy Council.

Unethical and unsafe practice in dentistry: whistle blowing

As a professional, a dentist has an obligation to put the patient's best interest before any self-interest. Para 3.1 of the GDC's ethical guidance says:

As a member of a caring profession, a dentist has a responsibility to put the interests of patients first. The professional relationship between dentist and patient relies on trust and the assumption that a dentist will act in the best interests of the patient. Abuses of this professional relationship may lead to a charge of serious professional misconduct.

It is unethical for a dentist to mislead NHS patients by saying that certain treatments are not available on the NHS when the statement is untrue. Once a patient has been accepted for NHS care then it becomes the responsibility of the dentist to provide all the treatment that is available on the NHS, which the patient is willing to undergo to secure his or her oral health.

Some of the more common forms of unethical conduct are as follows.

- Providing composite restorations on posterior teeth without explaining the advantages and disadvantages of the filling material to patients, thus negating true consent.
- Instructing a dental technician to ask for denture work to be provided economically to meet NHS standards when the actual contract with the patient is for private work.
- Mixing of NHS and private work (which is permitted on NHS patients) without agreement and when genuinely the private treatment offered is not available on the NHS. Patients must not be misled.
- Over-prescribing treatment. All over-prescribing is deemed to be not only unethical but also to constitute an assault on the patient.
- Refusal to treat a patient solely on the grounds that the person has a bloodborne virus or any other transmissible disease or infection.
- Breaching patient confidentiality. A dentist so doing may be found guilty of serious professional misconduct.

Unsafe practice in dentistry occurs where there is:

- a lack of proper equipment
- poor record keeping and omitting to take an adequate medical history
- poor cross-infection control
- an incompetent practitioner or untrained staff, neither updating their professional skills
- undertaking techniques and forms of therapy which are unproven
- a dentist practising with a transmissible disease or a bloodborne virus
- impaired mental health due to drink or drugs or psychiatric illness
- non-compliance with health and safety issues
- undertaking sedation or general anaesthesia contrary to the GDC’s ethical guidance.

It is not possible to list all forms of unethical conduct or unsafe practice in this chapter. Readers are referred to the GDC's ethical guidance *Maintaining Standards*, the BDA's Advice Sheet B1 *Ethics in Dentistry* and *Quality Systems for Dental Practice*.

Whistle blowing

Under-performing dentists bring the whole profession into disrepute. The GDC's ethical guidance in *Maintaining Standards* states that:

> A dentist must act to protect patients when there is a reason to believe that a colleague's conduct, performance or health threatens them. The safety of patients must come first at all times and should over-ride personal and professional loyalties.
>
> As soon as a dentist becomes aware of any situation which puts patients at risk, the matter should be discussed with senior colleagues or an appropriate professional body.

Under-performing dentists will not only get themselves into trouble sooner or later, but in so doing they will undermine public confidence in the whole profession, as did happen in Appleton v Garrett 1997 where a dentist was convicted for committing a battery on his patients.

The Public Interest Disclosure Act 1998 protects whistle blowers from being victimised. It was enacted to protect employees and is of only limited value in dentistry as most dentists are self-employed. In 1986 the Federation Dentaire Internationale (FDI) passed a resolution that discouraged whistle blowing. However, in today's climate of high expectations, and the direction from the GDC, whistle blowing has been made respectable in the interests of the public and the profession.

Where there is concern about another dentist it is best to discuss the matter with senior colleagues, defence organisations, professional associations and the dentist concerned. If there is no improvement the dentist should be warned that a complaint may be made to the health authority concerned or to the GDC. The aim should be, as a first step, to support and educate the dentist. At this stage confidentiality should be maintained.

> Networking is a powerful tool, with the advantage being that it is informal and flexible. Whistle blowing is an ethical issue determined by a mix of attitudes, values and culture. Although there will always be guidelines, it remains an unwritten code, self-regulated and voluntarily accepted.[15]

The GDC has approved a Performance Review Scheme which will be established when the necessary legislative framework is in place. The aim of the scheme will be to protect the public and to educate dentists whose professional performance is seriously deficient. An independent Professional Review Committee will be set up with the power to impose conditions on a dentist's registration and an erasure for non-compliance. There will be a right of appeal to the Privy Council or the High Court.

Health and professional performance: risks, duties to disclose problems and sources of help

Para. 4.2 of *Maintaining Standards* says:

> A dentist who is aware of being infected with a bloodborne virus or any other transmissible disease or infection which might jeopardise the well-being of patients, and who takes no action, is behaving unethically. The Council would take the same view if a dentist took no action when having reason to believe that such infection may be present.
>
> It is the responsibility of the dentist in either situation to obtain medical advice which may result in appropriate testing and, if a dentist is found to be infected, regular medical supervision. The medical advice may include the necessity to cease the practice of dentistry altogether, to exclude exposure-prone procedures or to modify practice in some other way.

Failure to observe the above guidance may lead to a charge of serious professional misconduct.

The current Health Service Guidelines HSG (93) 40 *Protecting Healthcare Workers and Patients from Hepatitis B* recommend that healthcare workers infected with hepatitis B who carry the e-antigen, a marker indicating high infectivity, should not perform exposure-prone procedures, where there is a risk that injury to the healthcare worker could result in their blood contaminating the patient's open tissues.

Health Circular 1998/226 supersedes the 1994 guidance on the management of AIDS/HIV-infected healthcare workers. It reflects the conclusions of an independent review commissioned by the Department of Health on the risk of HIV transmission from an infected healthcare worker to a patient. Dental students and all healthcare workers are advised to read the new guidance that can be obtained from the Department of Health, Communicable Diseases Branch, Wellington House, 133–155 Waterloo Road, London SE1 8UG.

Alcohol and drugs

Complaints of drunkenness or misuse of drugs can lead to a charge of serious professional misconduct or referral to the Health Committee of the GDC. A dentist should prescribe drugs only in connection with the provision of *bona fide* treatment.

The Sick Dentist scheme was established in 1986 to help dentists who needed medical attention. It also served to protect patients and the reputation of the profession. There are regional referees and a scheme co-ordinator. If a dentist feels that a colleague may be in need of help (and to protect him or her from a complaint to the GDC) he/she should telephone 0207 487 3119. This number is widely advertised in the dental press.

Public expectations of dentistry: difficulties in dealing with uncertainty and conflict. Ethical importance of good inter- and intraprofessional communication and teamwork

Public expectations of dentistry are well summed up in the GDC's booklet *The Duties of a Dentist.* The information in this booklet was designed for dental students and the public. The topic is covered elsewhere in this book (*see* Chapter 7).

Uncertainty and conflict

Uncertainty and conflict lead to mental arguments as to how to act in certain situations. The dentist has to choose between alternatives. The rules of confidentiality may present such a dilemma, but remember, like discretion, confidentiality can never be absolute. Justice Tobringer has said: 'The protective privilege ends where the public peril begins . . .'.[16]

A request from the police to provide dental records of a patient may present ethical problems. There may be no problem if the records requested are only to identify a corpse. If patients intentionally want their whereabouts to be kept secret, they have every right to expect this and the dentist should not disclose addresses or any other information that may be used to trace them. Whenever faced with a dilemma a practitioner should carefully weigh the interest of society with that of the patient. If in doubt, advice should be sought from the defence body. A dentist, by law, has to help the police in a case where a crime has been committed. When a school telephones to ask if a child had a dental appointment, the dentist should

co-operate if the child is very young, say under 10, but seek advice from the defence organisation if the child is older as maintaining confidentiality becomes important.

In one case a wife informed the practice that she was pregnant and was therefore exempt from NHS charges. She said that her husband would be attending later that day and he should not know about her pregnancy. After his treatment, at the reception, the husband offered to pay for his wife. The receptionist, not knowing what to do, went to the dentist for help. She told the husband that his wife did not owe anything. Where a patient specifically requests confidentiality, even if it is from a spouse, confidentiality must be strictly observed.

There may be instances where a wife may not want her husband to know that she wears dentures. She is entitled to her rights of privacy. Some patients may not wish even the postman to know who their dentist is or when they will be at the dentist (security reasons). That is why the GDC encourages dentists to send reminder cards in envelopes.

A dentist may wonder what to do when a young patient requests the extraction of a painful upper anterior tooth, refusing endodontic treatment advised by the dentist. If such a patient is fully competent (has the capacity to consent) and the dentist has explained the consequences of extraction and the patient still wishes an extraction, the approach may be to prescribe antibiotics for the infection and to recall the patient after a few days. Often, if pain has been relieved, patients may change their mind. Involve the parents if the youngster is below age 16.

If it is uncertain even after taking radiographs whether there is decay in a tooth, a practitioner may wish to keep the surface under observation. The suspicion must be recorded. Good and clear records must be maintained. Clinical opinions can differ but the dentist must always act in the patient's best interest.

When there is conflict, the principles of patient autonomy should be weighed against those of benefit to the patient. Professor Dworkin has argued that mild paternalism may be considered as a 'social insurance policy'.[17] Treatment must not be forced on any patient. The wishes of the patient should be respected and treatment refused if that may harm the patient.

Inter- and intraprofessional communication and teamwork

Communication remains a vital element in every relationship, be it between the GDC and the public, between the GDC and the profession or

between the dentist and the patient.[18] This is equally true between the dentist and other members of the dental team: the hygienist, dental nurse, receptionist, dental technician and the practice manager. Good communication avoids misunderstandings in the dental team and adds to the efficiency of a practice. Sir Douglas Black, writing on the responsibilities of consultants, said:

> This wide field of communication is one in which all of us have still much to learn, sometimes sadly from our own mistakes. In the immediate present context, I would underline the importance of good communication in preventing complaints, and of bad communications in engendering them.[19]

The Royal Commission on the NHS reported that almost one third of inpatients did not consider they were given sufficient information about their treatment and care. Silence and half-truths under the guise of 'therapeutic privilege' will only add to vagueness and inconsistency, creating suspicion that undermines professional integrity.

Teamworking pervades all walks of life and is gradually becoming recognised as the concept for the future in general dental practice.[21] Dame Margaret Seward defines a dental team as: 'all members of the practice, clinical or hospital staff who are involved in the provision of oral healthcare to the patient'. The patient is an integral part of that team, with the dentist as team leader. Dame Margaret, a Director of Teamwork, has worked tirelessly to improve the recognition of individual members of the dental team. She says that: 'Fundamental to success is a realisation that decision making must be taken by the team and free discussions must be held amongst team members at regular intervals'.[20] Together Everyone Achieves More (TEAM). There are five volumes of Teamwork obtainable from: Teamwork Office, 19–21 Northumberland Road, Sheffield S10 2TZ.

References and notes

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