PROFESSIONALISM AND THE FOUNDATIONS TO DENTAL PRACTICE

Law & Ethics in Dentistry Theme

COURSE MATERIALS

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This material was originally prepared by the Centre for Biomedical Ethics, which is part of the Division of Primary Care, Public and Occupational Health. However it has been extensively revised to reflect a greater emphasis on the impact of ethics and law on dentistry and the delivery of dental care. This theme will introduce students to a comprehensive range of ethical and legal problems that arise in clinical practice. Dental students need to know how to recognise an ethical problem, how to analyse it in an orderly and rational way and to know what constitutes a good ethical reason and what does not. You need to understand the complexity of ethical decision-making and be able to present your own viewpoint and decisions confidently while at the same time remaining respectful of the views of others. This is not a course in moral philosophy, but an understanding of the ethical principles and theories that underpin the framework for analysis is essential. The course seeks to heighten your awareness and to raise your sensitivities to ethical and legal issues. It should encourage your reflection on your own values and help you to understand the values of others better.

In, *Preparing for practice* the GDC places ethics and law and the demonstration of professionalism as one of the four key domains that all dental registrants must demonstrate from their first day of registration. Importantly the GDC place an emphasis on students being able to demonstrate the attributes of professional attitudes and behaviour from the beginning of their training. At Birmingham, we have taken this to mean that it is important throughout your training and this module lays the foundation for teaching which will take place in other parts of the course. The General Dental Council, in its publication *Standards Guidance*, clearly sees ethics and law as continuing to be of great importance to your professional practice throughout your career.

The outline of the sessions looks like this:

**LECTURES:**

1. Introduction to Health Care Ethics & Law
2. Consent to Treatment: The Competent Patient
3. Consent to Treatment: The Incompetent Patient
4. Confidentiality
5. Negligence
6. Research
7. Truth-telling and Whistle-blowing
   Professional competence and performance
8. Poor Performance
9. Business Ethics
10. Consolidation and Revision

**SMALL GROUP SESSIONS:**

1. Consent: Competent and Incompetent Patients
2. Negligence and Confidentiality
3. Truth-telling and Whistle-blowing
4. Poor Performance
5. Business Ethics
WHAT IS ETHICS?

A useful definition of health care ethics is given by Professor Raanan Gillon, as:

“the analytic activity in which the concepts, assumptions, beliefs, attitudes, emotions reasons and arguments underlying medico-moral decision-making are examined critically” (Philosophical Medical Ethics, BMJ, 1985 at 2).

The purpose of this course is to question the ways in which we make controversial health care decisions and to learn how to defend the hard choices that we have to make in practice. The tremendous scientific and technological advances that have taken place in dentistry over the last half-century and the moral (and legal) dilemmas that have arisen as a result have brought health care ethics to the fore. In our “hi-tech” health care system it is possible to benefit patients, but it is also possible to cause them substantial harm. Exploring how to work within an ethical and legal framework will not only ensure that harm is avoided or minimised but will also provide a basis for decision making. Finally, may we take this opportunity of welcoming you all to Health Care Ethics and Law. We look forward to working with you.
LEARNING HEALTH CARE ETHICS AND LAW IN YEAR 1

Your foundation course largely follows the core curriculum devised by the UK’s teachers of Health Care Ethics and Law in a series of meetings and correspondence throughout 1997-8. The consensus document, which outlines the agreed curriculum was widely published (see: Journal of Medical Ethics 1998; 24: 188-192; British Medical Journal 1998; 316:1623-1624) and you might like to refer to it for interest.

Health Care Ethics and Law is based on a problem-solving model of learning. Sessions are divided into lectures and small group discussions. The lecture will complement and expand upon some of the main issues addressed in your handbook for each session. Then in your small group sessions various tasks/exercises will be set which will allow you to apply what you have learned in the lecture.

SMALL GROUP DISCUSSIONS

In the small group discussion sessions you will discuss cases and use problem-solving strategies to arrive at defensible decisions. Each discussion group will consist of approximately fourteen to eighteen students and the membership will remain the same for all sessions. The tutor assigned to your group will facilitate and guide the discussion and will try to help you with technical details, but the decisions that you reach about the cases will be your own and they will emerge from the contributions of the students in the group.

In order for the small group discussions to be effective, you must be respectful of the ideas and beliefs of other people. It should be an environment in which you feel free and comfortable to participate and voice your views. It is okay in fact it will be beneficial to the discussion if you do not all agree on a particular subject. We all come with our own agendas and our own belief systems. Discussing contrary opinions on the same issue is one of the goals behind these small group sessions.

Last but not least, your attendance at the small group sessions is compulsory and a register will be taken at each session. Failure to meet the minimum requirement without an appropriately signed note will result in your name being forwarded to the module co-ordinators.

SELF-DIRECTED LEARNING

It is your responsibility to attend the lectures, to participate in the small group sessions and to read and learn the handbook carefully. We expect you to read the cases for discussion in the small groups BEFORE coming to the session. We have also provided some further readings where possible to help you come to terms with some of the concepts discussed. Reading lists are provided for those who are interested in the area and are not compulsory reading for exam purposes. However, they should be referred to when there is something in the handbook that you do not understand.

SEEKING HELP

If there is something that you do not understand in the plenary, please ask. We do not mind at all if lectures are interrupted by questions - indeed, we would welcome greater interaction in the sessions. If there is something that you do not understand in the handbook, first refer yourself to the further reading. If you still do not understand, please make an appointment to see Dr K Hill 0121 466 5488.
SESSION ONE

INTRODUCTION TO ETHICS AND LAW
LEARNING OBJECTIVES:

At the end of this session students will:

- begin to differentiate between three theoretical frameworks commonly used in bioethics: deontology, utilitarianism and virtue theory
- be in a position to describe Beauchamp and Childress's 'Four Principles' of health care ethics - autonomy, beneficence, non-maleficence and justice.
- begin to understand the difference between civil law and criminal law
- begin to consider the various regulatory mechanisms which control professional practice
- begin to realise that law, ethics and self regulation must be questioned and analysed with regard to the appropriateness of its control.
- understand what their responsibilities are regarding reading ahead for the small group sessions

I. ETHICS

THE PURPOSE OF HEALTH CARE ETHICS AND LAW

It is not our aim to turn you all into minor philosophers or lawyers. Rather we aim to give you an understanding of some of the principles which underlie the practice of law and ethical reasoning in order that the practical reasoning becomes clearer. For instance, in the case of the law, why it is that some instances of medical malpractice are heard in civil courts and some in criminal courts and the constraints that are thereby placed on the plaintiff and defendant. Or why it is that patients pursuing a complaint through the civil courts have to receive financial compensation if their claim is successful. An example in ethics might include an understanding of why autonomy enjoys the significance it does when it comes to gaining consent. Or how it can be that five people can distribute resources differently and yet all reasonably claim to have done so justly.

We accept that whilst most of you will welcome the opportunity to look at some of the ethical issues and dilemmas which you may face in your future practice, many of you might find the theory of ethics difficult or apparently irrelevant. One of the things which we hope to illustrate in the first session is that applied ethics can be fun, but also that often all that we expect is that you are able to put your own ethical thoughts into a theoretical framework. This can be useful because there are often standard arguments that can be made for and against positions once this framework is established. This is both useful in attempting to see what reasons you might have for NOT holding the views that you do (which is vital if you are to tolerate or anticipate the views of other people), and also useful because it might enable you to argue your case against someone who does not share your views. As you progress through this year, we hope that your skills of argument will be enhanced, as will become clearer in session five.

HEALTH CARE IS AN ETHICAL ACTIVITY

It might seem strange to assert that health care is fundamentally an ethical activity, for it might well seem to practitioners it is about applying dental skills and providing for basic health needs to be met. One might ask, however, why it is important that these skills are applied (what's wrong with just leaving patients as they are?). To understand this, we ultimately have to ask why it is that we value our health and what good health is. It is generally accepted that health is a pre-requisite for other goods since ill-health is often a stumbling block to these goods. Consider how your own life might have been altered if, as a child, you had suffered such ill-health that you were unable to attend school regularly and think about how your career prospects might look if you suffer a serious accident and have to be off sick from University or work for several years. If you doubt this now, think about how unfair you will think us if we fail to take into account a sick note, which explains why it is that you did badly in your exams. It is because health is a fundamental good that preserving and restoring health is an ethical necessity.
Likewise it is reasonable to argue that good clinical practice amounts to practising ethically, and it would be unethical to practice if one’s clinical skills were poor. **Good ethical practice and good clinical practice should be interchangeable terms.** However, is it possible to be an ethical dentist and undertake poor clinical practice, or an unethical dentist who is a good clinician? Have a think about that one.

Be aware that ethics and law are not the same, they are different, although they may follow parallel paths and sometimes are closely interwoven. Generally ethical beliefs come first and laws are made to reflect them. Lying to your patient is always wrong (unethical). It may or may not be unlawful depending on the circumstances.

**ETHICAL REASONING AND CLINICAL PRACTICE**

We have already said a little about how we think ethical and legal theory can be useful in practice. You should also note that we aim to improve your powers of critical reasoning. The end product of your five years at Birmingham - as far as we are concerned - is a practitioner who recognises an ethical issue when s/he sees one, is able to form a judgement about this issue, is able to defend this judgement, is able to weigh his/her own views in the balance with other reasonable views and is consistent in his/her decisions. You will soon recognise that although an understanding of the law is vital in your clinical practice, simply learning current law is not enough to keep you out of trouble because where there is no clear case law, or where a situation has no case law, you will be expected by the court (should you find yourself in one) to be able to defend your decision on both clinical and ethical grounds. It is sobering to think that each precedent happened to someone for the first time - they were not able to draw upon case law to justify their actions. Likewise others find, perhaps to their chagrin, when they get to court, that the precedent they were relying upon was distinguishable (that is, not the same) and hence not applicable.

**THE MORAL PICTURE**

Think about how you ordinarily evaluate ethical or unethical behaviour - that is how you determine whether you think that someone has behaved well or badly.

The first thing to be identified is the **moral agent**. To be a moral agent, one must be responsible for one’s actions: i.e. Competent, acting with information, and not as a result of coercion or manipulation. Moral agents can be praised and blamed for their actions. Certain groups of people are not held to be morally responsible for their action because they lack competence, for instance, infants, the severely mentally ill or disabled.

The second thing to identify is the **subject of moral concern**. In dentistry this may be the patient, but it could just as easily be your colleague. Sometimes, the subject of moral concern might be difficult to identify. This may be partly to do with some controversy over what kind of being one has to be to be a subject of moral concern. There are examples of this kind of controversy in health care ethics. For instance, some people argue that the foetus, anencephalic newborn or those in a permanent vegetative state are not such beings. So what makes subjects worthy of moral concern? Is it their sentience (in which case other non-human animals are equally worthy of such concern)? Is it rationality (in which case case some humans would have to be excluded)? Is it autonomy (which, likewise, excludes some humans)?

It is said that ‘ought implies can’. What this means is that you cannot be held responsible for doing the impossible, but only for things over which you have some control. One of the things over which autonomous agents have control is the choices they make, so what connects the moral agent to the moral subject is some action or proposed action over which the agent has some **choice**. But since it is possible to be causally responsible without being morally responsible (take accidents, for instance) we need to know more about this action than simply its consequences for the subject
Some theorists hold that what is intended is of most significance (deontologists). They argue that since we can never be certain what will happen as a result of our actions, we should concentrate on what we do or will instead. Part of what we do/will is our motive for action. Motive provides the moral reason for action - it is the good or bad will which governs action. Motives include the virtues (such as generosity, prudence, justice, compassion, friendship, etc.) and the vices (greed, pride, cowardice, avarice etc.) Motive is very important in our moral understanding since it can radically alter our opinion of otherwise identical actions. For instance one might approve of me killing a patient in severe pain out of compassion for her, but how would one feel about me killing a suffering patient because I knew that I stood to inherit money in her will?

However, consequences of actions are also important. Whatever my intentions and motives, there must come a point where I must also be responsible for consequences which I can reasonably be expected to foresee. The actual outcome is important - for instance, did the patient die? Did they find out about the lie told to them? These kind of questions, which are raised in response to case studies, all show that we do attach great significance to consequences. Theorists who attach exclusive value to the consequences of actions are known as consequentialists. The kind of consequentialism we will be concentrating upon is utilitarianism.

Ethics and ethical practice are not globally the same. This course will consider Western Ethics, however there are many other moral philosophies that make for fascinating study. However, it is not just for fascination that you should be aware of non-Western ethical theories, you will be working in a diverse society with colleagues and patients from a wide variety of cultural backgrounds. A working knowledge of their ethical frameworks will aid your understanding of their decision-making in complex situations. See A Companion to Ethics, Part II and III.

THEORIES OF ETHICS

Ethical theories and principles are the foundations that guide us when we analyse situations and make decisions on how to act.

Consequentialism

Consequentialism is a normative moral theory and it states there is a very close connection between the right and the good. The right is whatever is our duty, what we ought to do, whilst the good is whatever is valuable or worthwhile. As the name implies, consequentialists believe that consequences are the major consideration in deciding whether a proposed action is ethically right or wrong. The right action is the one that produces as much good as possible – it maximises the good. The value comes first followed by the action that will promote as much value as possible, that action is the right thing to do. Consequentialism can be thought of as a family of theories, the various forms differ according to what exactly the good is. In health care ethics the most influential and widely applied consequentialist theory is utilitarianism. Basically stated, the utilitarian believes that the good is happiness or welfare. Accordingly, for the utilitarian, the standard we should apply in judging an action morally right or wrong is that the action should be expected to result in the greatest happiness or welfare for the greatest number of people. Alternatively, where no good outcome is possible because all of the options are negative, the utilitarian would opt for doing that which causes the least harm possible. Consequentialism is very popular as a tool in policy formation.

Like most theories, utilitarianism has its limitations. Critics of utilitarianism complain that it can sometimes be extremely difficult to calculate what the consequences of our actions will be. In addition, while seeking to promote the greatest amount of benefit over harm, it is not always clear what benefit is. One person's idea of benefit may not be the same as another's For example, one person might believe that the spare money a trust has should be spent on decorating patient waiting rooms so as to spread a little cheer to everyone, whilst another person might think that spare money should be used to buy drugs, even if there is only enough money to treat one patient. Both intend the greater good but disagree as to what is most beneficial. Finally, this theory can appear to place
too little weight on individual rights, a concept that we value highly in Western culture. It can also disregard the special obligations we feel we owe to those with whom we have special relationships. For example, there are circumstances under which a utilitarian might consider that confidential information may be disclosed, even though this disregards another individuals right to confidentiality and even though a promise not to disclose has been made. However, as we shall see, utilitarianism also recognises that the practice of confidentiality or promise keeping has an overall utility, which cannot be disregarded, but must be weighed in the balance with the bad effects which may occur in individual instances. Nevertheless, it is a major criticism of utilitarianism that it can permit the good of an individual to be sacrificed for the good of the majority.

Utilitarianism philosophies include:

- Act – the right act is the one that will maximise the good in each individual case. The right act is the one that makes the world a better place and creates the greatest happiness for the largest number of people. It is rooted in the present. Jeremy Bentham is considered to have formulated act utilitarianism
- Rule – deals with the rules governing individual acts and distinguishes between types of acts and the context in which they occur. However to maximise the good, everyone has to follow the rules, a rule that cannot be applicable to everyone cannot secure good overall consequences. This type of utilitarianism is rooted in both the present and the future. John Stuart Mill is considered to have formulated this variation.

Deontology

A contrasting theory is deontology (from the Greek 'deon' meaning duty). Deontological theories reject the consequentialist claim that the right action is always the action that produces the best available consequences. Therefore the right determines the good, this is the reverse of consequentialism. Proponents of this theory would argue that the standard in judging whether an action is morally right or wrong is whether it conforms to certain rules of conduct, irrespective of the consequences. Deontologists tend to emphasise impartiality because moral behaviour cannot be conditioned if it is to be fair. So, for instance, I might argue that I am honest with you because I am your friend, but this means that if we fall out, I can stop being honest with you. Deontologists - particularly ones who draw their thoughts from the philosopher Kant - would want to argue that if it is right that I am honest with you, it is right whether or not we are friends. Accordingly, deontologists will argue that moral behaviour should be unconditional or universal. This means that if an act is right or wrong, then it is right or wrong in every similar situation, regardless of time, place or person. The deontologist may well consider an action to be the morally right or obligatory one even if it doesn't promote the greatest possible balance of good over harm. So, for instance, if lying is wrong, it is wrong even if a lie would save a life. Likewise, if keeping information confidential is right, then it is right even if someone will suffer a harm as a direct result of a failure to disclose confidential information. It is the action that is intrinsically right or wrong, not the outcomes or consequences. An action can produce good consequences but still be wrong; equally a right action can produce undesirable consequences. A major criticism of deontology is that the rules of conduct that we should follow are too rigid and the theory doesn't allow for exceptions to the rules.

Some deontologists consider that special positions come with special duties, and just like the duties of normal moral behaviour, these duties are absolute (which is another way of saying that they are unconditional or universal). Dentists, for instance, may be held to have a special duty of care towards those who they offer to treat. (We will see how this principle equally gives rise to legal duties in a later session).

One of the most influential deontologists was Immanuel Kant, an eighteenth century German philosopher. Much of health care ethics is underpinned by Kantian ethics. Kantian deontology takes as its starting point the view that morality should conform with rationality and since rationality is universal, morality must also be universal. Another important aspect of Kantian ethics is respect for autonomy. Kant argued that autonomy is the basis of morality since moral judgements assume
that the one is free to choose to act well or badly. It would simply not be fair to judge someone as bad if they had no choice or understanding about what they were doing. Accordingly, in Kantian ethics, actions which are likely to undermine autonomy are considered to be wrong. This is often expressed as respect for persons, where persons means autonomous individuals. Kantian ethics is governed by what he calls the Categorical Imperative and it basically means that which must be done. He says that this Categorical Imperative can be thought of in three different ways:

1. Act in such a way that you would be happy for everyone to act
2. Never treat people as a means to an end but always as ends in themselves - respect their personhood.
3. When you are deciding what to do, imagine you live in a society which agrees that you are making laws for everyone which will bind you all equally and which always respect persons.

Although Kantian ethics have become synonymous with deontology in health care ethics, there are other deontological influences on our decisions in practise. For instance the law of the land, professional codes of conduct and the dictates of any religious beliefs which we might have. It is not impossible that these influences may be in tension with each other, even though each may assert a rule which it considers to be absolute.

**Virtue Theory**

As well as consequentialism and deontology, a third ethical theory is known as virtue theory. Aristotle is the ‘pre-eminent’ virtue theorist. Although we will not be covering this theory in any sort of depth during the course, we include it here for completeness. Virtue theory asserts that it is one’s character which is the essential mark of one’s moral life. In simple terms, it asks the question ‘what kind of person ought I to be?’ rather than ‘what shall I do?’ or ‘what is good?’ . It follows from this emphasis that in trying to determine what kind of person we should be, we will concentrate on character traits. It is these character traits, which we know as virtues - for instance, patience, humility, courage, integrity, honesty - and the vices - for instance, cowardice, dishonesty, boastfulness.

But how do we know what these virtues are and how they are to be manifest in practice? Initially, we have to look to role models and try to emulate this good behaviour. However, in time and with moral education, we develop critical skills, which give us an understanding of good behaviour which goes beyond simple emulation. This will include an understanding that virtues are often the mean of behaviour which lies between two vices, and that accordingly what is good for one person or one situation might be slightly different for another situation or person. For example, courage is the mean which lies between recklessness and cowardice. Accordingly, when determining how I should be, I have to take account of my own limitations. If I am naturally inclined towards cowardice, then I have to press myself to behaviour, which to me seems to verge towards recklessness. The parallel here might be eating: the taller and more active you are the more you need to eat but if you are greedy then what seems like a small amount of food might actually be quite sufficient. Similarly, different situations call for different responses. It is not surprising that what seems like a courageous act in war time might be perceived as sheer recklessness in peace time, for it is one thing to risk one’s life for one’s country or beliefs but quite another to risk it crossing the road.

Virtue theory is enjoying somewhat of a resurgence in contemporary health care ethics. Its proponents have argued that we have been too caught up with obligation and outcome-what we should do - and we have paid too little attention to what kind of people we should be. A morally good person with the right blend of virtues and motives is more likely than others to know **what ought to be done** in a given situation and be disposed to doing it.

The major criticism of this theory is that whilst it works in principle, in practice people can be blind to their own shortcomings and virtue theory can in this way perpetuate bad behaviour. For instance, if the senior partner says that he is the best role model it is difficult for a student to challenge this, and if this senior partner also acts badly on occasion, then the students will pick up bad rather than
virtuous habits. It has also been suggested that virtue theory can encourage us to be too self-absorbed. This is because the patient - or any other vulnerable person for that matter - can merely serve as the vehicle through which we, as practitioners, can behave virtuously. People in need can give us the opportunity to exercise our virtue so we might use them solely as the means to making ourselves look good.

Despite these criticisms, virtue theory has a great deal of intuitive appeal for it appears to put a value on decent people and also to permit a less rigid approach to ethical decision making as the agent is bound neither by absolute rules, nor obedience to consequences. On this level, it appears to accept a good deal of flexibility in ethical decision-making.

PRINCIPLES OF ETHICS

Contemporary textbooks on health care ethics tend to draw heavily on 'principlism'. This is a method of teaching ethics which encourages student to apply the so-called 'four principles of health care ethics' outlined by Beauchamp and Childress. These principles are respect for autonomy, beneficence, non-maleficence and justice. It is often argued that you can't go far wrong if when faced with an ethical issue, you attempt to identify what elements of each principle are in play. However, in so doing, you will have to ask just how significant each is to the circumstances and also determine which principle is most important in cases where they give conflicting advice about how to behave.

Principlism has its limitations. It can make the process of ethical reasoning seem formulaic and it can disguise some of the complexities and nuances of a situation. However, looking at the four principles can be a useful starting point and the principles themselves are often referred to the literature so it is wise to be familiar with them. At the end of the day, though, it is hoped that you will progress beyond merely chanting the '4 P's' in your small groups.

A) Non-Maleficence

Not harming (non-maleficence) is often considered to be the first principle of health care ethics because the obligation of non-maleficence is expressed in the Hippocratic oath, where it is written,

“I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them”.

This principle asserts the obligation not to inflict harm intentionally. However dentists inflict harm all the time. In a physical sense, you harm someone when you give an injection or extract a tooth. But on balance, the long-term benefits are believed to outweigh the short-term harm. We can use this as an example to reinforce our earlier discussion of motivation and intention. Your motive in extracting the tooth is that you know it is the only way to provide relief for the patient and save the patient from the consequences, chronic abscess formation, say. You do not intend harm, although it is foreseen. You’ve done this procedure often enough to know that, after the anaesthetic wears off, it hurts and the patient will suffer as a result. However, your intention is that, eventually, the patient will be restored to full health. What we are left with is a balancing act - the short term discomfort is outweighed by the long-term benefits, so the discomfort is justified. Your actions cannot be justified however, if you expect that no benefit to the patient is likely to result from the treatment you provide because all treatment come with risks and burdens which may potential cause harm. The only thing that justifies causing a patient harm is where the benefits outweigh the burdens. This is an important concept and one we will return to repeatedly.
B) Beneficence

Beneficence expresses positively what non-maleficence can express negatively. Non-maleficence requires that we avoid harm, which is beneficence of sorts, but the principle of beneficence refers to actively promoting what is good, rather than merely avoiding that which is likely to cause harm. When we act beneficently, our intention is to contribute to someone’s welfare. We have already discussed the sense in which the provision of health care is first and foremost an ethical endeavour because its aim is to promote the human good of health. Where we might run into some difficulty, is in trying to determine what good is, for we all have different views about what is good for us. Thus, in acting beneficently, we have to keep in mind autonomy - respect for an individual’s freedom to choose for him/herself.

Two concepts that are beneficence based are paternalism and proxy decision making. We will look at paternalism in more detail in Session 2. For now it suffices to note that when health care professionals act on the basis of what they think is the best for the patient without due regard for the patient’s own choice, they are acting paternalistically. Paternalism occurs when the decisions/wishes of autonomous patients are overridden because practitioners beneficently believe they are in the best position to decide for the patient. Proxy decision making, where one person decides on behalf of another person who is incompetent to make a decision, generally only exists between parent and child. However, it may also be said that health care professionals might have to decide for a patient who is not autonomous and cannot decide for him/herself as long as the decisions are made and carried out in the patient’s best interests.

C) Autonomy

We have already seen that autonomy has a vital role in determining both when we are in a moral predicament, and why we are moral agents at all. This principle asserts that competent and free people are their own bosses; they have a right to be self-governing, to have freedom of thought, action and will. Generally speaking we hold that individuals should be able to exercise their autonomy freely, the only limit being the extent to which their autonomy infringes upon that of others because clearly problems can arise when my exercising my right to autonomy conflicts with your right to exercise yours. For example your freedom to invite fifty friends to a party at your flat may conflict with my choice, as your next door neighbour, to get a good night’s sleep.

Respecting autonomy means accepting that autonomous people make different choices in life. To accept this is to accept that our desire to be beneficent or non-maleficient may have to be tempered with respect for what people themselves choose to do. This is reflected in the Kantian respect for persons, and never treating people as a means to an end. In health care ethics, this is particularly important in the area of consent, as we shall see. Occasionally, therefore, in order to respect an individual’s autonomy we might have to permit them to act in a way with which we wholly disagree, provided of course that the harm or risks undertaken fall solely on them. In this respect, we might permit individuals to destroy themselves by some means but not others. For instance we might argue that it is permissible (but undesirable) for someone to smoke themselves to death provided that they do not subject others to the effects of passive smoking. We may even argue that the calls which they make on the NHS should be limited
D) Justice

This is perhaps the most complex principle to grapple with, but for our purposes at the moment, let’s say that it means being fair or treating people equally. The problem is, how do we determine what constitutes being fair? Some people hold that justice means giving everyone exactly the same share, others believe that people should receive according to their need or urgency of the situation. Another concept of justice accepts that what is ethically right is to maximise resources on some kind of greatest benefit basis. This should be ringing bells - it is of course a utilitarian notion of justice described in the section on theories of ethics.

In the delivery of health care, we are deeply concerned with the concept of distributive justice, in other words trying to determine what is a fair, equitable and appropriate distribution of health benefits (who receives the goods) and burdens (who pays for the goods) in society. Problems of distributive justice arise under conditions of scarcity and competition, such as we now have in the NHS. Is it appropriate that specific patients that are responsible for their own ill health are able to use limited NHS resources?

Although the notion of distributive justice helps us to define choices and decide how benefits and burdens should be distributed, it won’t fully answer the questions about who should get the benefits and who should shoulder the burdens. If you held the purse strings, where would you put the resources?

II. REGULATORY MECHANISMS

Professional practice is controlled by a variety of mechanisms. Some of these mechanisms are more formal than others. Often, a practitioner will be regulated by a variety of sources at the same time. As well as the more obvious sources of legal and professional regulation, practitioners are also bound to comply with other regulations, which whilst not actually law, must still be complied with. This ‘quasi-law’ may take the form of NHS circulars, GDC practice notes and Department of Health memoranda. Alternatively, the source of the guidelines may be external, eg. Indemnity organisations or Association of British Pharmaceutical Industry (ABPI) guidelines, which have an important role in regulating clinical research. Additionally, all practitioners’ will have to comply with regulations laid down by their employers, working, for example, within established protocols or accepted custom and practice. Here however, we will concentrate on law and self-regulation.

THE LAW

Common Law/ Case Law

Law regulates all professional practice. Common law refers to law that is made by judges in court, rather than statute law. Radical change in the law is generally left to Parliament, but judges may extend, modify and even develop rules. However, it is not the function of a judge to make new law.

Common law encompasses both civil and criminal law. Whereas criminal law is concerned with society as a whole in so far as it regulates conduct between individuals and the state, civil law regulates private disputes between individuals. Thus, a dentist who assaults a patient may be prosecuted by the Crown Prosecution Service, and if found guilty, may be imprisoned, whereas a dentist who is negligent may be sued by the patient he has allegedly harmed, and, if found liable, may have to pay compensation to that person in the form of damages.

Law involves the application of legal principles to a set of facts, usually where one party is alleging some wrongdoing, in its broadest sense, against someone else. The common law is “precedent-based”. This means that a previous case that has been decided will serve as authority for future cases which have broadly similar facts. This is because the law is concerned with justice and impartiality and seeks to deal with like cases alike, so that cases build upon earlier cases which have already been
decided. In order for that principle not to apply, it has to be shown that there are features which distinguish the facts of the case in question from earlier decisions which seem superficially similar, and that these distinguishing features require the court to arrive at a different verdict.

The decisions made by the judges are considered binding precedent. This means that the previous decision of any court, depending on its position in the hierarchy of courts (see table below) is binding on a subsequent judge who is dealing with a case that is not otherwise distinguishable. However, a court of competent jurisdiction within the hierarchy of courts may declare that the decision in a previous case is no longer good law either because the court did not correctly interpret the law or because the later court considers the rule of law to be unsupportable or undesirable. So, the House of Lords may overrule the decisions of any court in the legal system (including its own) but the Court of Appeal cannot overrule a decision of the House of Lords (nor generally, its own previous decisions).

Note that a significant amount of the law governing health care practice is regulated by the common law. Consent to treatment for example is still entirely a matter of common law.

**Civil Law**

The civil law is adversarial and depends upon an aggrieved party employing formal legal procedures to bring a complaint to court i.e. suing someone. Actions in civil law will usually be brought in “tort” or “contract”. A tort is a civil wrong arising from a breach of duty created by the operation of the law. A breach gives rise to a cause of action in damages. The law of tort enables compensation to be made to a patient for damage caused to him by a health care professional. However, not all damage is actionable. Not all tortious conduct causes harm. Mistakenly removing a patient’s tonsils when they were due to have a tooth extracted would clearly be a legally recognisable action, but being rude to a patient and hurting their feelings would not be (although this may constitute professional misconduct). We shall be looking, primarily, at the torts of negligence and trespass (usually referred to as battery). Note that all NHS practitioners owe their patients a duty of care in tort.

The law of contract, on the other hand, arises from a more formal relationship, which often, though not necessarily, takes the form of a written agreement. Note here that the parties fix the duties themselves (as opposed to the law of tort where they are imposed by the law). Private practitioners will have contractual responsibilities toward their patients.

In order to bring a case before a court, an aggrieved patient must have a cause of action. This means that the wrong done to that person must fall within a category recognised by the court’s as one for which there is legal redress. The burden of proof is on the claimant-patient to establish that on a balance of probabilities the defendant-health care professional’s action (more likely than not) caused the harm alleged. If proved, then the defendant-dentist is liable in damages which typically takes the form of monetary compensation. Where a dentist is in private practice, he/she will be liable to pay the award, but if the dentist is employed by a partner in a private practice, or by the NHS, then the employer will be vicariously liable for the action. Other than damages, another remedy of redress is an injunction to prevent someone from persisting with the conduct complained of.

The right to sue operates independently of any other form of redress which an aggrieved patient may have against a practitioner. Thus, the fact that a patient may also be able to bring a complaint against a practitioner’s employers, or make a complaint to a practitioner’s professional body does not prevent them from instituting legal action as well.

**Criminal Law**

The criminal law is a mechanism to control the behaviour of members of society and provides formal sanction for behaviour that is considered reprehensible. In criminal cases, it is almost always the Crown Prosecution who initiates proceedings on behalf of the state. Even though criminal law is found in criminal statutes, this still forms part of the common law, because criminal cases are about judges applying statutory provisions to factual situations. Sometimes, this may involve an interpretation of
what various provisions in a statute actually mean. This again, builds up a body of case law so that in other criminal cases, statutes will be given the same interpretation that they have been in other cases.

In criminal cases the burden of proof is on the crown to satisfy that the defendant (health care professional) is guilty beyond a reasonable doubt. Some crimes carry a fixed penalty; others have a range from a fine or probation to community service or a suspended sentence. Though rare, the following offences may arise out of clinical practice:

**Gross negligence manslaughter:** Although manslaughter cases against health practitioners are extremely rare, where a patient has died and the practitioner’s conduct has fallen so far short of what could reasonably be expected, it is likely to give rise to criminal liability. (i.e. not only was the practitioner negligent, but was negligent to such an extent as to attract criminal culpability). There is no need for the court to prove that the practitioner intended to cause the person’s death, as is required to establish murder. For example in the case of R v Prentice two junior doctors injected a drug into a patient’s spine which should have been injected into a vein. As a result, the patient died. Neither doctor checked the drug label, which told them the appropriate method of administration. Regardless of intent, the doctors would have been found guilty if the jury had not been improperly directed. Error therefore is crucial to determining criminal responsibility.

**Unlawful killing:** Regardless of motive, a deliberate intention to shorten a patient’s life may constitute murder. Consequently, if a doctor or dentist gives a fatal dose of an opiate analgesic to a patient who is in terrible pain acting with the intention of relieving suffering, if the intention is that the patient dies and the patient does die, the professional is liable to be prosecuted for murder. Killing a patient deliberately for whatever reason (even for purposes of pain relief) constitutes murder. See the case of R v Cox (1992) where a doctor gave potassium chloride after repeated doses of heroin failed to ease a patient’s agony. The doctor was charged with attempted murder and not murder probably to avoid an acquittal on the part of a sympathetic jury. Note also that if the drug used had been a typical painkiller he may have been acquitted (see R v. Carr (1993)).
Scotland and Northern Ireland have their own legal systems, although in some areas of law there are no differences between the jurisdictions.

Source: http://www.judiciary.gov.uk/about-the-judiciary/introduction-to-justice-system/court-structure
Statute Law/Legislation

The other main source of law is statute law. The Government/Crown initiates most legislation. Statute law is supposed to express the will of the democratically elected Parliament and carry out social, legal and administrative reforms.

There are a number of statutes which govern both the provision and the practice of health care. The NHS and Community Care Act 1990 has substantially revised the way in which NHS provision is organised. Additionally, a number of statutes create certain professional duties. Examples include:

- The Health Act 1999
- The Abortion Act 1967
- The Data Protection Act 1998
- The Human Fertilisation and Embryology Act 1990
- The Human Tissue Act 1961
- The Mental Health Act 1983, amended by the Mental Health Act 2007.
- The Human Rights Act 1998

These statutes will be considered in greater depth as the course progresses. Most of these statutes create specific legal rights and legal duties. Failure to comply with statutory requirements may result in a criminal offence.

PROFESSIONAL SELF-REGULATION: THE GDC

Whilst the law operates retrospectively by applying legal definitions of acceptable behaviour after the event, Professional Codes of Ethics created by the General Dental Council (GDC) set out what is expected of a dental professional in advance. You can find the most up to date standards on the GDC website at:

http://www.gdc-uk.org/DentalProfessionals/Standards/Pages/default.aspx

Professional Codes set out standards of practice. They can co-exist with the law or can even require more than the law. Thus while they guide professional practice in much the same way as legislation, they do not have the force of law. Certain rules however can become legally obligatory if they are subsequently recognised by the courts.

The General Dental Council (GDC) is a regulatory body, which by virtue of legislation is mandated to oversee the dental profession and maintain a register of qualified practitioners. Its prime purpose is to protect patients and the public. In addition it sets the standard that dental professionals are expected to achieve at the end of their undergraduate education and training and which they must satisfy before admittance to the Dental Register. Those standards are set out in the document; ‘Preparing for Practice – Dental Team Learning Outcomes for Registration.’ The quality assurance of dental education is delegated to the Chief Executive and Registrar.

As well as an education function, the GDC is mandated to set up disciplinary structures to regulate professional conduct. The GDC has a fitness to practice structure, the function of which is to consider complaints lodged against a dentist (or other registrant). It determines if they have been guilty of serious professional misconduct or have been persistently deficient in their professional performance or have a health condition which adversely impacts on their ability to provide safe dental care to patients. In addition to conduct, performance and health concerns
the GDC is told by the police if a registrant has been convicted or cautioned in the United Kingdom. They can also consider convictions and cautions imposed abroad which, if committed in England and Wales, would constitute a criminal offence. Criminal convictions can include offences not directly connected with a registrant's profession or practice or which occurred while the registrant was not registered. For example, the Council would consider convictions for fraud whether related to dentistry or to personal finances, drink driving offences, sexual or physical assault or deception. The offence is considered by the Investigating Committee (IC) as to whether it requires a referral to a Practice Committee.

The GDC has an Investigating Committee (IC), a Professional Conduct Committee (PCC), Professional Practice Committee (PCC) and a Health Committee to consider complaints against registered professionals, see diagram below. If a case is referred to the Professional Conduct Committee, the practitioner, who will usually be legally represented, will be called to account for his or her actions. Expert witness will be called by the professional body to establish whether or not the practitioner's conduct fell below that which could have reasonably been expected.

If a professional conduct committee finds a health care professional guilty of misconduct, it has a range of penalties at its disposal. The practitioner may receive an admonishment, have restrictions placed on his/her practice, be suspended from the Dental Register, or, in the most serious cases, be erased from the register. In the latter instance, a practitioner would not be allowed to practice. Although reinstatement is possible, factors such as contrition, educational standards and availability of suitable employment will be taken into consideration. Disciplinary hearings are open to the public and the media commonly report details of any lurid case.

There is both an internal and external element of professional codes. It is internal in that the profession regulates its own members. They are given this privilege because of the highly technical nature of the skills involved. It is written by professionals for professionals. Often this internal aspect is criticised as being too insular and protective of its own. However, if professionals felt vulnerable to litigation by rules that they themselves developed, the result may be the defensive practice of dentistry and the refusal to engage in future innovative procedures for fear of possible litigation. There is also an external element to self-regulation in so far as it is supposed to regulate the relationship between professional and patient. However, since patient redress under professional codes is limited to disciplinary sanction of the professional, controversy exists as to whether the patient is in fact adequately protected. Note that we now have patient charters in the UK (as well as many other countries) that seems to indicate a willingness to more adequately protect patient rights.
Suppose John, your 26-year-old friend and dental partner is suffering from Hodgkin’s disease and has an extremely poor prognosis. He is undergoing chemotherapy and suffering badly from side-effects. He spends much of the time feeling nauseous and has completely lost his appetite. Although John has always been a non-smoker, someone he had come to know through out-patients gave him a joint, which calmed him down considerably and increased his appetite, allowing him to enjoy a meal for the first time in weeks. John asks you to procure cannabis for him, as this is the only drug that seems to control his side effects. You do not want to let your friend down, but as a new health care professional you are unsure whether it is appropriate to help. While you are aware of much debate surrounding the decriminalisation or legislation of cannabis for therapeutic purposes, it is still currently against the law.
Let's consider this case from an ethical, legal and self-regulatory perspective. Would it be ethical to give John the cannabis to help alleviate his symptoms and get him through what seems to be the end stages of Hodgkin's disease? How can we balance your moral obligation to help your friend with your duty towards your profession? If it seems ethically wrong to supply an illegal drug in light of both the Misuse of Drugs Act 1971 and professional codes of conduct which consider such an act to be serious misconduct (since it would bring the profession into disrepute), we may be adopting either a deontological or consequential perspective. Deontologically, it may be morally wrong to breach these rules of conduct irrespective of the fact that the cannabis is being used for therapeutic rather than illicit or merely pleasurable purposes. Deontology is strict in the sense that it does not consider consequences and may, under this interpretation, not consider the benefit to John. It may also be argued that supplying the cannabis is wrong since if dentists ignore the law everyone else can too. It is important to note that this latter argument is both a deontological argument, based on notions of ‘universability’ and a consequential argument, which looks beyond the immediate effect to the long-term consequences.

If it seems ethically right for you to help your friend who is suffering from a serious disease, we may be adopting a utilitarian or virtue theory perspective. A utilitarian may argue that if it reduces John's suffering, it is an ethical or justifiable breach of the law and professional codes of conduct. Under virtue theory, a virtuous practitioner may be sympathetic to John's plight and feel that he should supply John with the cannabis to alleviate some of his side-effects. The virtuous practitioner might think that s/he needs to tread a fine line between strict adherence to the law and lawlessness (along the lines of laws are there to be broken). It may well be that the good practitioner could not let his patient suffer irrespective of the consequences.

Legally, it is clear that the possession and supply of cannabis are criminal offences under the Misuse of Drugs Act 1971. But, this does not necessarily end the discussion. We should consider whether the law is appropriate in the circumstances. Given that the issue of legalisation of cannabis for therapeutic uses is under consideration, prohibitions in the area should be questioned all the more. This is not to say that the law should be ignored, but simply that the law should be questioned. It may be that the law is not the appropriate regulatory system for the issue at hand. Consider that the Act was written in 1971 and the varying social and political climate of the time. Consider also that a Bill has been presented to the House of Commons to allow the production, supply, possession and use of cannabis for medicinal purposes (March 9, 2000). Consider that cannabis was re-classified as a Class B substance (26 January 2009).

With regard to professional codes, whilst it is likely that the supply of cannabis would constitute serious professional misconduct, the extent of disciplinary sanction is unclear. Since the GDC have to take notice of criminal convictions, a conviction is likely to result in erasure from the medical register. However, we need to again consider whether professional discipline is appropriate here. Should the GDC be able to regulate the conduct of behaviour of practitioners at all times – even when they are not on duty?

The point is that simply because there are laws or codes of conduct in place, it does not mean that they should not be questioned or challenged if they do not seem appropriate. The fact that there is a law prohibiting certain action tends to terminate all further discussion. This may be because legal sanction carries considerable weight - leading to possible fine or imprisonment, whilst breach of ethical sanctions leads to being possibly socially ostracised or having disciplinary sanctions imposed. What is important is that you begin to think about what type of regulation is appropriate in any given circumstance. In some instances the law may be necessary and in others ethics may be able to regulate the situation without legal control. A critical and questioning eye is the first step to considering the function and interplay of law and ethics.
RECOMMENDED READING:


http://www.nursingtimes.net/5041821.article
General Dental Council – Principles

There are nine principles registered dental professionals must keep to at all times. As a GDC registrant you must:

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

The principles are supported by supplementary guidance that set out the principles and values that dentists should work with when making decisions.

- Standards for Dental Professionals
- Principles of patient consent
- Principles of patient confidentiality
- Principles of dental team working
- Principles of complaints handling
- Principles of raising concerns
- Principles of management responsibility
- Principles of ethical advertising
International Principles of Ethics for the Dental Profession

These International Principles of Ethics for the Dental Profession should be considered as guidelines for every dentist. These guidelines cannot cover all local, national, traditions, legislation or circumstances.

The professional dentist:

- **Will practice according to the art and science of dentistry and to the principles of humanity**

- **Will safeguard the oral health of patients irrespective of their individual status**
  The primary duty of the dentist is to safeguard the oral health of patients. However, the dentist has the right to decline to treat a patient, except for the provision of emergency care, for humanitarian reasons, or where the laws of the country dictate otherwise.

- **Should refer for advice and/or treatment any patient requiring a level of competence beyond that held**
  The needs of the patient are the overriding concern and the dentist should refer for advice or treatment any patient requiring a level of dental competence greater than he/she possesses.

- **Must ensure professional confidentiality of all information about patients and their treatment**
  The dentist must ensure that all staff respect patient’s confidentiality except where the laws of the country dictate otherwise.

- **Must accept responsibility for, and utilise dental auxiliaries strictly according to the law**
  The dentist must accept full responsibility for all treatment undertaken and no treatment or service should be delegated to a person who is not qualified or is not legally permitted to undertake this.

- **Must deal ethically in all aspects of professional life and adhere to rules of professional law**

- **Should continue to develop professional knowledge and skills**
  The dentist has a duty to maintain and update professional competence through continuing education through his/her active professional life.

- **Should support oral health promotion**
  The dentist should participate in oral health education and should support and promote accepted measures to improve the oral health of the public.

- **Should be respectful towards professional colleagues and staff**
  The dentist should behave towards all members of the oral health team in a professional manner and should be willing to assist colleagues professionally and maintain respect for divergence of professional opinion.

- **Should act in a manner which will enhance the prestige and reputation of the profession.**

Approved by the FDI General Assembly in Seoul, Korea, September 1997
FDI World 1997 Nov-Dec; 6(6):17
SESSION TWO

CONSENT TO TREATMENT

THE COMPETENT PATIENT
LEARNING OBJECTIVES:

At the end of the session students will:
- understand the ethical and legal significance of consent
- identify the elements of informed, valid consent
- recognise the distinction between paternalism and proxy decision-making
- distinguish between Deontological and Utilitarian justifications for the gaining of consent
- demonstrate an understanding of the practitioners duty of care
- distinguish between the tort of battery and acts of negligence as it relates to consent

WHAT IS CONSENT?

IN GENERAL

Consent is the process in which competent patients are given the information necessary to enable them to decide what tests, therapies or experimental procedures they will or will not submit to. Consent to dental procedures is not just an important issue in ethics, it is also a legal requirement that safeguards and respects patients’ autonomy and their right to make choices for themselves.

As you will observe as student clinicians, there is considerable variation in the way in which your seniors obtain consent from their patients. Sometimes, making sure the patient has signed the consent form amounts to little more than a ‘tick in the box’, carried out to satisfy the letter of the law, rather than representing any genuine attempt to inform the patient of what his/her options are. In other situations, obtaining consent represents what Beauchamp & Childress (2001) refer to as “autonomous authorisation” in which the clinician makes every effort to honour the patients’ need for information and his/her ultimate decision. Note that obtaining consent is not a static event; rather it is a process that should occur throughout the relationship between practitioner and patient.

The fact that a patient signs on the dotted line at a health care professional’s request by no means implies that he/she understands what that signature has authorised or the implications of the decision. From both ethical and legal standpoints, it is the practitioner’s responsibility to ensure that the consent obtained is valid. It is critical to appreciate this point, because if the procedure goes wrong, a patient may later sue for not having given sufficient information about the risks involved.

You should ensure that you read the GDC’s guidance on obtaining patient consent which can be found at the following website address:
http://www.gdc-uk.org/Newsandpublications/Publications/Publications/PatientConsent%5b1%5d.pdf

ETHICS

The significance of consent in ethics is that it respects autonomy and is a justification for harm, thus minimising the risk of non-maleficence.

Four elements are involved in obtaining a valid consent: adequate information, competence, voluntariness, and a decision by the patient, as to whether or not to agree to the procedure. We will review each of these in some detail.

Four Elements Of Informed, Valid Consent

i. Information: In order for patients to make a real choice about whether or not they wish to undergo a certain treatment, obviously they have to know what they are letting themselves in for. They also need to know what alternatives, if any, are available to them, and to realise that they may refuse to have any treatment that is offered. If they are mislead, or they don’t understand what a
health care professional is saying to them, then they might make a decision that they will later regret, and may blame the practitioner, lose trust in him or her, or if very angry, may even sue.

From the clinician's perspective one problem lies in trying to determine how much information should be given to the patient. A second problem has to do with learning how to communicate the information in a way that is comprehensible to the patient, as well as sensitive to his/her individual needs. (Hence the importance medical and dental schools now place on teaching communication skills to students). The health care professional must speak in comprehensible jargon free language so that it can be understood by the patient.

The practitioner must strike a balance between too much and too little information, since each has the capacity to alter the nature of the decision. Some clinicians believe that the “right” amount of information to be given is determined by the patient In other words, only the information that a patient requests is provided. This is unacceptable since it means the onus is on the patient to be sufficiently well informed to ask the relevant questions. Others tend to disclose what they imagine any other “reasonable person” in the same situation would want to know. This approach is often advocated by medical lawyers and is one of the legal standards of consent in Canada and the United States. The “reasonable” criterion is also problematic because, not only because the standard is difficult to ascertain but because each patient may have specific needs and demands which may alter the consent process. Patients may have specific needs as a result of unconventional beliefs, limited understanding of the English language, the specific health (or dental) problem, or a variety of other factors. The point is that the requirements of consent will, at times, have to be tailored to suit the individual needs of the patient.

The best solution would be to consider the practitioner-patient relationship as an alliance requiring the full participation of both parties (unless of course the patient says ‘it’s up to you Doc’). Within the context of the dentist-patient relationship, the patient should feel able to enter into conversation confidently, and know that his right (and need) for relevant, comprehensible information is an obligation that the practitioner takes seriously. Importantly this underpins the trust that patients need to feel in their dentist and that is crucial to the therapeutic relationship.

### Decision-making capacity:

Competence is linked to autonomy. A competent person is autonomous and vice versa. Some patients, no matter how well the facts are explained to them, are incapable either of understanding them or of understanding the implications of the decision they are being asked to make. Such patients are intrinsically unable to give consent. In other words, they lack decision-making capacity. A person is competent if s/he understands the information conveyed to him or her, understands that a decision is required, and that the decision will affect him or herself. Once these criteria are satisfied, it is likely that a patient will be considered competent. So, if a patient is unable to communicate either by language, gesture or behaviour s/he is not competent. The patient must be able to reason and weigh the risks and benefits and consequences of his or her decision.

Competent individuals who have been rendered incompetent by illness or disease must be distinguished from the mentally handicapped or the very young in so far as the latter are considered inherently incompetent. However, it should be noted that few people are rarely incompetent per se. In recent years, the notion of capacity or competence in decision-making has moved from the rigid dichotomy of either competent or incompetent to a much more refined analysis in which it is recognised that a patient may be competent to make some decisions and incompetent to make other decisions. So for example a patient may be competent to take care of his daily finances but incompetent to make a life or death health care decision. Competence then is not an all or nothing concept. A range of abilities must be considered. It is therefore necessary to determine whether the patient is competent to make this specific decision.

The competence of older children, the mentally ill, those with learning difficulties, people who are in great pain and those who are very old or very frightened may be questionable. Careful individual assessment in these cases is required. Individuals who fall into these categories may be competent to provide consent notwithstanding obvious concerns regarding competence. Health care
professionals therefore have an obligation to provide such patients with appropriate information and to the extent possible, to assist them in participating in their own health care decisions.

Competence must be distinguished from irrationality. A patient may be competent but make an irrational decision in the eyes of the health care professional. If competent, then even an irrational decision must be respected. In clinical practice, competence only tends to be questioned when a patient rejects a practitioner’s recommendation. Since competence is rarely questioned when patients agree with the advice of practitioners, patients often have to demonstrate their competence when they reject medical advice.

**iii. Voluntariness:** When a patient provides consent, it should mean that they freely agree to the treatment suggested by the health care professional. Of course, it can be argued that their choices are never truly voluntary because they are constrained by the situation in which they find themselves. For example, the patient may choose whether or not s/he will have the dental procedure, but s/he had no choice at all in the matter of developing dental disease in the first place. Or have they? You might want to consider how supportable those statements are.

In relation to informed consent, voluntary means that the decision was not coerced, that is not strong-armed or forcibly manipulated into making a decision that the patient would not otherwise make. Coercion is generally taken to occur if a credible and serious threat of harm is used by one person to control the actions and choices of another. Coercion or deception can appear in many guises, some subtle and some not so subtle. For instance, a practitioner might make therapy conditional upon a patient agreeing to some additional therapy or provide treatment if the patient will also consent to participate in a clinical trial of that same treatment. These would be examples of unsubtle or blatant coercion. Should coercion or deception occur then any consent obtained would not be valid, this is because coercion generally reduces the options available to individuals and skews the process of decision-making and choice.

Deception involves the control of information available to an individual and by so doing it reduces the ability of the individual to act with autonomy when making a decision because some of the important facts have been withheld.

Manipulation is more subtle and could take the following form. A practitioner might inform a patient about a particular therapy s/her wants the patient to undertake in a very positive tone, while describing the other options in a more negative tone. Or, as a second example, a practitioner may treat a patient curtly every time he or she raises questions about alternatives that the practitioner is not recommending. Or, a practitioner may economise on the information about the treatment being recommended or about the alternatives. Thus, where a patient is unduly influenced or coerced by deception, nondisclosure or manipulation of information, then his or her decision is not voluntary.

To summarise, lack of coercion would demonstrate that consent has been given voluntarily or freely, lack of deception would demonstrate that the information given is true. Of course, the end point may be what the individual actually wanted, but the process of getting there has been contaminated by the coercion, manipulation or deception.

**iv. Decision: Yes or No?** This final element of consent raises two issues for consideration. First, patients should actively participate in the decision /authorisation of treatment and not merely acquiesce to treatment. The former involves a conscious decision made by an autonomous individual while the latter does not. Second, a decision to refuse treatment should be as respected as a decision to accept treatment. For consent to be meaningful and valid one has to be free to decide either yes or no and any valid refusal of consent should have the same authority as valid consent. Patients must be free to say no without fear of reprisal.

Note that if the above elements of consent have not been satisfied then even if the patient signs a consent form valid consent will not have been obtained.
Autonomy and Consent

The notion of consent is grounded in the ethical principle of patient autonomy and self-determination. We generally accept the capacity of individuals to make choices in relation to their own lives. This is especially important in the field of medical treatment where the ethical presumption is that the individual has the right to decide what is to be done to his or her own body. But self-determination means that health care professionals must respect and even foster patients’ control over their own lives. It may very well be that in respecting autonomy, health care professionals will have to accept decisions that may produce less than the best possible outcome. Those who accept this are truly defenders of autonomy. Those who cannot let a patient make a seemingly wrong decision, may (beneficently) override patient autonomy.

Paternalism

Competent adults have the right to decide what they will or will not let others do to their bodies and minds. When health care professionals act on the basis of what they think is best for the patient without having due regard for the patient’s own choice, they are acting paternalistically. Paternalism occurs when patients are capable of deciding for themselves, but practitioners overrule their wishes (or don’t even bother to find out what they are) because they assume that they know best or are in a better position to be able to decide than patients. The motive in acting paternalistically is always benevolent, or beneficence-based, that is to say, it is borne out of the practitioner’s genuine desire to help the patient. The practitioner may believe that s/he would be placing an unnecessary burden on the patient in asking him to make a decision. Or the practitioner may believe that it would, in effect, harm the patient if s/he knew the truth about his or her condition and the risks associated with the treatment. As a result, the patient is not given the opportunity to participate in the decision-making and any decision the patient might have made is overridden. In such a case, the principle of autonomy (the patient’s right to choose) is brought into conflict with the principle of beneficence (the doctor’s obligation to do good).

For an action to be paternalistic, the patient must be autonomous. Where the patient is not autonomous or not competent (i.e. adult mental incompetents or young children) we are respectively looking at decision making made in the ‘best interests’ of the patient. This may be regarded as proxy decision making – but this is distinct from paternalism.

Historically, clinicians were encouraged to rely, almost exclusively, upon their own judgements about the patient’s need for treatment. However, in the last 30 years there has been a growing emphasis upon patients’ rights to make independent, informed judgements about their medical fate. Respect for patient autonomy has challenged the supremacy of beneficence as the foremost principle in the clinician-patient relationship. In a society where autonomy is highly valued, paternalism can be a dirty word. Where a person’s decision-making capacity is not diminished, no matter how well intentioned a practitioner may be, taking away a patient’s right to make decisions for him or herself may be ethically indefensible. However, not everyone agrees that paternalism is such a bad thing particularly since its purpose is to protect the patient. Whether one thinks paternalism is justified will in part depend on one’s view of autonomy.

Ethical Conclusion

Consent is the means through which the rather abstract ethical principle of autonomy (the right to self-determination) is given form and shape in the delivery of health care. The elements of consent foster autonomous choice as well as seek to protect patients from harm. They also encourage medical professionals to act responsibly in interactions with their patients. If you believe that the most important feature of consent is that it advances patient autonomy, then you would be using a Kantian or deontological justification. In other words, you hold to the view that a practitioner, as the moral agent, must respect the competent patient’s absolute right to make decisions for him or
herself, regardless of the harm that might come to him/her as a result. The right of a patient to exercise their autonomy is absolute, even though their decision may appear irrational to others.

On the other hand, you might hold the view that people ought not to be allowed to either consent or withhold consent when to do so might cause them harm (i.e. harm would be the outcome or consequence of their decision). If your position on consent is that its function is to prevent harm, then you are appealing to a utilitarian justification. From this position, you would also argue that since the rationale for gaining consent is that it protects patients from harm, if it fails to have this effect (by allowing patients the liberty to make harmful choices) then it is useless.

II. LAW: LEGAL ASPECTS OF CONSENT

Autonomy has only been recently recognised as a legally protectable interest. Generally however, the law tends to resort to rules which protect bodily integrity (battery) and rules which govern professional competence (negligence).

**Right to bodily integrity**

The common law has long recognised the principle that every person has the right to have his bodily integrity protected against invasion by others. In medical treatment, every touching is a potential battery. In 1914, Cardozo J said:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient’s consent commits an assault”. *(Schloendorff v Society of N Y Hospital* 105 NE92 (NY, 1914)*

To render a touching lawful, as we have seen, clinicians must obtain a valid consent. **Absence of consent turns the merest touching into a battery** i.e. a deliberate touching of another without consent, which may amount to a civil or a criminal offence. Consen$t turns battery into a legally acceptable touching. Nonetheless, there may still be an action in negligence if a dentist fails to give adequate information about material risks in the proposed therapy.

Let’s return to the four ethical concepts discussed above and see how they are interpreted in the law.

**Information**

Ethics, as we have seen, is concerned with the amount of information a patient needs to make a decision. The law, however, tends to be concerned with the actual knowledge and understanding of the patient (battery) and how much information a practitioner is required to disclose (negligence). In order to give valid consent (or refusal) to treatment, a patient must adequately understand what is involved in the procedure (or in refusing it). Insufficient information could lead to an action in battery – where the patient does not even have a broad understanding of the procedure - or negligence – where the patient understands the procedure (at least generally) but claims that the amount of information disclosed was insufficient to provide real consent. The attitude of the law as to just how much a patient should be told differs from country to country. In the past, many commentators argued that the law in the UK was too paternalistic, erring on how much information the dentist chose to disclose rather than how much information the patient wanted/needed to know. The law has however changed and courts will now look at whether it was **reasonable** to withhold information from a patient.

**Battery**

The patient must understand in broad terms the nature and purpose of the procedure s/he is agreeing to and what is to be done *(Chatterton v. Gerson* [1981] QB 432). However, this information need not be given in minute detail. For example, it may be sufficient that a patient knows she is
having root canal treatment to relieve pain without knowing the details of the procedure. Knowledge in general terms is sufficient.

Battery, or trespass against the person, as it is sometimes called, is a tort, or civil wrong, and in the health care context occurs when a practitioner intentionally or deliberately touches or comes into contact with a patient without that patient's consent. Battery is any non-consensual contact. Actions in battery demonstrate how much importance the law places on people being entitled to decide what happens to their own body. Battery is a tort of strict liability. This means that the law does not require the patient to prove harm or injury in order to sue; s/he merely has to establish that s/he has been touched intentionally against his/her will. There need be no tangible injury. Overriding the patient's autonomy is the harm in itself. So non-consensual touching is itself a legal wrong whether or not any specific damage can be shown as a result. Even if a practitioner justifies the unwanted touching on the basis of beneficence, it is still an unwarranted intrusion of the person's right to bodily integrity. Cases of emergency provide an exception (see exceptions below).

It is extremely rare for doctors to be sued in battery and such actions are generally discouraged, save in extreme cases. Practitioners are most likely to be sued in battery where

1. the patient has either given no real consent at all, or
2. has been tricked, coerced or manipulated into giving consent, or
3. has expressly refused consent, or
4. has only consented to one treatment, but the practitioner goes on to do an additional procedure for which consent has not been sought.

Examples of cases which could, or indeed have, given rise to findings of battery include: amputating the wrong limb, performing a tubal ligation (sterilisation) when the patient was told that she was undergoing an exploratory operation, or giving an adult Jehovah’s Witness patient a blood transfusion when the practitioner reasonably knows that the patient is vehemently opposed to this.

Returning to the notion of information, where the amount of information given is so unhelpful or so inadequate that a patient does not even understand in broad terms the nature of what is proposed, then his consent, for legal purposes is invalid and an action in battery may lie. The absence of information on the part of the patient will be regarded as non-consensual touching. Because it is regarded as undesirable for patients to be able to sue their practitioners in battery, the amount of information which must be disclosed to achieve even a basic level of understanding is set at an extremely low level. There is no requirement that a patient prove that had they been asked to consent to the relevant treatment they would have said no. The onus however does lie on the patient to prove that they did not consent.

Negligence

Negligence, in the context of information giving, is concerned with the practitioner’s failure to comply with a legally imposed duty of care. We will return to the concept of negligence more fully when we look at medical malpractice in Session 6. For now it suffices to note that there are three elements to establishing negligence:

- duty of care
- breach of duty
- causation of harm as a result of breach
Here we are concerned with whether a duty exists and what that duty consists of. We are looking specifically at the duty to inform. It is important to recognise here that where a complaint arises it is not because a particular procedure was carried out with improper care and skill (it may have been performed with utmost skill) but because it was carried out without full (or real) consent. The patient’s claim is that s/he was not aware of all the pertinent information and that if s/he had been s/he would never have consented to the treatment. If a patient is entitled to be informed, a practitioner is under a duty to provide information.

A duty of care arises once a practitioner’s assistance has been sought and the dentist has undertaken to offer treatment - that is once a practitioner-patient relationship has developed. In relation to information giving, this duty translates into a duty to inform so as to obtain valid consent from the patient.

In order to determine the standard of care expected of a dentist we must look at the case of Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 and the principle established which is now widely known as the ‘Bolam/Bolitho test’.

**The Bolam Case**

The Bolam/Bolitho test is the test of whether someone has or has not been negligent in falling below the due standard of care that is required of them. The standard of care is that of the ordinary skilled person exercising and professing to have that particular skill. McNair, J goes on to say:

> A man need not possess the highest expert skill at the risk of being found negligent. It is a well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

A dentist will not be negligent if he or she “acts in accordance with a practice accepted at the time as proper by a responsible body of medical [or dental] opinion”. It does not matter if some practitioners adopt different practices. The clinician does not have to follow the most common practice for doing something, merely carry out the procedure in a way that a recognised group of professionals would rightly accept as proper. To put it another way round, a dentist will only be negligent if he or she does something that no other reasonable practitioner would have done in the circumstances.

**Applying Bolam/Bolitho in the Context of Information**

Bolam is a test of negligence and not a benchmark of desirable practice. Critically, although the test has been accused of being too biased in favour of the practitioner, case law now suggests that that which is accepted as proper by a body of professional opinion must be reasonable in the circumstances. The law is from the case of Bolitho v City & Hackney HA [1997] HL which means that a body of professional opinion must be reasonable and responsible in the circumstances. Although judges may be persuaded by the views of other professionals particularly where there is professional agreement on the amount of information that should be disclosed, ultimately it is for the court to decide what the standard of care with regard to disclosure of information is and whether the lack of disclosure was reasonable in the circumstances. The issue then, in the context of information is: is it reasonable for a responsible body of dental opinion to withhold information that a patient may consider relevant to their decision making process. What are the dangers here? What if all the members of a profession were equally poor?

**The Sidaway Case**

The position on consent in English law was laid out in the case of Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] 2 WLR 480 HL. Mrs Sidaway sued the hospital board in negligence, claiming that she had not been told of all the things that could go wrong during surgery which, in the event, left her partially paralysed. The House of Lords was eventually asked to deliberate on the matter.
This case primarily said that the *Bolam* test of negligence should apply. This means that the practitioner’s duty in obtaining a patient’s consent is to provide the information that a responsible body of health care professionals would judge to be appropriate. Along these lines, if practitioners as a group choose to withhold certain information then a practitioner cannot be held responsible for not disclosing that information. As noted above however, and as we shall see in more detail below, the law is beginning to change and the notion of whether it would be reasonable to disclose in the circumstances is now starting to take hold.

One Law Lord in *Sidaway* attempted to modify *Bolam* somewhat by considering the notion of **substantial risk of grave adverse consequences**. He was of the opinion that although the degree of disclosure is an issue to be judged primarily on the basis of medical evidence or clinical judgement, where the circumstances of the proposed treatment involve substantial risk of grave adverse consequences, the dentist or doctor could be under a duty to inform the patient, regardless of the prevailing medical view. This is now where the law stands as a result of the case of *Chester v Ashfar* 2004 HL. So, where there is a 10% risk of stroke following surgery, a physician will be in breach of his duty to inform if he fails to disclose such material information. Therefore, notwithstanding any practice accepted as proper by a responsible body of dental opinion, in the absence of emergency or sound clinical reason for not disclosing, **where the risk is substantial, no prudent dentist should fail to warn of the risk**. The problem of course is, knowing what ‘substantial’ means.

In Mrs Sidaway’s case, the court found, on the evidence, that her consent to surgery was valid even though, in retrospect, she felt she should have been better informed of the risk. The House of Lords held that the doctor’s duty to inform is part of the duty to exercise reasonable care and skill, which is governed by the *Bolam/Bolitho* principle. However, in a subsequent case: *Chester v Ashfar* 2004 HL, the House of Lords expressly recognized a patient’s autonomy as a legally protected right and the courts have therefore moved to the point where they are insisting that doctors give fuller consideration to the autonomy of the patient. This means that practitioners will have to give their patients sufficient detail/explanation about ‘significant risks’ of proposed treatment otherwise they will be responsible in negligence for insufficient information. The amount of information that needs to be disclosed is not absolutely clear-cut. Relevant considerations such as the ability of the patient to comprehend the information, and the mental and physical state of the patient may be taken into account. Again, this will be governed by the notion of reasonableness in the circumstances. (See *Pearce v. United Bristol healthcare Trust* (1998) 48 BLMR 118; and *Carver v. Hammersmith & Queen Charlotte’s Special Health Authority* (25 February 2000).

Note that one of the Law Lords in *Sidaway* stated that a doctor has a duty to truthfully answer questions asked of him. Oddly, in a subsequent decision of the Court of Appeal, it was held that a doctor was not under such a duty. This meant that, in keeping with the *Bolam* decision, as long as a responsible body of dental opinion would regard it as appropriate not to answer a patient’s question or not to answer it truthfully, then a practitioner would not be held responsible for failing to do either. This position has since been clarified/rectified. It is now clear that when a patient asks a question or asks about the risks of treatment, it is a practitioner’s legal duty to give an honest answer (unless there is a therapeutic reason for not providing the information).

In summary then, courts will consider the reasonableness of the responsible body of dental opinion that would not disclose the information. This is based on the legal duty of the health care professional to advise patients of significant risks that may affect their decision to undertake treatment. It seems that the court will consider what a reasonable patient would want to take into consideration. It is difficult to define what a significant risk is, but at the end of the day the patient must be able to establish a causal connection between the non-disclosure and injury and show that disclosure of the information would have lead to a different decision. In deciding this, all circumstances will be considered including the ability of the patient to understand and his/her physical and emotional state. In exceptional circumstances, where it could adversely affect the health of the patient, there may be justification for invoking therapeutic privilege and not informing the patient (see exceptions to consent below).
As mentioned, a patient who claims a breach of duty to inform must show that damage was caused by the defendant practitioner. The damage is that the procedure was done without proper consent. The claimant patient must show that if s/he had been properly informed, s/he would not have consented.

**Capacity**

Capacity is a question of fact and requires that a patient is able to understand what is involved in the decision to be taken. It does not depend on a person's status or age therefore a child or person suffering from a mental disability is not necessarily incompetent. There is a presumption that competent patients are able to consent to or refuse treatment. This is a rebuttable presumption. An assertion that a patient does not understand must be accompanied by evidence. Similarly, in relation to children, there is a presumption created by the Family Law Reform Act 1969 s. 8 that children at the age of 16 can consent to medical, dental or surgical treatment. While there is a presumption that children below 16 are not competent to provide consent, they may be Gillick competent and have the capacity to consent to the particular treatment at issue.

As explained in the ethics section, a patient may have the capacity to make all treatment decisions, some but not all treatment decisions, or may not be capable to make any treatment decisions. The law looks to the patient's innate ability to understand what is involved in consenting to or refusing treatment. If the patient does not understand then s/he has not given valid consent, but this does not necessarily mean that the patient is not competent. There is a difference between having the ability to understand and actually understanding.

But what exactly does the patient have to understand? A patient will be considered competent if s/he can understand the nature and purpose of the treatment. This involves appreciating what will be done if treatment is accepted, the likely consequences if treatment is not accepted and the condition goes untreated, and understanding the risks and side effects explained by the practitioner, that is, the information material to making the decision.

**The Re C Three Stage Test**

The courts have developed a three stage test to assess a patient's capacity to understand. In Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819 the court held that a patient must:

i. comprehend and retain the relevant information
ii. believe it
iii. weigh it in the balance so as to arrive at a choice.

Note that the patient must comprehend the information. The patient is not required to make a wise or rational decision. So, for example, religious beliefs which lead one to refuse life saving medical treatment do not affect a person's capacity even if some may believe the refusal to be irrational. The patient must understand the information adequately. Provided s/he does so there is no reason to deprive the patient of decision making power. The patient must also be able to retain the information, which is important when dealing with patients with brain injuries or who suffer from degenerative brain disease such as Alzheimer's disease.

Whilst a decision that is understood and retained can be an irrational one, it must not be based on a misperception of reality arising from a mental disorder. Thus the patient who due to a mental disability requests that you remove her perfectly healthy teeth because she has ants living in them is incompetent to make a decision. Note that the disbelief must arise from mental disability – merely disagreeing with a practitioner’s assessment does not mean that a patient is incompetent.

A patient's capacity may be called into question for a host of reasons ranging from mental disability to pain, fatigue, shock or sedation. These factors will play a role in the patient's ability to weigh the information and make a choice. If a patient is incapable, his or her capacity to weigh must be more than reduced – it must be virtually absent.
A patient’s capacity must be commensurate with the gravity of the decision to be taken; the more serious the decision the greater the capacity that is required. Courts are very careful when it comes to patient’s refusing life saving treatment and tend toward providing treatment when capacity is in doubt.

Incapacity can also arise from the inability to communicate due to physical disability or being unconscious, for example as a result of being in an accident or being in a persistent vegetative state. Here, mental disability is not required. Providing the patient has no way to communicate at all, the patient will be regarded as incompetent to make a treatment decision.

**Voluntariness/Coercion/Manipulation**

The patient’s consent must be freely and voluntarily given. It is possible for a patient to be competent and informed but to be prevented from giving free consent because of coercion or manipulation, that is improper pressure or undue influence. The facts of each case must be considered in order to determine voluntariness. In *Re T (adult: refusal of medical treatment)* [184] 1 All ER 1036, the leading case in the area, the court found that a young woman was unduly influenced in her refusal of treatment by her mother who was a Jehovah Witness. Note that the court may be eager to find lack of voluntariness in cases of refusal of treatment rather than when patients are in agreement with medical opinion.

**Decision**

Consent and refusal to consent are opposite sides of the same coin. ‘A competent adult has an absolute right to choose whether to consent to dental treatment, to refuse it or to choose one rather than another of the treatments being offered. This right of choice is not limited to decisions that others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or non-existent’.

Theoretically it seems that a competent patient can refuse any treatment, even life saving treatment such as a blood transfusion or necessary surgery. But, in line with needing a greater level of understanding depending on the gravity of the decision, patient autonomy is sometimes overridden in cases of refusal. We must however ask whether it makes sense to say that a patient is competent to consent to treatment but that very same patient is incompetent to refuse that same treatment.

**EXCEPTIONS TO THE REQUIREMENT OF CONSENT**

Consent is required for most dental procedures and is always required where the procedure carries significant risks or is being carried out for non-therapeutic purposes, such as research. There will, however, be certain situations when the immediate consent of the patient is not required:

- **Necessity/Emergency** - For example, when a patient is unconscious and immediate treatment is required to save a life or preserve the health of the patient. Note that it is limited to treatment immediately required to save the patient’s life and no more. Anything more is a potential battery. Practitioners should not administer emergency treatment without consent if they have reason to believe that the patient would refuse such treatment if s/he were capable of doing so. This will not apply to routine dental work, but may arise during a procedure if emergency treatment becomes necessary.
- **Implied consent** - situations where patient’s consent to procedure can be implied e.g. opening mouth for routine examination.
- **Patient incapable of giving valid consent** e.g. minors (usually a proxy consent will be given on the basis of the patient’s best interests) and incompetent patients.
- **Patient waiver** - no duty to force information on reluctant patient.
- **Therapeutic privilege** – i.e. rare situations where it would cause significant harm to the patient to obtain consent. This should be narrowly construed, for example in a palliative care situation where you assess that the burden of giving the patient an additional choice outweighs the benefit.
- **Public health requirements** - may require compulsory examination and treatment. See e.g. Public Health (Control of Diseases) Act 1984
- **Mental Health Act 1983** – where treatment is for the mental illness of the detained person it may be given without consent in defined circumstances under Part IV of the Act.

A FINAL NOTE

The relationship between health care professional and patient is characterised by an inequality in which the practitioner holds the balance of power. Not only does the practitioner have more knowledge about the patient’s condition, but s/he also has the power to decide how much information to disclose and which treatment options to offer the patient. By way of contrast, the patient may be physically compromised, confused or in pain, and intimidated by the health care context. This imbalance can, in and of itself, be coercive. It is the practitioner’s responsibility to attempt to redress the inequality in the relationship and to carefully guard against manipulation of the patient’s choice and consent.

RECOMMENDED READING:


FURTHER SUGGESTED READING:


# [NHS organisation name]
## consent form 1

**Patient agreement to investigation or treatment**

<table>
<thead>
<tr>
<th>Patient details (or pre-printed label)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s surname/family name............</td>
</tr>
<tr>
<td>Patient’s first names ...................</td>
</tr>
<tr>
<td>Date of birth ................................</td>
</tr>
<tr>
<td>Responsible health professional.............</td>
</tr>
<tr>
<td>Job title ........................................</td>
</tr>
<tr>
<td>NHS number (or other identifier)..........</td>
</tr>
</tbody>
</table>

- Male
- Female

Special requirements ................................
(eg other language/other communication method)

---

To be retained in patient's notes
Patient identifier/label

**Name of proposed procedure or course of treatment** (include brief explanation if medical term not clear) .................................................................
........................................................................................................................................
........................................................................................................................................

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits  
............................................................................................................................
........................................................................................................................................
........................................................................................................................................

Serious or frequently occurring risks  
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Any extra procedures which may become necessary during the procedure

☐ blood transfusion .......................................................................................................................  
........................................................................................................................................
☐ other procedure (please specify) ...................................................................................................
........................................................................................................................................
........................................................................................................................................

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

☐ The following leaflet/tape has been provided .................................................................

This procedure will involve:

☐ general and/or regional anaesthesia  ☐ local anaesthesia  ☐ sedation

Signed:.......................................................................................... Date . ........................................
Name (PRINT) ................................................. ....... Job title ...........................................

**Contact details** (if patient wishes to discuss options later) ......................................................

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed ................................................................. Date ......................................................
Name (PRINT) ........................................................................................................................
Top copy accepted by patient: yes/no (please ring)
Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

Patient’s signature………………………… Date……………………
Name (PRINT)…………………………………….

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature………………………… Date……………………
Name (PRINT)……………………………………………………

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed:………………………………………… Date……………………
Name (PRINT)…………………………………………………..
Job title………………………………………………..

Important notes: (tick if applicable)

☐ See also advance directive/living will (eg Jehovah’s Witness form)
☐ Patient has withdrawn consent (ask patient to sign /date here) ...........................
Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child’s care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.
SESSION THREE

CONSENT: THE INCOMPETENT PATIENT
CONSENT AND THE INCOMPETENT PATIENT

This session will address the difficulties that arise when a patient is unable to consent to a proposed dental procedure. Generally speaking, as we have seen in the previous session, it is unlawful to treat a patient who has not consented to treatment. Any treatment without consent would normally constitute a trespass to the person, in other words battery. So how should a practitioner proceed when the patient is unconscious, young, mentally incapacitated or perhaps just very confused?

REVISITING COMPETENCE

It is important to bear in mind that a patient’s competence may be temporarily affected, affected by fluctuating lucidity (incompetent one moment but lucid the next) or permanently affected. A patient’s capacity must be commensurate with the gravity of the decision that they are required to make. If the patient has the requisite capacity, then his/her decision must be respected. If the patient is not competent, then a practitioner is free to treat the patient in what is believed to be their best interests.

INCOMPETENT ADULTS:

TEMPORARY INCAPACITY: THE UNCONSCIOUS PATIENT

It would clearly be very strange if the law were not to recognise that there are bound to be some circumstances when a doctor may lawfully treat a patient, even in the absence of consent. The problem arises most acutely where the patient is unconscious and the situation is an emergency. The legal position is that the practitioner may treat the patient in accordance with his or her best interests, as determined by the Bolam test if, but only if, it is necessary to do so to either save life or to ensure an improvement or prevent a deterioration in physical or mental health. However the practitioner may not treat if he or she knows that the patient would have objected to treatment. So, for instance, if the doctor knows or has reasonable cause to believe that a patient is a Jehovah’s Witness and would refuse a blood transfusion irrespective of the circumstances, then giving blood, even if it saves a life, would be battery. Moreover, if the patient is only likely to be temporarily incapacitated, the practitioner should do no more than is reasonably required in the best interests of the patient to remove him form the situation of extremis. Beyond this, the patient should be consulted further when he or she regains consciousness. Otherwise, the practitioner may again be perpetrating a battery.

PERMANENT INCAPACITY

No proxy consent exists for the permanently incapacitated adult. That is, no one can give consent on the patient’s behalf. This is categorical as a matter of law. Further, whilst it may be good practice to ask family members, particularly when they are carers what they think about proposed treatment, there is no legal basis for this at the moment. However, doing so may reduce the chances of a possible future complaint made against you by family members or carers.

The question of who consents for the mentally incapacitated adult and in what circumstances treatment without consent will be lawful, was considered by the House of Lords in F v West Berkshire Health Authority (1989). That case concerned the proposed sterilisation of a mentally handicapped woman. The judges decided that if an adult lacks capacity to consent to medical treatment, then there is no person or court who can give consent on the incapable person’s behalf (unless the treatment is for a mental disorder, in which case the Mental Health Act 1983 applies). However the court can grant a declaration that it would be lawful to proceed, even without consent, if the treatment can be justified on the grounds of necessity, as being in the best interests of the patient. This is defined as “treatment carried out to either save the patient’s life or to ensure improvement or prevent deterioration in the patient’s physical or mental health.” Note that a declaration from the court is not strictly speaking required before a health care
professional can treat an incompetent patient – but in cases of sterilisation (as in the case above) or the withdrawal of life sustaining care from PVS patients, it is regarded as good practice.

So, practitioners are obliged to treat their patients in accordance with their best interests. Providing they do so, there is no need for prior court authorisation because the lawfulness of the treatment depends on it being in the best interests of the patient. Should there be any challenge to the care offered, the professionals will be found to have acted properly provided their judgement as to what best serves the interests of the patient proves acceptable to a responsible body of professional opinion. The best interests test is therefore defined by Bolam which is problematic since a negligence test cannot come close to determining beneficence. Delivery of dental treatment in the case of the profoundly learning disabled patient may require physical or chemical restraint to be used on those unable to cooperate. The use of restraint is controversial. The courts have considered the use of physical restraint in the case of Norfolk v Norwich Health Care Trust (1996), where restraint was described as part of the treatment, and so deemed to be in the best interests of the patient. This would seem to be relevant to dental care where a profoundly learning disabled patient could be restrained if such restraint is part of the treatment. To use physical restraint to perform a routine check-up is more problematic, as check-ups are not treatment, but considered to be investigations. Chemical restraint (conscious sedation) is also called pharmacological restraint and refers to the use of a sedative or other drug to manage a patient's movements. In addition, conscious sedation usually requires mechanical and/or physical restraints to effectively manage a patient's movements.

The law is rightly concerned that patients who cannot make their own decisions about their treatment are not deprived of treatment which they need and to which they are entitled. But this is not a guarantee under the law as it stands. Professionals have to decide what is in their patient’s best interests and risk being sued if they get it wrong. Meanwhile, patients have no way of protecting themselves from treatment that they neither want nor need however well-intentioned it might be. There is also the worry that those who cannot ask for treatment will not be offered it. The law in this area is currently unsatisfactory and both patients and dentists are vulnerable. The Faculty of Dental Surgery (Royal College of Surgeons) has produced useful guidance on care pathways for people with learning disability (2012).

MENTAL CAPACITY ACT 2005

The Mental Capacity Act 2005 was passed in April 2005. It covers the law governing the way in which decisions are made on behalf of people lacking mental capacity. It was subsequently amended by the Mental Health Act 2007 which introduced Deprivation of Liberty Safeguards (formerly known as Bournewood safeguards) in to the MCA 2005.

The legislation introduced a Code of Practice, by which all professional and paid carers are under a statutory duty to have regard.

The Mental Capacity Act 2005 covers a number of issues of importance to doctors/dentists in their care of patients who lack capacity to consent to medical management or to manage their personal and financial affairs. The Act is particularly significant in two ways relevant to consent to medical management:

1. It allows consent to be given or withheld, for the medical treatment of patients who lack capacity, by another person (typically a close relative). Under the previous law there was no proxy consent for adult patients who lack capacity.

2. It provides, for statutory recognition of ‘advance directives’. These are statements made by a person whilst competent about the treatment that they would want, or not want, in specified situations, in the future were they to lack capacity at the time the treatment would be relevant.

The whole Act is underpinned by a set of five key principles in Section 1 of the Act.
• A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
• The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
• That individuals must retain the right to make what might be seen as eccentric or unwise decisions;
• Best interests – anything done for or on behalf of people without capacity must be in their best interests; and
• Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

NB The Act is not relevant if the patient is under 16 years old

Definition of incapacity

The Act essentially puts into statute the position developed in common law; which makes it clear that a person should be assumed to have capacity unless proven otherwise.

The Act states:
A person is unable to make a decision for himself if he is unable—

(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means).

A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

The information relevant to a decision includes information about the reasonably foreseeable consequences of—(a) deciding one way or another, or (b) failing to make the decision.

Best interests

One of the main principles of the Act is that: “an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.” The Act gives guidance on how those making decisions about treatment should judge the patient’s best interests. The assessment process however was challenged legally and safeguarding procedures were subsequently introduced into the Act by the Mental Health Act 2007.

In determining for the purposes of this Act what is in a person’s best interests, the person making the determination must not make it merely on the basis of—

(a) the person's age or appearance, or
(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

He must consider— (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and (b) if it appears likely that he will, when that is likely to be.
He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

He must consider, so far as is reasonably ascertainable— (a) the person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.

He must take into account, if it is practicable and appropriate to consult them, the views of— (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind, (b) anyone engaged in caring for the person or interested in his welfare, (c) any donee of a lasting power of attorney granted by the person, and (d) any deputy appointed for the person by the court, as to what would be in the person’s best interests.

Proxy consent to medical treatment under the Act - Lasting powers of attorney

The Mental Capacity Act 2005 made provision for people to choose someone to manage their affairs on their behalf should they become incapable. This includes decisions about finance, property, health and welfare. Lasting power of attorney (LPA) replaced Enduring Power of Attorney (EPA) in 2007 when the Mental Capacity Act came into force. LPAs can be made specifically for property or specifically for personal welfare. Personal welfare LPAs can include the power for the attorney to give or refuse consent to medical or dental treatment. It must be added expressly to the terms of the LPA. Such an LPA takes precedence over a previously made advanced decision refusing treatment (see below). The attorney of an LPA has the power to make the decision to accept or refuse treatment without reference to the prior advanced decision. However, the individual can make another advanced decision and that would be binding on the attorney.

A personal welfare LPA must be registered at the Office of the Public Guardian and only can be used once the individual has become mentally incapable of making decisions about their own welfare. An LPA may have one or more attorneys, they may have been appointed to act together, or together and independently.

Advance decisions to refuse treatment

An ‘advance decision’ is one made by a person aged at least 18 years old who has capacity to make the decision. The decision relates to a refusal of treatment at a later time should the person then lack capacity to decide. The directive should specify the treatment and circumstances “even though expressed in layman’s terms”.

The directive is not valid if: the person has withdrawn the directive (and has capacity to do so); has given authority to an attorney with regard to the treatment to which the advance decision relates after the advance decision was made; has done anything clearly inconsistent with the advance decision; if the treatment is not the treatment specified in the advance decision, or any circumstances specified in the advance decision are absent; there are reasonable grounds for believing that there are circumstances not anticipated by the person and that would make a difference to the decision.
Two key points for doctors/dentists:

“A person does not incur liability for the consequences of withholding or withdrawing treatment from P [the person] if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment.”

“Nothing in an apparent advance decision stops a person: a) providing life-sustaining treatment, or b) doing any act he reasonably believes to be necessary to prevent a serious deterioration in P’s condition; while a decision as respects any relevant issue is sought from the court”.

In addition, the Act creates a framework to allow the following:
* For the court to appoint deputies to make decisions on behalf of a person about matters in relation to which that person lacks capacity.
* Creation of Independent Mental Capacity Advocates to support and represent people lacking capacity who have no one else to speak for them when decisions need to be taken about serious medical treatment and long-term residential care.
* New safeguards controlling many types of research involving people who lack capacity.
* The introduction of a criminal offence of ill treatment or neglect of a person who lacks capacity, with a maximum sentence of five years.

The Act created two new public bodies:
* Court of Protection - the new court will have jurisdiction in relation to the Mental Capacity Act. It will have special procedures and judges.
* Public Guardian - This public official took over from the Public Guardianship Office. The Public Guardian is the registering authority for lasting powers of attorney and deputies.

Competency and Fear

Dentists often encounter patients who are too frightened to undergo dental treatment. Perhaps more alarming is the suspected number of people who have no regular dental care because of fear. Undoubtedly, fear can render a patient incompetent. Once we have established that a patient is incompetent in the area of dental care, we must decide on which courses of action are open to us to deal with the patient. The courts have been asked to examine cases where fear of certain aspects of treatment has led to patient refusal. *Re MB* (1997) concerned a lady who was refusing anaesthesia for an emergency caesarean section because of fear of needles. The judge ruled that because her extreme fear was causing her to be incompetent, proceeding with the emergency caesarean section against her wishes was lawful. The ruling in *Re MB* is difficult to apply to dentistry because of the difference in the consequences of upholding refusal on the grounds of fear. In the case of the emergency section, if the judge had upheld MB’s refusal, both mother and child would have died. If a patient refuses dental care because of fear, the consequences are likely to be less severe. The courts, in considering the best interests of the patient, are only likely to overrule refusals when not to do so would result in the patient dying needlessly or being severely harmed.
MENTAL ILLNESS

Patients who have a mental illness should not necessarily be deemed incompetent. It may be that their mental illness only affects certain aspects of their decision-making capacity, and not others. For instance, it is quite possible that a patient who has an obsessive-compulsive disorder that affects their perception about hand washing would be competent to decide about surgical treatment for an unrelated illness. The Mental Health Act 1983 subsequently amended by the Mental Health Act 2007, provides for compulsory treatment without consent, but only if specific instances, and only for assessment and treatment of the mental illness. There is a specific session in year 2 that deals with the ethics and law of caring for patients with mental illness.

MENTAL HANDICAP

Mental Handicap is the legal term used to describe patients who are of adult age who have not reached adult capacity. Mental handicap is not a term we currently use in healthcare, preferring instead to talk about people with learning difficulties. When the law considers such groups, it usually focuses on those with profound difficulties, whose mental age is significantly different from their actual age. Legal cases have usually concerned procedures where the requirement for informed consent would be very high in a person with capacity, such as sterilisation. Here, the professionals are required to judge what is in the patient’s best interest.

CHILDREN

In cases where children are unable to give consent or where the child is able to consent but refuses to do so, the law allows for proxy consent either by parents (or someone having parental authority) or the courts. It is beneficence based in order to protect people with learning difficulties. When the law considers such groups, it usually focuses on those with profound difficulties, whose mental age is significantly different from their actual age. Legal cases have usually concerned procedures where the requirement for informed consent would be very high in a person with capacity, such as sterilisation. Here, the professionals are required to judge what is in the patient’s best interest.

CHILDREN 16 AND OVER

Under English law, one is considered an adult and presumed competent at the age of 18. However, this principle has been modified with regard to health care treatment decisions, by s. 8 of the Family Law Reform Act 1969, which provides that at 16 a child’s consent is as effective as if s/he were an adult. Section 8 reads:

“The consent of a minor who has attained the age of 16 to any surgical, medical or dental treatment which in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.”

Simply this means that young people of 16 and 17 years of age can give valid consent to any surgical, medical or dental treatment, without regard to their parents’ wishes.

Although health care professionals may assume that a child’s consent is valid; 16 and 17 year olds do not have complete autonomy because their consent can be overridden by a court ‘in their best interests’ (but not by a parent).
Additionally, the law treats refusal of medical treatment differently to consent to medical treatment. Both the courts and parents can overrule a 16 or 17 year old’s refusal of medical treatment, irrespective of that child’s competence: *Re W* 1992 3 WLR 758.

Therefore, a parent cannot overrule a 16 or 17 year olds’ consent to treatment but may overrule his/her refusal to treatment. Moreover the courts can overrule both consent and refusal. Clearly then the law (unfortunately) does not provide the 16 or 17 year old with full autonomy.

**CHILDREN UNDER 16**

A minor’s power to consent emanates from the common law. The ability of minors under the age of 16 to consent to treatment was considered by the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* in 1985. Here the court had to decide whether children under the age of 16 could seek contraceptive advice and treatment without parental consent. The court held that there is no fixed age at which a child can be said to have the capacity to consent.

The test of maturity must be assessed in respect of each individual child and each separate procedure. Accordingly, girls under the age of 16 could consent to contraceptive treatment without parental consent providing that they were sufficiently mature, both emotionally and intellectually to understand its nature and implications. This test of maturity was known as ‘*Gillick* competency’, because the young person was assessed as competent to consent to treatment as defined by the case of *Gillick*.

‘*Gillick competency*’ has now been applied to other types of medical and dental care involving children under the age of 16 and is the standard test used to assess an under 16 year olds’ competence to consent to dental treatment. The key to ‘*Gillick competency*’ is in the child’s understanding and intelligence. A majority of their lordships held that a child below the age of 16 can consent to medical and dental treatment ‘*if and when [s/he] achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed*’.

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgement of the *Gillick* case in the House of Lords (1985), which apply specifically to contraceptive advice. There can be confusion between Gillick competency, which identifies under-16s with the capacity to consent to their own treatment, and the Fraser guidelines, which are concerned only with contraception and focus on the desirability of parental involvement and the risks of unprotected sex in that area.

**Assessing Gillick Competence**

Whether a child has sufficient maturity, understanding and intelligence to consent to what is proposed is ultimately a fact finding mission, with the child being asked specific questions about their illness and proposed treatment, in order to determine whether they are ‘*Gillick competent*’ and therefore able to consent to treatment themselves.

Capacity is clearly not automatically acquired at a fixed age, although the ability to understand will normally increase with age. However, the degree of understanding and intelligence required varies according to the complexity of the issues involved. In other words, the degree of understanding increases with the complexity of the proposed treatment.

Some decisions, such as orthodontic treatment therefore require a very high level of understanding and intelligence, whereas others, such as minor dental treatment may require a much less developed intellectual maturity. It is therefore consistent that the same child may be assessed at the same time as being ‘*Gillick competent*’ to consent to one treatment, such as wart removal but not ‘*Gillick competent*’ to consent to another treatment, such as a serious surgical procedure.

Most 12 year olds will probably have sufficient understanding to consent to having a dental examination, but few 12 year olds will have sufficient understanding to consent to or refuse some form of life-saving therapy with its attendant risks as well as potential benefits, though previous experience may indicate sufficient understanding.
In order to answer the question of whether a particular child under 16 is able to consent to medical treatment, doctors need to be sure of what the definition of ‘Gillick competence’ is and then apply the definition to the facts of that particular case taking into account: the patient’s age, intelligence, maturity, experience and the seriousness of the procedure.

The difficulty with the test of Gillick competence’ is that it sets a standard for understanding that is seemingly higher than the one set for adults. Few adults have a full understanding of all of the implications of accepting or refusing treatment, yet they are not barred from consenting or refusing treatment as children with similar knowledge may be.

Just as with competent 16 and 17 years olds the courts can overrule a Gillick competent child’s refusal or consent but a parent can only overrule a refusal of consent.

Under 16s Who Are Not ‘Gillick Competent’

When a child is clearly incapable of consenting, the dentist will turn to the parents for consent. Immature children cannot consent to medical or dental treatment and so parents or persons with parental authority can consent on the child’s behalf.

So in cases where children are unable to give consent or where the child is able to consent but refuses to do so, the law allows for proxy consent either by parents (or someone having parental authority) or the courts. A proxy is usually a parent or another person with parental responsibility. In making a decision about dental treatment the proxy must act in the child's best interests and if this is not the case then the decision can be overridden by the court. Usually consent need be obtained only from one parent (although if treatment involves an operation that is irreversible and not medically necessary e.g. major cosmetic work; if the two parents disagree it is advisable to seek advice from the court). If there is a difference of opinion between the parent (s) and the clinician regarding best interests the matter can be referred to the Official Solicitor who is likely to make an application to the court. In an emergency situation, where a parent cannot be contacted, the child can be treated without consent, but only where treatment is immediately necessary.

Therefore, parents do not have an unfettered right to approve or reject treatment on behalf of their children. The court may intervene if, in its opinion, the parent's decision is not in the child’s best interests. Most of the recent decisions have concerned babies and very young children who are desperately unwell. The courts may also be asked to consent when the parents fail to make any decisions at all, for whatever reason. The court will try to balance the benefits of treatment against its burdens to determine what is in the child’s best interests. This will not inevitably mean that the child’s life must be preserved; the quality of that life and the likely distress and pain to the child will be crucial factors in the decision.

Cases where the court has intervened

Even where a young person may have the capacity to consent at common law, this does not necessarily mean that s/he has a right to refuse treatment (Re R (1991) and Re W (1992)), even though s/he may seemingly have sufficient understanding to make a decision. The law is clearly more ready to recognise the child’s ability to consent than to refuse treatment. A competent child’s refusal is likely to be overridden if it appears to be in the child’s best interests to do so, no matter how mature the child may be.

The case of Re R involved a 15-year-old girl who was refusing to give her consent to receive psychiatric treatment. The Court of Appeal held that Gillick competence was not applicable in respect of a ward of court refusing treatment, which the court felt was in her best interests. Moreover, it was held that even if a child under 16 were Gillick competent the court could override that decision. Gillick competence then, does not give a competent child the right to refuse treatment which a parent, or someone with parental responsibility, or a court, believes is in the child’s best interests. In such
cases, treatment can be authorised despite the child's refusal. Parental rights to consent seem to co-exist along with Gillick competence.

Although this may be helpful to practitioners seeking to treat in the face of a child's refusal, it is impossible to reconcile with the notion of respect for autonomy.

The Health and Social Care Act 2008 replaced the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission with a single, integrated regulator for health and adult social care - the Care Quality Commission. The Care Quality Commission began operating on 1 April 2009 as a non-departmental public body.

RECOMMENDED READING:


*Clinical Guidelines and Integrated Care pathways for the Oral Health Care of people with Learning Disability* (2012). Royal College of Surgeons, Faculty of Dental Surgery. London

FURTHER SUGGESTED READING:


Mental Health Act (2007) HMSO, London
SESSION FOUR

CONFIDENTIALITY
LEARNING OBJECTIVES:

At the end of this session students will:

- recognise the importance of confidentiality in the dentist-patient relationship
- being to understand the legal and ethical obligation to maintain confidentiality
- describe the limits to confidentiality as set out by the General Dental Council
- understand the students’ obligations with regard to information learned about patients in the clinical setting.

IN GENERAL

Confidentiality is one of the cornerstones of the practitioner-patient relationship. As a result the GDC has produced specific guidance about maintaining patient’s confidentiality and you should ensure that you are familiar with the contents of this publication, which can be found at the following website address:


The Hippocratic Oath Reads:

Whatever, in connection with my professional practice, or not in connection with it, I see or ear, in the life of men, which ought not be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

The issue of truth telling may come into conflict with the notion of confidentiality particularly where the information involves more than just the patient. The issue of disclosure of information becomes significantly more complicated when more than two people are involved, so that the duty to tell the truth may conflict with other duties like that of confidentiality or the responsibility to protect third parties from potential harm. Respecting one person’s choice or autonomy regarding who can know what about them, may mean that another person must be deceived. This may be the case when a wife asks a dentist about her husband’s condition and the husband has insisted that the dentist not tell her anything.

ETHICAL OVERVIEW: A RELATIONSHIP OF TRUST AND CONFIDENCE

As will be discussed in the session on truth-telling, the professional relationship with a patient is fiduciary in nature, in other words it rests on a certain trust and confidence that commitments between the parties will be respected and upheld. In the practice of their profession, dentists, like priests and lawyers, must be able to hold in confidence the information they learn about patients.

There are two important aspects to confidentiality. The first is the patient’s right to privacy and the second is the practical necessity for a condition of trust. The Lindop Commission on data protection defined privacy as follows: “… the claim of individuals, groups or institutions to determine for themselves when, how and to what extent information about them is communicated to others”.

From this definition we are reminded of the extent to which privacy enables us to exercise our own autonomy. In controlling the disclosure of information about ourselves, we maintain significant control over our own lives. For example, I might suffer from epilepsy but I don’t want you to know about it because I believe it will change the way you relate to me. Therefore I do not tell you and I instruct those few trusted others who have access to this privileged information that they too, must not disclose this information about me. Such exercise of my right to privacy enables me to maintain some degree of control over whether my relationship with you will continue and it prevents me from being stigmatised. No one is harmed if you don’t find out about my epilepsy - it really is none of your business. It might be, if I was going to be your chauffeur, but I’m not. The exercise of my individual right becomes problematic when it conflicts with either the exercise of someone else’s autonomy or the public good. We will say more about this later.
For health care to be effective, patients must have trust in their practitioners such that they can talk freely and confidently about intimate aspects of their lives, without worrying that others will find out. Confidential treatment of patients’ records and disclosures are essential if trust in the health professions is to be maintained.

With good reason, patients operate under the assumption that what they tell you about themselves will not be broadcast to all and sundry as soon as their backs are turned. As far as the public is concerned, the obligation of confidentiality is an implicit promise of the professional or an implicit contract of the professional relationship; it is something that patients expect, even if you don’t explicitly commit yourself to it in your discussions with them. To break a confidence then, is to break a promise. But, as will be discussed below under the legal overview of confidentiality, notwithstanding the importance of confidentiality, patients do not have an absolute right to confidentiality. You can no doubt imagine that a rule of absolute confidentiality would be unethical, particularly if it meant that you could never prevent foreseen harm. It would mean you were powerless to protect innocent third parties if a patient told you about her violent impulses towards her child or if the would-be rapist disclosed to you the name of his next victim.

One of the most controversial ethical problems to arise in recent years is whether or not practitioners should disclose their patients’ HIV positive status to their patient’s sexual partners, either if the patient refuses to do so or if he or she refuses to engage in safer sexual practices. Arguments in favour of disclosure contend that the potential harm to the partner from HIV infection - because it almost invariably leads to AIDS, for which there is as yet no known cure - is greater than the harm that disclosure would do to the patient. In ethical terms, concern for the preservation of life is usually greater than concern for the preservation of confidentiality. Against this argument, would be the insistence that the primary concern for the practitioner is the patient who has sought their assistance - the patient seated before them - and to this particular person only the promise has been made to maintain confidentiality. You will remember when we looked at deontology, that rules are absolute and a promise is a promise. The duty to keep that promise, or to respect the patient’s privacy, if you were a deontologist, would apply irrespective of the harmful consequences that adopting such a rigid position might lead to.

If, on the other hand, you were to adopt a utilitarian position, you would argue that the relationship with this patient may be ruined by such a breach because he will no longer trust you and the flow of information between you will be inhibited. Thus, your ability to provide effective health care is substantially diminished. Worse still, from the perspective of utilitarianism, the more practitioners breach confidentiality, the less likely patients will be to undergo HIV testing. This in turn could lead to greater overall harm as more people might contract the disease. Therefore, if practitioners can’t be trusted, a great deal of harm could occur to large numbers of people. Remember, utilitarianism seeks to promote the greatest benefit to the greatest number, so you might appeal to this theory to argue against breaching the confidentiality of HIV positive patients.

LEGAL OVERVIEW: THE DUTY OF CONFIDENTIALITY

The relationship between the doctor or dentist and the patient, unlike the relationship between the lawyer and the client, is not protected by legal privilege. This means that while a lawyer can never be called upon to breach professional confidentiality, a dentist can. Both the individual and public good will, at times, demand that you disclose information about the patient that you learned in the practice of your profession, although the conditions under which you may breach this trust are not always crystal clear.

The law recognises an important interest in maintaining professional duties of confidence, but as noted above, such duties are not absolute. They can be overridden when there is a stronger public interest in disclosure. The court must balance the public’s interest in maintaining confidentiality against its interest in disclosure. There is a great difference between wanting to know and needing to know.
The cases of *X v. Y* [1988] 2 All ER 648 and *W. v. Egdel* [1990] 1 All ER 835 illustrate how the public interest exception can work both ways. In *X v. Y* where a newspaper was going to publish an article identifying two doctors with AIDS who were continuing to carry on general practice in England, the court held that it was not in the public interest to disclose such information since the result would be that patients (in general) would not come forward for testing for fear that their private records would be divulged. The interest in confidentiality generally and specifically in relation to AIDS patients outweighed public interest in disclosure, having a free press and informed debate. However, in *W. v. Egdel*, the disclosure of a private psychiatric report by a psychiatrist to the Home Secretary in order to prevent a mental patient convicted of murder from obtaining a conditional discharge was considered a justified disclosure in the public interest. Whilst the doctor had a duty of confidentiality to the patient he also had a duty to the public to maintain its safety. In *Egdell*, the public interest in disclosure outweighed the interest in maintaining confidentiality. However, it is important that disclosure is for an appropriate purpose and to the proper authorities. So if the psychiatrist in the *Egdell* case had disclosed the information in a ‘tell all’ book or on a talk show, he would have been liable for breach of confidentiality. Disclosure in the public interest to avert a real risk of harm requires that there be a real risk of physical harm. (See below for GDC exceptions to confidentiality).

ACCESS TO PATIENT INFORMATION

The Human Rights Act 1998 provides that the NHS (as a public authority) recognise people’s right and balance them properly against other competing interests. The right to respect for private and family life, under Article 8 covers disclosure of private information. It is likely that a failure to provide access to health records or health information is a violation of this article.

In the past access to health records was divided and there were different Acts for manual and electronic records. The Data Protection Act 1998 brings all rights of access together. Patients are entitled access under the Act to ‘accessible records’. Health records are accessible records. They are defined as:

Any record which -

a) consists of information relating to the physical or mental health or condition of an individual; and

b) has been made by or on behalf of a health professional in connection with the care of that individual

Patients have access to all health records regardless of when they were made/created. However access to health records may be withheld where it would likely cause serious harm to the patient’s mental or physical condition or where a third party requests access and the patient refuses disclosure.

THE OBLIGATIONS OF STUDENTS

Were it not for the fact that your teachers and other health care providers will repeatedly disclose to you confidential information about patients, you would learn very little during your undergraduate years. So does this mean they are all acting unethically and illegally? Do you wonder what the patients know about you? Have they consented to your being privy to some very intimate details of their lives? Do they know that you will read their records, talk over their cases with other students and caregivers and even talk about them with your friends on the bus on the way home? It may surprise you to learn that the answer to these questions is likely to be “no” and because of that, your responsibilities to the patients whom you meet are not trivial.

Like all other caregivers, students undergoing vocational training in the health sciences are under the same obligations to maintain confidentiality. Teaching hospitals usually discuss the issue of
student learning in patient information pamphlets and individual clinicians will often seek the permission of patients for you to talk to them or perform some part of a physical examination. Rarely are patients told that students, like others involved in their care, are not at liberty to disclose information learned about them in the clinical setting. In your interactions with patients there is nothing to stop you from confirming with them your own commitment to confidentiality. In fact they may well appreciate it. But about this bus journey home - talk about anything else but not your patients. Of course you may confer with your fellow students about patients you have seen, about their problems and treatment. But like other caregivers who also discuss cases among themselves, make it a rule of thumb to avoid doing this in public places. You have no idea who may overhear you.

**PRINCIPLES OF CONFIDENTIALITY**

1. Patients have a right to expect that you will not disclose any personal information about them, which you learn during the course of your professional duties, unless they give permission.

2. When patients give consent for disclosure you must make sure that they understand what will be disclosed, the reasons for disclosure and the likely consequences.

3. You must uphold requests by patients that information about them will not be disclosed to third parties, except in exceptional circumstances where, for instance, the safety of others would be jeopardised.

4. If you have to disclose confidential information you should release only as much as is absolutely necessary for the purpose and you must be prepared to justify your decision.

5. You must make sure that those to whom you disclose confidential information, understand that it is told to them in confidence which they must respect.

6. When discussing cases with fellow students and colleagues, avoid using names or other identifying information wherever possible.

The Caldicott review (1997) and the Data Protection Act 1998 enforce strict ethical and legal guidelines to the storage, maintenance and access to patient information. The Freedom of Information Act 2000 and the Information Governance initiative both support the need to maintain the principles of effective confidential data control.

Whilst the information management principles are not a legal requirement, they are seen as essential to support the requirements of Data Protection Act.

The six Caldicott principles are:

- Justify the purpose(s) of using confidential information
- Only use it when absolutely necessary
- Use the minimum that is required
- Access should be on a strict need-to-know basis
- Everyone must understand his or her responsibilities
- Understand and comply with the law

The Caldicott principles are excellent guidance when considering whether it is appropriate to use
and disclose confidential information, see: www/doh.gov.uk/ipu/confiden

The 'Confidentiality: NHS Code of Practice' was published by the Department of Health following a major public consultation in 2002/2003. It is a guide to required practice for those who work within or under contract to NHS organisations concerning confidentiality and patients’ consent to the use of their health records. It can be found at:


RECOGNISED EXCEPTIONS TO THE DUTY OF CONFIDENTIALITY

We have already encountered some exceptions to the duty to respect patient confidentiality. The following are situations which the GMC/GDC have identified as examples of when a practitioner may be justified in breaching confidentiality. Note that while the courts pay great heed to these guidelines, the issue of overriding confidentiality in the public interest remains one for the courts and not the professional bodies.

- **disclosure with the patient’s consent:** if the patient has given permission to disclose confidential information then you are not overriding their autonomy to do so. Patients must be able to understand what will be disclosed, the reasons for the disclosure and the likely consequences.

- **disclosure within health care teams:** this is on a strictly ‘need to know’ basis, borne out the duty of beneficence and the growing tendency for health care to be delivered in teams. The consent here might be implicit and need not be express. Where patient refusal to share information is explicit, it must equally be respected.

- **disclosure without consent in the patient’s medical interests:** there may be situations where the patient is too ill to ask whether information can be disclosed, or you feel that consulting the patient would cause them harm.

- **disclosure in the interests of others:** this utilitarian justification only permits limited disclosure to protect specified 3rd parties from risk of identifiable harm. Typical examples here tend to be disclosure to the Driver and vehicle Licensing Authority where a patient continues to drive when unfit to do so, disclosure of a colleague who is putting patients at risk with their illness or condition, and HIV/AIDS.

- **disclosure in connection with legal proceedings:** if a patient is alleging negligence, their medical records will be disclosed in the proceedings.

- **disclosure in accordance with statutory requirements:** certain statutes, such as the Prevention of Terrorism Act require the disclosure of confidential information, but practitioners should always make sure that the disclosure is really necessary.

- **disclosure for the purposes of clinical teaching, research or audit:** it may be necessary for patient records to be discussed in this context, but confidentiality should still be preserved, information should be anonymised as far as this is possible, and consent should be obtained.

Remember that in all of these situations other than when the practitioner is specifically compelled to divulge information by law, the practitioner has a discretion (rather than an obligation) to disclose information. Confidentiality should always be respected unless there are compelling reasons for breaching it. It is a prima facie ethical principle, that is it should be upheld unless trumped by another prima facie principle, for example robust public interest.
RECOMMENDED READING:


SESSION FIVE

NEGLIGENCE
LEARNING OBJECTIVES

At the end of this session, students will:

- Identify the three elements (duty of care, breach of duty and causation) necessary to establish negligence
- Demonstrate an understanding of these elements
- Consider the professional responsibility of disclosing mistakes and apologising

THE LAW OF NEGLIGENCE:

Patients have a right to expect that treatment will be carried out with due skill and care. A health care professional who fails to exercise the requisite degree of skill and as a result, causes the patient harm, may be liable to the patient in damages. Most actions for negligence are civil in nature arising from a breach of a health care professional's duty of care. Criminal actions for gross negligence are rare. The critical difference is that a negligent act (in civil proceedings) is an unintentional act. We will mostly concentrate on civil negligence actions.

The burden of proof is on the patient-claimant to establish on a balance of probabilities that the defendant dentist caused the harm alleged. In a negligence claim, the burden remains with the patient-claimant even if negligence has been proved or admitted.

As we saw in session 2, to prove negligence, a patient-claimant must successfully establish:

I. that the defendant-health care professional owed him a DUTY OF CARE
II. that the health care professional was in BREACH OF DUTY; and
III. that the harm which the patient complains of was caused by the health care professional's carelessness, (CAUSATION: HARM CAUSED AS A RESULT OF THE BREACH)

DUTY OF CARE:

All practitioners owe a duty of care to their patients. Generally, there is little difficulty in establishing that a duty of care is owed to a patient. The duty of care is the duty to exercise reasonable care and skill in all aspects of the relationship with the patient, that is, in diagnosis, information giving and treatment. The duty of care is the same regardless of experience of the dentist. The crucial issue is whether the health care professional assumed responsibility by undertaking the care of the patient.

Generally, a practitioner owes a duty to patients on his list, and the entire practice staff owe a duty to patients attending for treatment. If the patient is a NHS patient, the duty derives from the law of tort, which imposes a duty whenever one person can reasonably foresee that his conduct may cause harm to another.

Where the patient is a private patient, the duty arises from his contract with the health care professional. The parties are free to set the terms of the agreement except that the dentist cannot exempt himself from liability for any injury arising from his negligence. Contracts are rarely written and tend to be implied from the relationship. The duty of care is the same whether it arises from tort or contract.

Note that health care practitioners are not required to act as good Samaritans. There is no legal duty to respond when some asks if there is a practitioner in the house. However, once a practitioner responds, then their duty of care arises.
THE STANDARD OF CARE/BREACH OF DUTY

Once a duty of care is established, the patient-claimant has to prove that the health care professional fell short of the standard of care that could reasonably be expected of him. The basic test for negligence is whether a practitioner was reasonable in all the circumstances. Reasonable conduct is not negligent; unreasonable conduct is. Negligence is the omission to do something which a reasonable man would do or doing something which a reasonable man would not do.

The basic standard, as we have already seen, is that of the reasonable dentist in the circumstances. The standard of care demanded of a health care professional is the standard of the reasonably skilled and experienced health care professional. The classic statement of the standard of care expected of a dentist is set out in the judgment of McNair, J. in the case of Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118:

The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill… it is sufficient of he exercises the ordinary skill of an ordinary competent man exercising that art.

This means that the general practitioner must meet the standard of the competent general practitioner and orthodontist must meet the standard of the competent orthodontist practicing that specialty. So, a patient seeing her dentist for jaw alignment problems cannot complain if the dentist fails to have the skill of a consultant maxillo-facial surgeon. BUT, the patient can complain if the dentist fails to refer her to a consultant if her condition should have alerted the reasonable dentist to the need for further or special treatment.

The standard of care does not vary depending on the experience of the health care professional. Inexperience is not an acceptable excuse. Therefore foundation trainee (FT) dentists cannot avoid a negligence action by claiming that they did their best in light of their inexperience. (Wilsher v. Essex AHA [1988] 1 All ER 891.) The law requires all dental staff to meet the standard of competence and experience society expects from those filling such positions. However, FTs may meet the standards required of them by acknowledging their inexperience. So, where a FT calls their trainer to check what he has done, the FT is likely to be protected from a negligence action even if he has made a mistake that the trainer does not catch. It is the trainer who will likely be found negligent. Another point that all practitioners must keep up to date. The excuse of “I've already carried out treatment this way” may be classed as negligent. GDC standards advise that all practitioners “maintain, develop and work within their knowledge and skills.”

Accepted Dental Practice

Courts will ascertain the standard of care based on accepted dental practice. Bolam, as we have seen, states that a practitioner is not negligent if s/he acts in accordance with a practice accepted at the time as proper by a responsible body of professional opinion, even if there is a body of opinion that takes a contrary view. According to Bolam, professionals are judged according to the prevailing standard of their peers. If a professional fails to measure up to the standard in any respect they will be held negligent.

It is clear that there is room for differences in dental opinion and practice. The courts tend to be reticent to intervene in challenging expert opinion. As we noted in session 2, they are more likely to intervene with regard to disclosure of sufficient information than with respect to diagnosis and treatment since the latter involves more clinical judgment.

Diagnosis

A wrong diagnosis is not by itself evidence of negligence on the part of the health care professional. A patient alleging that a wrong diagnosis was negligent must establish that the
practitioner failed to carry out the examination/tests that the patient’s symptoms called for or that his diagnosis was one that no competent dentist would have arrived at. A practitioner need not be totally infallible but his mistake must be reasonable.

Practitioners may find themselves in a catch 22 situation: where they fail to arrange for a test and the patient is found to suffer from some condition that the test would have revealed they may be sued for failing to order the test. Alternatively, if they arrange for a test and an inherent risk of the test harms the patient, the patient may sue if the test reveals that the dentist’s suspicions were groundless.

**Treatment**

Where a patient claims that the treatment was negligent, the claim is either that the treatment was inappropriate or that the treatment was correct but that it was carried out negligently. Whether the treatment is appropriate depends on whether it conforms with accepted practice and whether it is reasonable in the circumstances. If the treatment is appropriate but negligently administered, it is necessary to look at what went wrong and why. The practitioner must have all the necessary information to treat – that is, they must be aware of the patient’s medical history, including allergies, drugs that the patient may be taking that may be contraindicated with a particular treatment, etc.

It is important to reiterate that not all dental mistakes amount to negligence. An error in judgement need not necessarily be negligent. It depends on the nature of the error and whether a practitioner acting with ordinary care might have made the same error. However, manifest errors, like wrong drugs and wrong dosages will generally lead to successful negligence claims.

**Disclosure of Information**

See Session 2 for a full discussion on this issue.

**CAUSATION**

The final element of establishing negligence is the most difficult one to satisfy. The patient-claimant must prove that what was done, or not done, amounted to actionable negligence. The patient-claimant must show that “but for” the defendant’s negligence, the harm would not have occurred. This is often difficult to prove, particularly in the dental context where there may be a variety of reasons as to why the harm has occurred.

It is important to remember that establishing negligence does not necessarily mean that a patient’s claim will be successful. In addition to establishing negligence (that the diagnosis, treatment or advice given was not in accord with accepted practice) the patient-claimant must also show that his injury or his worsened or unimproved condition was caused by the dentist’s negligence. The issue here is: even if the practitioner is negligent, would the harm have occurred anyway? If yes, then the action will not be successful.

A patient must convince the court that it was the practitioner’s negligence and not the natural progression of the disease or the inherent risks of the procedure that caused the harm. So, where the scientific evidence is ambivalent or suggests a variety of competing causes for the patient’s condition, the action in negligence will likely fail.

Patients can also claim for a loss of chance of full recovery. Where treatment is not given in a timely fashion and a patient suffers injury as a result, if his chances of full recovery are decreased as a result of the negligent delay, then the patient may be able to receive compensation for the diminished prospects of an uncomplicated recovery. However, it must be clear that ‘but for’ the practitioner’s negligence, the patient-claimant would not have suffered the injury. Where a practitioner is found negligent for failing to do something, it is necessary to then consider in the hypothetical what would have happened if the duty had not been breached. Where a
practitioner breaches her duty to see a patient in a timely fashion and the patient suffers respiratory
distress and ultimate brain damage that could have been avoided if the patient had been intubated
promptly, the court will consider whether a responsible body of medical opinion would not have
intubated in the circumstances. If it is reasonable not to have intubated, then the practitioner will not
be found negligent (see Bolitho v. City and Hackney Health Authority [1997] 4 All ER 771).

CRIMINAL LIABILITY

Negligence in the health care context is typically a civil matter, not a criminal one. Gross
negligence causing death can lead to a conviction for manslaughter. It requires more than
ordinary negligence and usually involves morally disgraceful conduct – i.e, practising while drunk
or under the influence of drugs, or extreme negligence.

To establish criminal liability, ‘the negligence of the accused [must go] beyond a mere matter of
compensation between subjects and [show] such a disregard for the life and safety of others as to
amount to a crime against the state and conduct deserving of punishment’.

This test has been somewhat redefined by the courts. A non-exhaustive list of states of mind that
could lead to a finding of gross negligence manslaughter include:

- Indifference of an obvious risk of injury to health;
- Actual foresight of a risk coupled with a determination nevertheless to run it;
- An appreciation of the risk coupled with an intention to avoid it but also coupled with such a
  high degree of negligence in the attempted avoidance that it justifies conviction;
- Inattention or failure to avert a serious risk which goes beyond mere inadvertence in respect
  of an obvious and important matter which the defendant’s duty demanded he should address.

DAMAGES

If a patient-claimant is able to establish (civil) negligence the legal remedy will be an award of
damages to compensate the patient. The purpose of damages is to put the patient-claimant in
the position s/he would have been in but for the negligence. Claimants must mitigate their loss
otherwise they may be considered to have contributed to the negligence.

Generally, an award of damages will be made up of special damages (quantifiable damages up to
the trial) and general damages for future care, including a sum for pain and suffering and loss of
amenity and anticipated future loss of earnings. Damages may be awarded by way of lump sum,
or by means of a structured settlement.

Compensation awards have risen over the last few years. Awards for damages following ‘botched
deliveries’ have risen to over £3 million. (For example, see the case of Samuel Mansell who in
1998 won a £3.28 settlement for medical negligence following a delivery which left him with
cerebral palsy). This obviously translates into a heavy burden for the NHS. In 1996/1997 the cost
to the NHS was £11m, in 1997/1998 £66m, and in 1999/200 it is expected to be £278m. (Health
Law, Health Care for Professionals, 5(5) May 2000.)

WHO SHOULD BE SUED?

If a patient can identify a particular individual s/he can sue that person (dentist, nurse,
anaesthetist, etc) or he can sue the person’s employers. Since 1990, NHS indemnity provides
that any liability incurred by an NHS hospital practitioner will be met by his employers (in the case
of NHS treatment, the employer is normally the district health authority or the NHS trust). If the
dentist is employed by a health authority to provide dental care to its client group, then the dentist
will be covered under vicarious liability. Vicarious liability is where the employer in law is
responsible for the practice of its employees in the performance of their role. When the dentist is
practicing privately, then they will be covered by their own private legal cover. A private dental
practice must also have legal cover that extends to its employees, such as hygienists, nurses, receptionist’s etc.

LIMITATION PERIODS

All actions for personal injuries must be brought within three years of the injury. However, the three years may run from the time the patient becomes aware of the injury or from the time he becomes aware or should have become aware of his legal remedy. (Limitation Act 1980). Courts have discretion to override this 3-year period where it is fair in the circumstances. Note that in the case of a minor, the 3-year period begins to run from the age of majority (18) – thus it is prudent to keep records. There is no limitation period for adults that lack capacity.

THE ETHICS OF PROFESSIONAL NEGLIGENCE: CANDID DISCLOSURE & APOLOGIES

Here we are talking about assuming responsibility and not about liability. It is generally regarded as good practice to explain to patients when care or treatment has gone wrong. It is believed that a full and frank explanation to patients will do much to defuse anger, upset and resentment and reduce the risk that the patient will seek redress in court. A full and candid disclosure may also identify the cause of the problem and prevent recurrence. The Medical and Dental Defence Union of Scotland (MDDUS) suggest that patients who complain about their dental care are looking for a variety of outcomes, including: being “heard out”; acknowledgement of a wrong done; explanation of why things went wrong; convincing assurance that the problem will be addressed and will not happen again either to the patient or other patients; apology demonstrating sincere regret. A survey of 1007 complaints to MDDUS found that the primary concern of patients was to ensure that the same thing did not happen to another patient. Only 7% of patients who complain do so in hopes of financial compensation. Keeping these desired outcomes in mind when dealing with concerns can often prevent escalation to a formal complaint.

In session 7 on truth telling we will consider the issues raised and whether a practitioner is ever justified in not disclosing a mistake. Consider whether the patient’s autonomy would be undermined by the disclosure (i.e. by being incapacitated by depression) or whether the patient simply does not want to know. Some practitioners may feel that since the relationship between themselves and their patients is one of trust, full disclosure will undermine this essential element. On the contrary, though a practitioner may first want to go over the explanation with colleagues or even one’s defence union, a willingness to explain what has gone wrong and to show a little humility may go a long way to maintaining a strong practitioner-patient relationship. Rather than destroying the relationship, the knock on effect may be greater confidence in the health care system generally.

Both consequentialism and deontology assist in the notion of disclosing mistakes. Consequential ethical theory holds that one ought to do that act which will realize the best overall consequences. Here it would be necessary to balance the benefits and harms of disclosure. So for example one would have to weigh possible increased trust and avoidance of worrying about symptoms related to the mistake against the harm of patient alarm, anxiety, and burden of knowing.

Deontological theory maintains that one ought to do that act by which one fulfills one’s duties and obligations. A duty of disclosure of mistakes can be premised on Principism (beneficence, nonmaleficence, autonomy and justice).

In telling a patient about an error, it would be helpful to describe the decisions that were made and why. This should always be described in non-technical language. The nature of the mistake should be disclosed and the practitioner should apologize for the mistake. The possible harm of disclosing a mistake may be minimized if it is open and prompt and apologies are made.
Obviously, however, if the injury suffered is severe, however full the explanation, patients may sue to obtain damages to compensate them for example for loss of earnings or the cost of future care.

Nevertheless remember that ‘to err is human’. But to cover up your errors is not acceptable.

**RECOMMENDED READING:**

Brazier, *Medicine, Patients and the Law*, Chapter 6

Montgomery, *Health Care Law*, Chapters 7 & 8

SESSION SIX

ETHICS AND LAW OF HEALTH RESEARCH
LEARNING OBJECTIVES:

At the end of this session students will:
- consider the notion of dental research and what it entails
- begin to understand the tension between the interests of future and current patients posed by research
- begin to understand what is meant by independent ethical review and why it is required
- review notions of consent (as they pertain to research)
- begin to understand the legal limitations on scientific research

WHAT CONSTITUTES HEALTH RESEARCH?

The purpose of health research studies is to provide information on health and disease. Whether something constitutes dental research as opposed to dental practice depends largely on the intent of the practitioner. In dental practice the sole intention is to benefit the individual patient, not to gain knowledge of general benefit, though such knowledge may incidentally emerge. In dental research the primary intention is to yield generalisable knowledge to benefit patients in general, although the individual research subject may receive no direct benefit.

Not all innovations, however uncertainly applied, are formal research projects. Every new procedure or treatment should ideally become part of a research project early in its development. In at least two areas of medicine, namely gene therapy and animal to human transplantation, all innovation is classed as research (Gene Therapy Advisory Committee 1994)

Treatments may also have already become widely used and accepted before they have been tested by controlled experiments. It is hard to test these treatments once they have become standard treatments because practitioners tend to imbue them with confidence on the basis of their personal observations and preferences and so are less willing to submit their patients to randomisation where they may get a control therapy.

A distinction is often drawn between:

(a) therapeutic research: this has the dual intention of seeking to benefit the patient who is the research subject and to gather data of generalisable nature
(b) non-therapeutic research: gathers data that will not or is unlikely to benefit the individual participant. It is usually carried out on healthy volunteers or otherwise healthy patients.

This distinction is likely to be dropped from the revised Declaration of Helsinki because it is more useful to calculate risks and benefits of treatments offered in trials against treatments available routinely on a case-by-case basis. However, this distinction still has legal relevance especially when the research involves children, as we will see later. So for this session, we will maintain the distinction.

WHY IS RESEARCH IMPORTANT?

Research is important because it enables the dental profession to provide future patients with treatments we know to be effective. This will make society healthier and happier. It enables advances in dental practice and the alleviation of suffering. There is thus a strong utilitarian argument for making sure research is carried out in such a way as to promote the greatest good and the least harm. This would rule out research that is unlikely to benefit anyone and it is important to use the right scientific methods to give answers that are clinically meaningful and socially valuable. So, scientific design of the research is an important consideration, because bad science is bad ethics.

It is also important that the research has not already been done because it could then be scientifically unnecessary. Of course confirming and checking previous results is important and legitimate research. In addition, there is often a concern over protocols for what are known as ‘me
too' drugs, where there are several other drugs already on the market and a company wants to promote its own brand.

WHAT ABOUT CURRENT PATIENTS?

A balance must be struck, however, between facilitating the justifiable advancement of dental knowledge and protecting research subjects from harm. It is accepted nowadays that the interests and rights of current patients should not be overlooked in our quest for improved treatments. But dentists have potential conflict of interests between doing research to help future patients and looking after their current patients. It is thus advisable to put each research proposal to independent ethical review.

INDEPENDENT REVIEW BY ETHICS COMMITTEES

The Health Research Authority (HRA) was established on 01 December 2011 as an NHS Special Health Authority. Its purpose is to protect and promote the interests of patients and the public in health research. It protects patients from unethical research while enabling them to benefit from participating in research by simplifying processes for ethical research. The National Research Ethics Service (NRES) is part of the HRA. It reviews over 6000 applications per year through its 80 Research Ethics Committees (RECs) (England) with 1,200 voluntary REC members. Ethical review is the most important protection for research participants. RECs help ensure that any risks of taking part in a research project are kept to a minimum and explained to participants in full. Their approval is a key reassurance to potential participants. All research involving NHS patients has to have this approval before it can start.

NRES has two roles:

- to protect the rights, safety, dignity and well-being of research participants; and
- to facilitate and promote ethical research that is of potential benefit to participants, science and society.

RECs, also known as local research ethics committees (LREC) review applications for research and give an opinion about the proposed participant involvement and whether the research is ethical. They are entirely independent of research sponsors (that is, the organisations funding and hosting the research) and investigators. This enables them to put patients at the centre of their research.

All NRES RECs review applications within the Governance Arrangement for Research Ethics Committees (GAfREC). In addition, some are also recognised for the purpose of reviewing clinical trials of investigational medicinal products (CTIMPs). Only RECs with this recognition may review CTIMP applications.

Despite the current legal standing of ethics committees, the two major incentives for all researchers to seek ethical committee approval are that few publishers are prepared to publish results without it, and it is difficult to secure funding for research which has not gained ethical committee approval.
REVIEWING RISKS AND BENEFITS

The expected risks associated with treatments in research must be balanced against their expected benefits. Risk is assessed in terms of the probability of an undesired outcome, and how bad that outcome would be for the patient. The risk to which the research subjects can be exposed must be the minimum compatible with securing that data.

Ethics committees can be paternalistic in protecting subjects from grave risks for research purposes irrespective of the expected benefit. There are also legal limits to the degree of harm a person can willingly consent to. However, the risk or expected harm associated with treatments being tested in research can only really be assessed by the subjects themselves (provided all the relevant information has been given to them by the researchers).

It is very important to assess the risks and benefits associated with going into a research project against what is available routinely.

- Sometimes, experimental treatments are really untested standard therapies and are already widely available. In this case, participation must be based on the participants’ altruism or willingness to help others. Where standard therapies are compared, it is important that patients realise that they could get any preferred treatment without going into a trial and the patient information leaflet should spell this out.
- Sometimes, a treatment is only available within the research project so the only way a patient could gain access to it is by participating in the research. It is important that patients are not persuaded to participate just because they are desperate for whatever treatment is offered in the research study.

CONSENT TO PARTICIPATE (See session 2)

The primary legal concern is that the subject must have given his fully informed consent to take part in the research study, whether as a patient or as a healthy volunteer. As with any treatment, the rationale is that nobody should be exposed to any degree of risk, however slight, unless he has consented to it. This is especially relevant in relation to non-therapeutic research, where the subject is not even expected to benefit directly from the trial. The need to obtain a legally binding consent is central to all research, and usually, written consent of the research subject will be required, for all but the most non-invasive forms of research e.g. post-market surveillance. In the case of research on patients, the consent should always be recorded in the patient’s dental records.

(a) Information

How much information must be disclosed to patients participating in research? Is the appropriate amount of information to be disclosed that which a reasonable body of dentists would disclose, or is there certain information that research subjects should always be told about e.g. substantial risks of grave or adverse consequences? Rarely will dentists be justified in withholding the fact that the patient is being included in a trial.

Information about the proposed study must always be given in a form that the subject can understand, and most ethics committees will require the researcher to provide subjects with a written information sheet, which they can take away and read in their own time. An adviser should be available to answer any questions. The consent form must be explicit about the expected benefits and the degree of risk to the subject and the nature and extent of any discomfort which the subject is likely to experience. The volunteers must also be aware of any alternative options to the research, especially if they could get the research treatments outside the research programme.

(b) Voluntariness

To give a valid consent to be a research subject, consent must be voluntary. Apart from the genuinely altruistic, people’s motives to take part in a research trial must be clear. Both the
investigator and the LREC must ensure that no improper inducement exists which would persuade an otherwise unwilling person to become a research subject. The obvious inducement, in the case of healthy volunteers, is money. How much would you accept to give a blood and urine sample for every day for three weeks?

The factors likely to influence someone who is already a patient to take part in a research project may be more subtle, and could involve the disequilibrium of power inherent in the practitioner/patient relationship. Probably, most patients would accede to their practitioner’s request to participate in a research trial.

It is vital that all research subjects are informed of their right to withdraw from a trial at any stage, without censure. This is particularly important in relation to patients, who, for the above reasons, may need particular reassurance that their withdrawal from a trial will not affect their treatment.

(c) Competence (see Session 2)

Special considerations apply to research involving vulnerable groups who may not be competent to give proper consent. Although the need for consent is usually paramount, if research could never be carried out in cases where it is not possible to obtain the subject’s consent, then valuable scientific enquiry would be prevented in areas where it is most needed, e.g. research into mental illness. If the research could first be carried out on competent patients, then it should be. In order to allow research projects to go ahead involving special groups, additional ethical safeguards may be required, and a LREC, in considering these proposals, may have to enlist specialist advice.

Children

For children 16-17, consent to be a research subject depends on whether the emphasis is placed on the fact that it is therapeutic or on the fact that it is research. If regarded as therapeutic research, children 16 – 17 are able to consent as per the Family Law Reform Act (FLRA) (see Session 9). If however, the emphasis is on research, the FLRA may not apply since it is limited to surgical, medical or dental treatment. It is possible that this definition can be extended to therapeutic research where the child stands to directly benefit from the research. If the FLRA does not apply, then the common law (e.g. Gillick) would govern until the child reaches 18.

Children under the age of 16 can also give valid consent in law if they are ‘Gillick competent’ - capable of understanding the nature and purpose of what is proposed. Here, though, because of the dentist’s dual intent in therapeutic research, a child will be expected to demonstrate a greater degree of understanding before being allowed to agree to take part in research. It is likely however that the law will take a paternalistic stance and presume incompetence in any but the simplest and most risk-free procedures. Current law has it that a child’s refusal (even if Gillick competent) can be overridden if the parents consent. However, whilst the researcher can seek consent elsewhere, it would be unwise to ignore the refusal of a competent child.

Consent to non-therapeutic research is even more problematic, and doubts exist as to who, if anyone, can consent for a child to take part in non-therapeutic research, and what the limits are to that consent. The prevailing view has been that because parents are under a duty to look after a child’s best interests, they can only give proxy consent on that basis. Accordingly it has been thought that parents cannot give their consent to any non-therapeutic procedure, including non-therapeutic research, because that cannot be said to be in their child’s best interests (although the RCP have interpreted this as an obligation not to do anything which is clearly against the interests of the child).

Where there is genuinely no valid alternative to the use of children in research, the principle of minimal risk has become widely adopted, i.e. others can consent on a child’s behalf provided the research carries no, or only minimal, risk.
MENTALLY ILL AND INCOMPETENT SUBJECTS

There is a need, as with other vulnerable groups, to balance the inability of subject’s to give a valid consent, against the need to carry out research into mental disorders. LRECs must pay particular attention to situations in which the subject’s ability to consent is impaired. It may be that following an influential case on the treatment of incapacitated patients, doctors may carry out therapeutic research on the mentally incapacitated, provided it is in their best interests (i.e. they effectively act as proxy). In the case of incompetent adults, it seems unlikely that the law would seek to deprive this group of the anticipated benefits of research, which would probably be permissible provided the researcher could satisfy the LREC of the trial’s scientific validity and ethical propriety.

Section 251 exemption to consent

Section 251 of the NHS Act 2006 (originally enacted under Section 60 of the Health and Social Care Act 2001), allows the common law duty of confidentiality to be set aside in specific circumstances where anonymised information is not sufficient and where patient consent is not practicable. For example a research study may require access to patient identifiable data to allow linkages between different datasets where the cohort is too large for consent. This would require time-limited access to identifiable information where gaining consent from a large retrospective cohort would not be feasible and would require more identifiable data than would be necessary for linkage purposes.

The National Information Governance Board for Health and Social Care (NIGB) oversees Section 251 approval. It has established an Ethics and Confidentiality Committee (ECC) to consider and advise on ethical issues relating to the processing of health or social care information.

The ECC receives between 90-100 applications each year. An application for section 251 support requires explicit details about data flows and full justification about why each identifiable piece of information is required and how this allows the aims of the study to be met. Evidence that no other reasonable alternative, such as anonymisation, pseudonymisation or consent, exists will be assessed via the application form.

Any section 251 approval will be subject to an annual review in order to assess that the applicant has met the conditions or report plans, and/or action towards meeting them. It is the applicant's responsibility to ensure that this is submitted on the anniversary of approval. Each application for section 251 support is considered carefully and a judgment made on whether the benefits of the NHS activity or proposed research are significant enough to set aside the common law duty of confidentiality in favour of public interest.

REVIEW OF TYPES OF RESEARCH

There are many types of research, some experimental, others more descriptive. As, we noted above, sometimes research does not involve the patient directly or personally at all. Different types of research often throw up different methodological and practical issues relating to how the interests and rights of current patients can be protected.

CLINICAL TRIALS

Experimental dentistry involves evaluating health technologies or “interventions” in some way. Research trials can only go ahead on human subjects once substantial laboratory and/or animal experiments have taken place. At some stage, however, human studies must be carried out, initially on healthy subjects except in some cancer trials. Ultimately, an experimental treatment must be tested on patients suffering from the condition, which the research is attempting to alleviate.

There are different designs of clinical trial and they usually take place one stage at a time and finally lead to the most valuable scientific results possible. The most basic trial involves nothing more than “observing” the participants’ condition before and after an “intervention” has been administered. If
there is any improvement, then the “intervention” may be causing this change. However, the improvement may be caused by something else and this variable is called a “confounding variable”. In order to rule out the influence of a confounding variable, the intervention may be compared with a “control” treatment. The trial now has two arms not just one. Some patients still get the intervention, but some similar patients now get the control treatment instead. There may still be changes in the condition of those getting the intervention, but there may also be changes in the condition of the controls. This way, the experimenter can measure the changes experienced by the controls and compare them with the changes experienced by those getting the new treatment. The intervention patients must show still greater improvement than the control patients. These clinical trials are called “controlled trials”. A placebo or inert substance is sometimes used as this control treatment. In all controlled trials, patients may not be told which treatment they are getting so that they cannot influence the experimental results by tampering with their treatment regimen. This is called “blinding”. In addition, the experimenter may wish to avoid the situation where a dentist puts healthier patients on the new drug and less healthy patients on the control, for example. This problem is called “selection bias” and can be avoided by assigning subjects randomly to each trial arm. This is known as a “randomised controlled trial”.

These different stages of clinical trial usually take place in different phases. These are usually sponsored by the pharmaceutical industry. New treatments are restricted to trials before they can be released for more general use. After the following phases, the NHS may wish to further test the products for cost-effectiveness once the treatment is more widely available.

- **“Washout” before any of the following phases.** Sometimes it is necessary to ensure that patients who are already on active therapy when they are entered into any of the following trials are not benefiting (during the trial period) from the drugs they were taking before the trial began. For this reason, some trials have to use a ‘wash out’ period. During this period the patient will either be given a placebo or be instructed to stop taking their previous medication. Clearly, during the ‘wash out’ period the patient is receiving no active treatment at all. Since it is safe to assume that treatment would not have been prescribed unless the patients needed it, the ‘wash out’ period may compromise the patient’s health. Accordingly, ‘wash out’ periods are generally only acceptable when it is not possible to conduct the trial using new patients, the risk to the patient is minimal and all patients are carefully monitored.

- **A phase I trial usually has only one arm (see above).** The dose may be increased during the trial and any suspected toxic effects are observed. Because this is the first time a treatment may have been tried on humans, close monitoring is essential and it may involve staying in hospital throughout the trial to make this easier. The trial can be stopped at any stage if the treatment seems to be more harmful than beneficial.

- **Phase II trials sometimes have two arms and are “controlled” (see above).** The aim is now to see whether the drug or procedure is active against the disease. These trials will also be closely monitored and are larger in scale than phase I trials.

- **Phase III trials also have two arms, but they are invariably randomised (see above).** They are the largest trials so far. Monitoring continues to be important.

- **Phase IV trials are usually undertaken after a new treatment has been marketed.** Longer-term safety can be assessed to some extent by these trials.

**ETHICAL ISSUES IN “CONTROLLED” TRIALS**

**Blinding**

In some research, the participants are not told which treatment they are getting so that they cannot influence the results by changing their treatment half way through, for example. This is “blinding”
(see above) Consider this in relation to information giving. On the one hand, if the information is disclosed the point of the research design would be lost. On the other hand, failure to disclose is deception. All participants should know that the research project involves the possibility of getting either trial arm and participants can consent on this basis.

**PLACEBOS AS CONTROLS**

A placebo is usually an inert substance having little if any therapeutic effect. It is important to stress that controlled trial must compare the new therapy with *the best available therapy* to demonstrate that it is an improvement on existing therapies, e.g. having fewer harmful side effects. Where existing therapies exist, placebos are usually regarded as unethical. It should be reiterated that the reason for testing a new drug or procedure is not usually to show that it is better than a placebo but to find whether it is preferable to existing treatments. The control groups should typically receive standard available therapy. The use of placebos where standard available therapy is available is controversial but may be justified in exceptional circumstances. Placebos are therefore most commonly to be found where a brand new therapy or intervention is being tested where no therapy currently exists.

**RANDOMISATION**

Because dentists still have a duty to offer their patients the best treatment that is available, randomisation must be considered very carefully. It is an ethical prerequisite that, at the very least, the dentist and patient are uncertain as to which treatment is more efficacious for that patient. This is called being in a state of "* equipoise*". A dentist would also have to disclose the extra characteristic of randomisation to patients, along with the expected risks and benefits associated with the research.

**INTERIM ANALYSIS**

The larger the trial, the more important it is to make sure that the trial can be stopped earlier than planned if extreme results come in during routine monitoring. Investigators are under a continuing duty towards research subjects after the research has been started. An experiment must be stopped as soon as it transpires that the research treatment is more harmful to patients than existing therapies, and if this is the case patients must be transferred to an alternative regimen.

**DESCRIPTIVE RESEARCH INVOLVING PATIENTS DIRECTLY**

Sometimes, surveys are used to gather descriptive data. Often patients are given questionnaires or are interviewed. Consent to participate in such research is still an important consideration and an ethics committee must assess whether the questionnaires are reasonable and not too invasive or distressing.

**RESEARCH USING PATIENT RECORDS**

Sometimes, research does not involve the patient personally and directly at all, but uses their records that have been obtained routinely already. This is a potentially valuable source of epidemiological information. However, the issue of confidentiality arises because patients may not have already given their consent to participate in research or to have information about them used and possibly published. Ethics committees will need to satisfy themselves that adequate precautions have been taken to ensure the confidentiality of any data relating to the research subject, and that no subject will be identifiable from published results without his or her explicit consent. Information should be effectively anonymised in order to protect the confidentiality of the patient.

Clear data identifies individuals, this can be either directly, for example name, date of birth, or by combining information for example, post code with diagnosis to identify a person. If a person can be identified then privacy and confidentiality can more easily be violated or breached if the record is accessed inappropriately. To protect privacy a number of mechanisms can be employed, these include restricting access only to certain individuals, using access systems that are only known to those who have a need to access the record and using technological solutions to code or mask clear information. Pseudonymisation is a method of coding information. The identifiable data
items, like name, address, ethnic category are replaced by pseudonyms that scramble the original data and make it unreadable unless the reader has the key to reverse the process and re-identify the data item. The personal identifiers have not been removed, they have only been masked, for example, replacing the NHS number with a random number or replacing an address with a location code. Pseudonymised data should appear meaningless and it should not be possible to infer the true values from the pseudonym. The identifiable data has been substituted by a pseudonym; in effect the anonymisation is reversible. In addition to coding or masking clear information all identifiers can be removed to make it impossible to deduce who the information originated from, this is known as anonymisation. Anonymisation of data increases its security and removes the risk of identification of individuals when the data are viewed. Its use enhances privacy and maintains confidentiality. Pseudonymisation allows personal identifiable data about the same person to be linked, which can be important when carrying out research. anonymisation does not.

It is a legal requirement that when patient data is used for purposes not involving the direct care of the patient, i.e. Secondary Uses and this includes research, the patient should not be identified unless other legal means hold, such as the patient's consent or Section 251 approval. This is set out clearly in the NHS policy and good practice guidance document 'Confidentiality: the NHS Code of Practice', which states the need to 'effectively anonymise' patient data prior to the non-direct care usage being made of the data.

A recent court case has cast doubt over whether even anonymised information can be used. The court ruled that the disclosure of anonymised data concerning the prescribing habits of GPs without their consent to a pharmaceutical company constituted a breach of confidentiality. The Appeal Court ruled that this does not affect the legal acceptability of disclosing such information for purely research purposes instead of for commercial gain, provided confidentiality can be maintained.

**COMPENSATION**

Although the risk of injury due to participation in research may be small, nonetheless it is reasonable for patients to expect that they will be compensated in the event of such an occurrence. It seems reasonable that where a research subject has agreed to take part in a trial, and there is a benefit to society, then society should bear some of the risk in financial terms. At present however, a research subject will have to rely on bringing an action in negligence, unless an out-of-court settlement can be reached.

In 1988, the ABPI published “Guidelines on Medical Experiments on Non-patient Human Volunteers”. These recommend that volunteers should be given a clear commitment that in the event of injury they will receive appropriate compensation without having to prove either that such injury arose through negligence or that the product was defective in the sense that it did not fulfil a reasonable expectation of safety.

**FURTHER RECOMMENDED READING:**


DECLARATION OF HELSINKI
(Revised October 1996)

RECOMMENDATIONS GUIDING MEDICAL DOCTORS IN BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS

Introduction

It is the mission of the medical doctor to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfillment of this mission. The Declaration of Geneva of the World Medical Association binds the doctor with the words: “The health of my patient will be my first consideration,” and the International Code of Medical Ethics declares that, “Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.”

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease. In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies a fortiori to biomedical research.

Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects. In the field of biomedical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research the essential object of which is purely scientific and without direct diagnostic or therapeutic value to the person subjected to the research.

Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to ever doctor in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

I. Basic Principles

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific tradition.

2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experiment protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.

3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.

4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interest of science and society.
6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject’s physical and mental integrity and on the personality of the subject.

7. Doctors should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Doctors should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the doctor is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject’s freely-given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the doctors should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is completely independent of this official relationship.

11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

II. Medical Research Combined with Professional Care
   (Clinical research)

1. In the treatment of the sick person, the doctor must be free to use a new diagnostic and therapeutic measure, if in his or her judgement it offers hope of saving life, re-establishing health or alleviating suffering.

2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.

3. In any medical study, every patient - including those of a control group, if any - should be assured of the best proven diagnostic and therapeutic method. This does not exclude the use of inert placebo in studies where no proven diagnostic or therapeutic method exists (added 1996).

4. The refusal of the patient to participate in a study must never interfere with the doctor-patient relationship.

5. If the doctor considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee.
6. The doctor can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

III. **Non-therapeutic Biomedical Research Involving Human Subjects**  
(Non-clinical Biomedical research)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom biomedical research is being carried out.

2. The subjects should be volunteers - either healthy persons or patients - for whom the experimental design is not related to the patient’s illness.

3. The investigator or the investigating team should discontinue the research if in his/her or their judgement it may, if continued, be harmful to the individual.

4. In research on man, the interest of science and society should never take precedence over considerations related to the wellbeing of the subject.
SESSION SEVEN

TRUTH-TELLING AND WHISTLE BLOWING
LEARNING OBJECTIVES:

At the end of this session, students will:

* Begin to understand the significance of truth-telling in the dentist-patient relationship
* Recognise the ethical obligations of disclosure of information
* Begin to formulate deontological and utilitarian arguments for telling the truth
* Understand the importance of sensitivity in disclosing bad news
* Recognise the distinction between lying and not telling the truth

IN GENERAL

In the practice of dentistry, truth telling involves giving information not only so that patients can make informed choices about their health care but also so that they can simply be informed of their situation. Truth telling requires accuracy and honesty so that the patient gets a true impression of the situation. Truth telling requires the information be presented in such a way that it can be understood and applied. Deception on the other hand involves intentionally leading another to adopt a belief that one holds to be untrue. Note that deception can occur through telling the truth or telling part of the truth. So, someone can tell the truth but nevertheless be misinformed. If misinformed, the deception would not be deliberate. However, where the deception is deliberate, for example, not telling a patient that he has terminal cancer, the question which must be asked is whether the intentional deception will harm the practitioner-patient relationship. On the one hand, given the unequal balance of power in the relationship and the fact that not telling the truth undermines patient autonomy and the ability to consent, it may be argued that any form of deception is wrong. On the other hand, it may be argued that not telling the patient is the best thing to do for this particular patient, that we accept departures from the truth in our every day lives with little difficulty, and that the deception, more than doing no harm, may actually do good.

In order to situate the issue of truth telling in the health care context, it may be helpful to ask the following general questions: Can lying ever be beneficial? Is it possible to rank lies? Are some lies worse than others? Is lying inherently wrong? We need to establish what purpose telling the truth serves versus lying, so that we can know what might be the best thing or the ethically correct thing to do in given circumstances.

DEALING HONESTLY WITH PATIENTS

To a great extent, the importance of ethics in health care arises from its shaping of the clinician-patient relationship. This relationship is based on mutual trust where both parties rightfully expect that each will be honest in the exchange of information, that is in giving and receiving information, expressing concerns, disclosing attitudes and beliefs and clarifying meaning. Each hopes that the other will treat them decently and respectfully. In short, each party has a responsibility to self and other and honesty is at the heart of the responsibility.

In practice, telling the truth in a health care setting may be more complicated. We’re not necessarily talking about telling bold-faced lies, we’re talking more about not completely disclosing the truth, about shading the truth for the patient’s benefit. Most practitioners, but not all, would agree that it is absolutely wrong to tell outright lies to patients or family members. But many of the same clinicians would probably assume that they have a right to withhold information from a patient about his or her condition. They would probably justify their actions by claiming that withholding the bald facts of the situation might be in the patient’s best interests. The question then becomes: “how do we define best interests in this situation?” Are these interests best served by failing to tell the patient about the grim or fearful reality that they face, or are they best served by telling the truth, even if the patient will be deeply troubled by the information imparted by the health care professional?
Our decision whether to tell the truth, the whole truth, or to deceive by evasion will probably depend on our assessment of what the patient would want to know. In order to make this sort of decision we must know the patient very well if we are not to fall into paternalistic stereotypes. In health care ethics, our concern is predominantly on the effect that lying/deceiving will have on the patient. We assume that patients and their families will generally wish to know the truth as this will help them deal with illness and cope more effectively with their problems. This is an important assumption about how people deal with problems and uncertainty. Various coping strategies will be used by the same people at different stages of their illness. These are likely to include acceptance, denial, knowledgeable involvement, anxiety, fear, confusion, anger and frustration.

TELLING THE TRUTH: IS IT POSSIBLE?

Health care does not always have/rarely has a definite answer. Many of the issues concerning truth-telling involve the difficulty of dealing with medical uncertainty and the concern that the bad news might harm the patient. It can also be difficult when medical error occurs and when the patient’s family is opposed to truth telling.

The pervasive uncertainty in medicine and dentistry can and should be shared with patients. Telling patients about clinical uncertainties and the range of options available to them allows them to appreciate the complexities of dentistry, to ask questions, to make informed, realistic decisions and to assume responsibility for those decisions.

Predicting what information a patient will find upsetting, or foreseeing how upsetting certain information will be, can be difficult. Patients may indicate, explicitly or implicitly their desire not to know the truth of their situation. When such desires are authentic they should be respected. It is possible to deliver the truth in a way that softens its impact. ‘The truth may be brutal but the telling of it should not be’.

Health care professionals should disclose the occurrence of adverse effects or errors to patients. This does not mean that they resulted from negligence. The admission of an error is not an admission of substandard practice. Moreover, telling the truth can defuse resentment on the part of the patient and reduce the risk of legal action. Patients often sue out of a need for an explanation – to know how the injury happened and why. Telling the truth at the appropriate time may not only allow timely corrective treatment, it may also foster rather than undermine the patient’s trust in physicians. Patients are more likely to forgive a practitioner if s/he is wrong and the error is admitted to. Obviously the converse is also true: patients are less likely to be forgiving if practitioners are wrong, fail to admit it, and then, to add insult to injury, do not say sorry.

ETHICAL REASONS TO TELL THE TRUTH

If, as a practitioner, you deceive a patient, you may effectively be manipulating him into making decisions that he might otherwise not have made. Had you told the patient that he probably had no more than six months to live, he may not have bought that new car. He may have saved his money to make better provision for his children after his death. If you deceive him, you deprive him of his autonomy. If the patient doesn’t know what’s happening to his body and what’s happening to his life, then effectively, you have robbed him of the capacity to run his own life and make the choices that he considers best suited to his predicament.

As Veatch (1993) notes, dishonesty usually turns out to make no sense either for the person being dishonest or the person being deceived. The liar, when found out, has ruined her reputation; the lie is self-defeating. Being dishonest is perilous because it has the capacity to destroy the trust that is at the heart of the dentist-patient relationship.
ETHICAL THEORY

If we translate the above reasons into ethical theory, utilitarian and deontological arguments to tell the truth and not to lie would include some of the following considerations:

Utilitarian arguments

A Utilitarian approach to truth telling holds that the only morally relevant feature of behaviour is the outcome, the benefits and harms.

* an act utilitarian would look at the immediate consequences that the act of lying would have on the individuals involved. A patient might be angry when and if the truth finally does emerge. As a result, there may be a loss of confidence in practitioner and the relationship of trust might break down.

* a rule utilitarian would look at the consequences of lying generally. Since lying would affect the practitioner-patient relationship generally, which depends on mutual trust and openness, it should be avoided. Thus, rather than considering the issue in terms of duties, which deontology does, it seeks to determine whether the universal adoption of the rule would or would not maximise happiness.

Deontological arguments

A deontological approach looks beyond the consequences to other features of the action that are relevant. Respect for autonomy is one of these, telling the truth is another.

From a strict deontological perspective (Kant), telling the truth no matter what the consequences may be for oneself or others, is an absolute duty. Kant can therefore envisage no circumstances in which this duty should be abrogated. Lying cannot be consistently universalised because to do so would undermine the practice of truth telling. It is therefore irrelevant that some lies may be benevolent - even if they do more good than harm. So, under a strict deontological view, a practitioner should always be truthful (even if this conflicts with the notion of beneficence in as much as the truth may harm some patients). Since keeping patients in the dark stops them from exercising their autonomy at the very time when they may choose to make significant life-changing steps, under this view there is no reason for not disclosing information.

Many consider this view to be too inflexible. It is probably better to say there is a prima facie duty to tell the truth which can be overridden by another more compelling prima facie duty.

ETHICAL REASONS NOT TO TELL THE TRUTH

There are rare instances where lying can be ethically justified, that is when lying does more good than harm. The lie you tell might save a life if you can convince the would-be-murderer that his intended victim (who’s hiding in the attic) left the country last week. Occasionally, but again this is rare, patients who fear that they might be very ill could expressly ask you not to tell them the truth if, indeed, the truth is what they fear. We could argue, on the one hand that this is as valid an exercise of autonomy as wanting to know the truth; but on the other hand we could contend that individuals have a duty to avail themselves of relevant information before they make treatment decisions.

As the practitioner, you may not want to enter into a conspiracy of silence with the patient because you believe it’s deceitful and compromising of your own integrity. In other words, you believe that not talking over the patient’s condition with him will be an enormous obstacle in the development of a therapeutic relationship between the two of you.
You might want to explore the patient’s reasons for not wanting to know information about himself and, needless to say, this would have to be done very gently. What you might find (as is sometimes the case) is that what underlies the request is the fear of being overwhelmed by too much bad news all at once. In this instance withholding the whole story so that it can be revealed slowly and in accordance with the patient’s capacity to adjust would, in no way, amount to lying; rather it would demonstrate your sensitivity to the needs of this particular patient.

**LEGAL OBLIGATIONS TO TELL THE TRUTH**

Return to Session 2 and the legal notion of information outlined there for a more comprehensive overview. As noted, the duty to tell the truth or answer a patient’s questions honestly will be considered in light of the notion of reasonableness. Thus taking all the factors of the situation into account, you need to determine if a responsible body of dental opinion would think it appropriate to tell only part of the truth or not tell the truth at all. Even if a responsible body of dental opinion would not tell the truth or the whole truth, again based on the circumstances, it will be necessary to consider whether this was reasonable or not. The degree of the risk of the treatment or side effects and the patient’s disposition/demeanour (i.e. prone to nervousness or hysteria) will be taken into account. (Again see Pearce v. United Bristol healthcare Trust (1998) 48 BLMR 118; and Carver v. Hammersmith & Queen Charlotte’s Special Health Authority (25 February 2000)).

**IS THE TRUTH REALLY SO DAMAGING?**

Although there are situations when we think that not telling the truth may benefit the patient, like it or not, shading of the truth is a form of deception and so we do need the strongest of reasons in order to defend it.

The belief that bad news can seriously damage patient well-being was largely untested until fairly recently. In his review of available evidence, English (1994) concluded that the belief is unfounded. Very few patients are harmed by the knowledge of their condition and probable outcomes. Far greater harm can occur when patients are kept in the dark or are informed in callous, insensitive ways.

**PATIENTS’ RIGHTS**

Current trends in clinical practice support the idea that information about the patient belongs to the patient. The idea is that cutting people off from the knowledge of what is going on in their bodies and lives can promote the development of an elaborate, mutually reinforcing charade that can have the result of isolating the patient and their caregivers from each another.

As noted above, there is the argument that if a patient asks not to be told the truth, then the practitioner must not disclose it for fear of trampling all over the patient’s autonomy. In other words, patients can choose to be kept in the dark and practitioners must play the game. There is also the argument that ‘it would be better if the patient didn’t know the truth” without any input whatsoever from the patient. Some questions you might like to ask yourself as you reflect upon these positions include a) Whose well-being is being considered here, the practitioner’s, the family’s or the patient’s? b) Why is the practitioner assuming that withholding the truth is in the patient’s best interests? c) If the patient really has made the request to not be given the information, why is this so? and d) What could be done to maximise the capacity of the patient to participate in their care?

**WHISTLE-BLOWERS**

The Public Interest Disclosure Act 1998, more commonly known as the Whistleblowers Act was implemented in 1999, to combat cover-ups and secrecy in the NHS. The Act gives statutory
protection to employees who disclose wrongdoings reasonably and responsibly in the public interest and are victimized as a result. An employee who is victimized because of disclosing information can bring a claim at an employment tribunal. Further, they can be fully compensated for their losses.

The Act applies to people at work raising genuine concerns about risks to patients or financial malpractice and any cover up of these. There are 3 tiers of disclosure:

1. **Internal Disclosure** - a disclosure to the employer will be protected if the whistleblower has an honest and reasonable suspicion that the malpractice has occurred, is occurring or is likely to occur.

2. **Regulatory Disclosures** - Disclosures to regulatory bodies, such as the GDC will be protected where the whistleblowers meets the tests for internal disclosures and, additionally, honestly and reasonably believes that the information and any allegation contained in it are substantially true.

3. **Wider Disclosures** - (e.g. to the police, the media, MPs and non-prescribed regulators are protected if, in addition to the tests for regulatory disclosures, they are not made for personal gain and if they satisfy a further two provisions. That is the concern must have been raised with the employer or a prescribed regulator, unless, there was a reasonable belief that disclosure might have resulted in victimization, there was no prescribed regulator and there was reasonable belief that there would be a cover up, and the matter was exceptionally serious. If one of these preconditions is met and the tribunal is satisfied that the disclosure was reasonable, the whistleblower will be protected.

**REFERENCES AND RECOMMENDED READING:**


**SUGGESTED FURTHER READING:**


SESSION EIGHT

Poor Performance
Poor Performance

Introduction

Before we think about the role dental professionals have in addressing poor performance it is important to be clear on what is meant by poor performance. A useful definition was proposed by the National Clinical Assessment Service (2010).

Poor performance defines any aspects of a practitioner's performance or conduct which:

- Poses a threat or potential threat to patient safety
- Expose services to financial or other substantial risk
- Undermine the reputation or efficiency of services in some significant way
- Are outside acceptable practice guidelines and standards.

Poor performance is an issue for everyone; our profession, our patients and individual members of the dental team. Most health care professionals practise to a high standard but there are times when some may work in ways that pose a serious risk to patient safety. In most instances poor performance is unintended. It may be the result of illness, professional isolation, overwork or a number of other contributory factors, but it must be addressed.

Setting the context

Patterns of oral health are changing, with an ageing population, increased service uptake, new and increasing patient expectations, and an exponential growth in scientific and technological developments pertinent to dentistry. Thus there are increasing factors that have the potential to influence the performance of a dental practitioner. Other factors include changing working patterns, changing demographics and skill-mix of the dental workforce, the environment and workload.

Dentists who poorly perform are not rare. A poorly performing dentist can have a devastating effect on patient's and their wellbeing. If not identified early and dealt with properly many patients can be harmed. The number of fitness to practice cases that the General Dental Council (GDC) hears has been increasing. In 2011 they received 1,578 cases and this rose to 2,274 in 2012. It is important to remember that this includes all registrant groups and not just dentists.

Preparing for practice (GDC)

The GDC in their document, Preparing for Practice – Dental team learning outcomes for registration, lay out the outcomes that an individual must be able to demonstrate by the end of their training. There are seven overarching outcomes and one of these is particularly relevant to performance:

Accurately assess their own capabilities and limitations, demonstrating reflective practice, in the interest of high quality care and act within these boundaries.

In addition, outcome 11.7 is specifically concerned with performance;

Recognise, take responsibility for and act to raise concerns about their own or others’ health, behaviour or professional performance, as described in The Principles of Raising Concern (2006).

It is particularly interesting that this outcome is not only concerned with a registrants' own health, behaviour or professional performance but also that of other registrants. Therefore should you become aware that another registrant could be struggling with their performance you are duty bound to do something about it and not ignore the issue. The GDC gives examples of issues they consider registrants should report to them and these are:
Very poor treatment
Failure to get a patient's consent for treatment
Not having professional indemnity insurance
Cross-infection issues (for example, using dirty equipment)
Sexual assault or abuse
Being under the influence of drink or drugs
Fraud or theft

The duty goes even further in that standard 2.5 of the GDC guidance Principles of Raising Concerns, states:

Remember, it is your duty to put patients’ interests first and act to protect them. If you fail to do so by not raising a concern, your registration could be at risk.

This means that if you ignore the poor performance of a colleague you may be answerable to a fitness to practice committee yourself and ultimately you could lose your own registration. The protection of the public and patients overrides personal and professional loyalty. We are ethically bound to put the interests of our patients over the interests of either ourselves or of our professional colleagues.

Why do dentists get into trouble?

Dentistry is mostly about good dentists trying to do a good job. Most dentists are committed, compassionate and intelligent. So, why do some of them get into difficulty? There are many reasons, for example rising patient expectations may make it difficult to resist a patient demanding a particular treatment that the dentist knows is not in the patient’s best interest and could actually harm their oral health. Ill health of a dentist can seriously undermine their ability to perform as they would like to and know they should. Dentists are people too and can experience bereavement, divorce, relationship difficulties that can impact on their ability to work and perform well. Sometimes the culture or climate of the work environment is poor or even ‘toxic’ which can make it impossible to perform well. This might include bullying or harassment or not being provided with the right equipment. Some dentists struggle to keep up to date and continuing professional development is not high on their priorities. Dentistry is a fast moving profession that is highly technical. You can be out of date very, very quickly. If you continue to practice as you did just after leaving dental school it will be only a few years before new techniques and new treatments mean you are out of date and not providing the best service to your patients. Some dentists develop difficult or challenging behaviours that make it very difficult for them to thrive in a team, for example, they can become arrogant, angry, manipulative or uncommunicative. Working in isolation can contribute to poor performance. It is important to have support from colleagues and those dentists who prefer to remain isolated can often begin to perform poorly without realizing it. Isolation does not mean single-handed practice, a dentist can be isolated in a large practice if they do not interact with colleagues. A single handed practitioner may regularly network with colleagues, undertake peer review or attend local dental meetings. Some dentists take on more than they are competent to do. It is vital to know where your strengths and weakness lie. If you are not strong at a particular intervention ensure you include it in your personal development plan. A dentist who attempts to undertake a procedure they are not trained to do is much more likely to perform poorly. This can also be the case if you undertake a procedure only rarely.

So, it is easier than you think to perform poorly.

It can be helpful to think of factors underpinning performance in four domains; health, behaviour, environment/context and clinical knowledge and skills. Sometimes an individual who is poorly performing does so because of factors in a single domain, for example they may be ill. However, often poor performance is manifest because of issues in more than one domain. A dentist who is a poor communicator with low confidence who struggles with endodontics, and becomes stressed would be poorly performing as a result of factors in three of the four domains. Poor performance is often multi-factorial.
Some of the danger signs that can lead to poor performance

<table>
<thead>
<tr>
<th>Clinical Concerns</th>
<th>Behavioural concerns</th>
<th>Health issues</th>
<th>Work environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor clinical decision-making/ diagnosis</td>
<td>Low level of professional development - CPD</td>
<td>Persistent lateness for surgery or leaving early</td>
<td>High workload</td>
</tr>
<tr>
<td>Consultation skills poor</td>
<td>Poor communication with patients and/or colleagues</td>
<td>Substance misuse</td>
<td>Poor facilities, old equipment</td>
</tr>
<tr>
<td>Technical skills poor or out of date</td>
<td>Poor attitude to colleagues</td>
<td>Suspected cognitive impairment – inability to plan or organise</td>
<td>Poor team working</td>
</tr>
<tr>
<td>Record keeping</td>
<td>Poor stress management</td>
<td>Physical illness</td>
<td>Isolated working</td>
</tr>
<tr>
<td>Clinical knowledge and skills poor or out of date</td>
<td>Avoids or mismanages conflict</td>
<td>Major life event – bereavement, divorce</td>
<td>Poor support systems</td>
</tr>
<tr>
<td>Makes inappropriate referrals</td>
<td>Frequent cancellation of surgeries</td>
<td>Sudden change in behaviour – mood swings</td>
<td></td>
</tr>
<tr>
<td>Difficulty understanding the limits of their competence</td>
<td>Difficult in managing time or organizing practice</td>
<td>Withdrawal from interaction with colleagues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of probity or professional values</td>
<td>Inability to prioritise</td>
<td></td>
</tr>
</tbody>
</table>

Health issues

Research has shown that there are higher rates of depression and anxiety amongst dentists, they are more stressed than other workers generally and that stress is often linked to mental ill health. In addition dentists have higher rates of suicidal thoughts and completed suicides, than other workers, a statistic they share with doctors, nurses and pharmacists.

The health needs of dental professionals may go unnoticed or unmet because of fears the practitioner may have of stigma or that there might be a risk to their career if it was known they were unwell. This is particularly the case with mental illness. There may also be concerns about confidentiality, particularly if they are being treated locally where there is a possibility of meeting one of their patients. Dentists who are ill may feel they have let down their patients, colleagues or family. Consequently a dentist that is ill may not seek help for some time. Stress is often associated with anxiety and depression, which can predispose to alcohol and drug abuse.

It is generally accepted that dentists encounter numerous sources of stress throughout their career, beginning as early as when they are at dental school (Newbury-Birch et al. 2002). On entering general dental practice, the number and variety of organisational and individual stressors can often grow (Kay and Lowe 2008). For some dentists, these issues may significantly affect their general and/or mental health (Myers and Myers 2004). Clinical disorders such as burnout (Gorter et al. 1998) and depression (Gale 1998) may then result.
Levels of stress in dentists

Studies have suggested that dentistry generates more stress than any other profession, primarily because of the nature and working conditions of the dental surgery (Cooper et al. 1987, Moore and Brodsgaard 2001).

Many dentists develop stress disorders early in their careers, and studies have shown increasing evidence of stress-related problems in young dentists and dental students (Humphris 1999, Newbury-Birch et al. 2002, Willet and Palmer 2009). Such stressors in the early years of practice come from the combined effects of the high number of patients to be seen in a day, finances in general, not knowing what to expect as a performer, making mistakes, the fear of litigation, and the belief that patients can be too demanding (Baldwin et al. 1999).

Organisational causes of stress include patient demands, practice management/staff issues, fear of complaints/litigation, non-clinical paperwork (Kay and Lowe 2008). The emotional demands of working with patients has also been identified as contributing to high levels of stress, for example, dealing with nervous or anxious dental patients or managing patient demands.

Cooper and Humphris (1998) highlighted an additional stressor which concerned uncertainty felt during times of change. This is an important factor given the changes that the health service and dentistry has undergone in the last two decades and the changes still to come.

Burnout

Burnout is considered a long term possible consequence of having to deal with occupational stress. Gorter et al. (1998) demonstrated how certain aspects of dental practice, such as time pressures, patient-related problems and management of auxiliary staff, were contributory factors. However, levels of social support in the workplace, measured by the number of dentists in a practice, can also have a protective role against some aspects of burnout (Croucher et al.1998, Denton et al. 2008).

The impact of alcohol and drug misuse

Drug and alcohol use and misuse can have a detrimental effect on performance at work, reducing the service provided to patients and the individual's capacity to work safely. It can harm the misuser, both physically and mentally and, through the misuser's actions, other people and the environment (Department of Health 2001). Excessive drug and alcohol use may also result in criminal prosecution with obvious repercussions for professional status. There is significant evidence to demonstrate that alcohol misuse amongst dentists can begin as early as dental school (Underwood and Fox 2000, Newbury-Birch et al. 2002, Underwood et al. 2010).

It is reported that the culture of the profession may make dentists a vulnerable group for alcohol and substance abuse. Factors such as denial and stigma may impede early detection.

Behavioural issues

The type of non-clinical concerns you may come across during your career can include; theft, fraud and other financial irregularities; misuse of practice resources or equipment, for example undertaking private clinics and using NHS equipment and materials. You may encounter dentists who breach the terms of their contract, others who breach confidentiality of their patients. Some problems are not usually directly related to work, although they can arise in the practice for example, accessing legal or illegal pornography at work. This may also be a breach of terms and conditions in using work technology for non-work purposes. Other personal concerns can include sexual misconduct, assault, threatening behaviour, bullying, harassment or unfair discrimination.

Many performance issues practitioners have more to do with attitudinal and behavioural problems than clinical competence. This can make them complex and more difficult to remediate.

Communication skills
Poor communication skills, or a lack of proper communication, can impact significantly on the performance of a dentist, (Tiernan 2006). Gender differences have been a particular focus within communication research. Both in verbal and non-verbal behaviour, men and women tend to show differences in the way they communicate. Women, more than men, are likely to engage in a communication style that is characterised by: a symmetrical equal communication pattern; striving to obtain cooperation; a focus on the emotions and feelings of their conversation partner; exchanging recognition of these feelings; creating harmony and equality. Men, on the other hand, are likely to engage in a style that is characterised by communicating asymmetrically, providing information to the other as a teacher instructs a pupil, and to find solutions instead of focusing on feelings, and hence their interactions are more competitive (Gorter and Freeman 2005).

Communication skills can play a fundamental role in determining performance at work. Poor communication skills, or a lack of proper communication, can especially compromise performance, and these factors are often key drivers in many complaints and claims.

The psychological impact of failure on the dentist and dental team

Due to the scientific nature of dentistry, outcomes can be quite clearly defined as successful or a failure. Therefore the attitude towards failure and its potential impact upon performance needs to be considered. Newton (2007) suggests that generally, the psychological impact of failure is negative and linked to feelings of self-blame, lowered self-esteem and often a breakdown in the patient-dentist relationship. This could have an indirect impact upon performance.

There are potentially important ways in which personality and other individual characteristics can affect the performance of dentists. Traits such as conscientiousness and agreeableness tend to be common in dentists. Dentists may also be more susceptible and reactive to stress than most people.

Dentists’ attitudes can impact upon their ability to complete a task to a pre-determined standard, both in a positive and negative sense.

Core values can have a significant impact upon performance, both as an individual dentist, and within the dental team. In particular, the way that individuals behave will vary according to the nature and strength of their basic core values.

In dentistry, the quality of clinical performance is strongly related to the ability of the practitioner to respond to change. This may be the ability to deliver different treatments due to changing oral health needs, to undertake new governance procedures in line with emerging regulations, or through continued learning and self-development. Change can generate uncertainty and additional stress for practitioners, which could certainly impact negatively upon performance, especially during transitional stages.
Behavioural factors – how strengths can become weaknesses

There has been some interesting work done by Hogan and Hogan (1997) that demonstrates how behavioural strengths can become weaknesses under pressure. The figure below shows some of those strengths and the dysfunctional behaviour that an individual under pressure might display. So, a practitioner that is usually confident, when put under pressure can display arrogance (an extreme form of confidence).

<table>
<thead>
<tr>
<th>Strength</th>
<th>Dysfunctional Behaviour</th>
</tr>
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<tbody>
<tr>
<td>Enthusiastic</td>
<td>Volatile</td>
</tr>
<tr>
<td>Shrewd</td>
<td>Mistrustful</td>
</tr>
<tr>
<td>Independent</td>
<td>Detached</td>
</tr>
<tr>
<td>Focused</td>
<td>Passive-Aggressive</td>
</tr>
<tr>
<td>Confident</td>
<td>Arrogant</td>
</tr>
<tr>
<td>Charming</td>
<td>Manipulative</td>
</tr>
<tr>
<td>Vivacious</td>
<td>Dramatic</td>
</tr>
<tr>
<td>Imaginative</td>
<td>Eccentric</td>
</tr>
<tr>
<td>Diligent</td>
<td>Perfectionist</td>
</tr>
<tr>
<td>Dutiful</td>
<td>Dependent</td>
</tr>
</tbody>
</table>

Source: Hogan and Hogan (1997); King (2008)

Dysfunctional behaviour, if allowed to continue, leads to an individual who cannot or will not function well with other people, to the extent that his or her behaviour, by words or actions interferes, or has the potential to interfere with quality healthcare delivery. In effect dysfunctional behaviour becomes disruptive and is derived from an overplayed strength.

Adapted from: The College of Physicians and Surgeons of Ontario, Canada

Insight/Self Awareness:

A practitioners’ understanding and acceptance of problems once identified can be a powerful tool in remediation. The following definition is helpful when thinking about what insight is.

‘A predisposition to engage in acts of affective (emotional) and intellectual inquiry into how and why oneself and/or others behave, think and feel.’ Grant (2001)

Insight is not an all or nothing concept and practitioners can have partial insight. Here are a few pointers to help gauge the level of insight someone who is performing poorly might have:

- ‘It’s not me, it’s them’
- ‘Let’s get this over – how hard can it be?’
- ‘I’m a good clinician – I don’t see the need for all this paperwork’
- Could be resistant to engage or
- Agree to everything – and do nothing

“Sometimes it is tempting to avert your gaze from a problem - particularly if it involves confronting deep seated issues within the organisation. To look away is almost always a mistake. The courageous route is to face up to it and resolve it despite the difficulties.”

(Sir Liam Donaldson speaking on ‘Clinical risk management’ at the annual gathering on clinical pathology)
accreditation held at the Commonwealth Institute in London, 19th March 2002.)

Work environment

Job satisfaction

Job satisfaction can significantly impact upon performance. In general terms, job satisfaction can be defined as an individual’s general attitude toward his or her job. It is directly related to the attitudes, values and personality inherent to a dentist and it can thus influence the working patterns. Furthermore, it has been found that a person with a high level of job satisfaction may invariably have positive attitudes toward their job, whilst a person who is dissatisfied may have negative attitudes about their job (Robbins 1998). Cameron (1973) explained that job satisfaction is therefore not a single entity, but a complex set of interrelationships of tasks, roles, responsibilities, interactions, incentives and rewards.

Professional networking

Unlike many other parts of the NHS, dentists can often be very isolated from their colleagues. Professional networks, both formal and informal can have a major influence over the performance of dentists. GDPs who do not belong to any network, are professionally isolated and lack support mechanisms are at increased risk of under performance. Often when struggling, dentists will tend to turn to friends and colleagues for help and support, Watt et al. (2004b), Iqbal and Glenny 2002.

Underperformance by colleagues – what can you do?

Indicators of poor performance vary considerably from a serious isolated incident through to a pattern of frequent and numerous complaints. Colleagues are often well placed to recognise problems when they arise and it is best to act early. Acting on concerns about a colleague is never easy but all registered healthcare staff have a professional duty to do so in order to protect patient safety and help the practitioner involved. Keeping quiet can put your own registration at risk. Struggling colleagues are often the last to realise there is a problem, and by highlighting the concern you may help them to seek the support they need.

Registrants of the dental team are required to meet the General Dental Council’s (2013), principles and standards for dental professionals. The eighth of the nine principles states that we must always put patients’ safety first. Standard 8.1.1 is very clear on what a registrant must do if they are concerned:

You must raise any concern that patients might be at risk due to:
• the health, behaviour or professional performance of a colleague;
• any aspect of the environment where treatment is provided; or
• someone asking you to do something that you think conflicts with your duties to put patients interests first and act to protect them.

You must raise a concern even if you are not in a position to control or influence your working environment.

Your duty to raise concerns overrides any personal and professional loyalties or concerns you might have (for example, seeming disloyal or being treated differently by your colleagues or managers).

Essentially, if you have a concern that either your own or a colleague’s performance is putting patients at risk you can not ignore it - you must do something about it.

Area Teams, the local arm of NHS England, have the responsibility for investigating concerns about the performance of dentists.
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Grant, A.M. Rethinking: Psychological mindedness; metacognition, self-reflection and insight. Behaviour Change, 2001; 18 (1), 8-17


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SESSION Nine

Business Ethics
Business ethics

“The public be damned. I’m working for my stockholders”. William Vanderbilt.

Introduction:

Business ethics can also be termed corporate ethics. It is a form of applied ethics that considers the ethical principles and problems that arise in a business environment. In dentistry that is: the dental practice; salaried service; department within a Trust; body corporate or social enterprise. Business ethics is concerned with the conduct of individuals (dental professionals) and the organization. Conducting business has been with us for a long time. The Ancient Sumerians were undertaking business transactions about 6,000 years ago (Kramer, 1959). In contrast business ethics is new and began to receive philosophical attention from the 1970s and 1980s. Business practices got poor press from Aristotle who declared that ‘trade for profit’ was an activity wholly devoid of virtue and called those engaged in it ‘parasites’. Adam Smith (1776), The Wealth of Nations, began the fight back for the parasites. However, it is still a relatively new field of ethical concern, certainly compared with professional ethics of the health professions.

As you have learnt in earlier chapters, ethics are moral guidelines that help us to behaviour in good or right ways. We behave ethically by doing what is morally right.

“A business that makes nothing but money is a poor kind of business”.
Henry Ford

This quote seems particularly pertinent to health businesses.

It has been written before, but it’s a good refresher to remember that law and ethics are not the same, although they often share the same path. Ethics is about doing what is right, law if about acting lawfully. As a very general rule law follows ethics. In the dental profession we must make decisions about our practice that are both ethical and lawful.

In earlier chapters you have studied how ethics impacts on individuals. You have read about individual moral dilemmas of modern healthcare (and dental) practice. This chapter looks at how corporations (dental businesses) can incorporate an ethical perspective into business practices. Traditionally the two struggle to come to terms with the imperatives of the other.

If a dental practices’ (company) purpose is to maximize shareholder returns, then sacrificing profits for other concerns (for example, quality of care) is a violation of it’s fiduciary responsibility. So, if a dental practice is all about making money then paying more for anything other than basic materials would compromise the bottom line. This immediately presents a conflict with providing patient care and putting patient’s interests first.

The Business of Dentistry

The majority of dental professionals in the UK work in primary care and most of those operate as private contractors to the NHS, providing NHS dental services in businesses owned and operated by private individuals. Dental practices are owned either by an individual or a partnership of dentists, they are small or medium sized businesses. In addition, practices can be owned by a dental body corporate that is, an incorporated company with three or more dental practices. Before 2006 there were restrictions on the ownership of dental practices by dental bodies corporate. These restrictions were relaxed in 2006, since then dental body corporates have been expanding their share of the dental market and a few of these have become major stakeholders in NHS dentistry. These companies are often big organisations that hold large numbers of NHS dental contracts with great worth and their contribution should not be overlooked. Lang and Buisson (2011) report that corporate dentistry supplied 11.3% of NHS dental services in primary care and an estimated 10 per cent of the overall dentistry market in 2010.

The Office of Fair Trading (2012) reported that the dentistry market in the UK had seen significant growth over recent years, with the value of the market rising by around 90 per cent between the period of 1999-2000 and 2009-10. The dentistry market is valued at an estimated £5.73 billion a year, with spending on NHS dental treatment accounting for approximately 58 per cent of the market value, and spending on private dental treatment accounting for the remaining 42 per cent. The business of dentistry is clearly not inconsiderable.
GDC learning outcome domains:

The GDC document, *Preparing for Practice, dental team learning outcomes for registration*, defines what an individual must be able to demonstrate by the end of their training, to enable them to register with the GDC. The outcomes are divided into four domains, as shown below. None of the domains specifically reference business outcomes, however a number of outcomes can be related to ethical business. They have been included in the diagram.

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat all patients with equality, respect and</td>
<td>Explain and check patients’ understanding of treatments, options, costs and</td>
</tr>
<tr>
<td>dignity</td>
<td>informed consent and enable patients to make their choice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionalism</th>
<th>Leadership/Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put patients’ interests first and act to protect</td>
<td>Put patients’ interests first and act to protect them</td>
</tr>
<tr>
<td>them</td>
<td>Effectively manage their own time and resources</td>
</tr>
<tr>
<td>Act with integrity and be trustworthy</td>
<td>Recognise the significance of their own management and leadership role and the</td>
</tr>
<tr>
<td>Recognise and act within the GDC’s standards</td>
<td>range of skills and knowledge required to do this effectively</td>
</tr>
<tr>
<td>and within other professionally relevant laws,</td>
<td>Ensure that all aspects of practice comply with legal and regulatory</td>
</tr>
<tr>
<td>ethical guidance and systems</td>
<td>requirements</td>
</tr>
</tbody>
</table>

Components of Business Ethics

Ethical business behaviour promotes the good, it is not necessarily individual, although individuals make up businesses. It includes the standards of behaviour expected of individuals including relationships that is, how people are treated. It is actions as well as thoughts, particularly how behaviours affect and impact upon others. Business ethics is separate and above ‘following what everyone else does’. It does not slavishly follow technical ability, therefore just because something is technically possible does not mean that an ethical business will do it. Business ethics also includes how businesses (practices) are structured. The components are:

- Individuals (dental professionals)
- Businesses/organisations) (dental practices, bodies corporate)
- Society (Department of Health, General Dental Council, Government)
What is Business?

A business aims to make a profit, however how it makes profit is often an ethical consideration. An ethical business makes profit and it does so by supplying quality goods and services, providing jobs and by being a valuable part of the community.

<table>
<thead>
<tr>
<th>Quality goods and services</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A registered professional who is trained to a standard, maintains that standard and performs that standard</td>
<td>Over 100,000 registered dental professionals, plus the infrastructure of non-dental registrants</td>
</tr>
</tbody>
</table>

Valuable part of community

- A service that the population needs, wants and values – oral health
- Professionals who are trustworthy

Profit

- A fair return for quality goods and services.
- Not exploitation of patients or staff

In an ethical business, profit is not the sole goal of the dental activity, the profits are re-invested in the practice to build the business, enhance services, maintain quality and reward employees. A dental practice that treats its’ staff poorly, has poor quality premises, broken equipment and offers little beyond basic dentistry, undertaken badly, will have difficulty attracting contracts from either the NHS or private patients. This can be the result if profit becomes a one-way street, without re-investment, the business will shrivel and die. Profit cannot be considered an end in itself, it is a means to an end – the end of a higher quality business with motivated, valued staff. The pursuit of profit is only one aspect of business, it is one of many goals. This is particularly true when considering healthcare business such as dentistry. Dental professionals are not shop-keepers they are health care providers who provide the services of dentistry to patients.

Patients are the key:

Patients and the patient relationship is the key to ethical business in dentistry. Dentistry is a commodity, unlike most other healthcare provision, the majority of patients pay directly for the dental care and treatment they receive, whether that be NHS or private care. Patients buy the commodity of dentistry from dental professionals, therefore patients are the way that dental professionals gain reward. This means there is a potential conflict where economic considerations could be placed above patient welfare. Add to this the fact that unlike most financial transactions where an individual buys a commodity there is a duty of care between the provider and the purchaser. This lies at the core of the need to balance professional ethics with business ethics. There is no duty of care between an estate agency and the people who buy houses. In an ethical dental business the patients interests and their health needs are the prime focus, not making as much profit as possible. Profit is secondary to providing a service. This is probably the most fundamental difference between ‘pure business’ and healthcare business.
Business ethics v professional ethics

<table>
<thead>
<tr>
<th>Professional</th>
<th>Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient welfare</td>
<td>Share holders (inc. staff)</td>
</tr>
<tr>
<td>Duty of care</td>
<td>Contract issues</td>
</tr>
<tr>
<td>General Dental Council</td>
<td>Government/Society</td>
</tr>
</tbody>
</table>

No profit, no business. No business, no dentistry

It seems the two aspects are intertwined and cannot exist without the other.

Without patients there can be no business. If the professional does not meet regulatory standards, then they are likely to be removed from the register and can no longer provide dentistry. A balance must be struck.

As referred to above, dentistry is first a profession, however the practice of dentistry usually involves financial compensation for professional services. Such compensation necessitates, by its very nature, some form of business structure to accommodate these transactions. The patient is the beneficiary of the dentist's services. Since dentists are in a position to gain financially from their professional recommendations, they are at risk of having a conflict of interest, whether actual or perceived.

The bioethical principles of autonomy, beneficence, and justice may be overwhelmed by the values of market competition resulting in maleficence, (for the patient and the ultimately the dentist).

How do we prevent this tipping over?

A conflict exists, that cannot be denied nor removed, it therefore needs to be managed to prevent the conflict from harming patients. Professional decision-making involves many factors, for example, the age of the patient, the level of oral hygiene, medical conditions, etc. However, the level of financial gain to the dentist must never be a consideration in any of the dentist’s professional recommendations. A patient's ability to pay for services may be a consideration in the recommendations of the dentist, but that is to be discussed between the dentist and the patient and for the patient to decide when they have been informed of all the facts and options, including cost.

If the patient’s relevant interests are always considered the primary focus, the profession of dentistry can ethically exist within a business structure.

Ponder – whose ethics? Reflect on the following statements:

- Can corporations care about individuals – patients or employees?
- Can the professional values of dentistry endure corporatization?
- Does money always taint professional ethics?
- Patients should always be treated as ends in themselves, never as means to some other end, (Kantian deontology)

Corporate social responsibility

Corporate social responsibility (CSR) is closely lined to business ethics. A socially responsible dental practice should be an ethical dental practice, whilst an ethical dental practice should be socially responsible. The concepts are hand in glove (so to speak). However, there is an important difference between the two concepts. CSR is about being responsible to all stakeholders, not just shareholders, whilst ethics is about morally correct behaviour. In dentistry we can consider shareholders to include the owner(s) of the practice, whether that be an individual or a group, plus the employees as well as conventional shareholders as might be found in a corporate body. Stakeholders include the patients, NHS England, the department(s) of health, the government. Professionally all dental registrants must follow the ethical code (principles) laid down by our regulatory body, the General Dental Council. If we do not we can find our fitness to practice called into question and, in extreme cases, we can be erased from our professional register and prevented from working in dentistry. It seems our professional ethics is well defined, we know what we should do and we know the consequences if we do not act in that way.
business ethics is less well defined. How can we ensure our business ethics is as well defined as our professional ethics?

One way would be to construct a code of practice, similar to that of our professional code. Some of the sections of that code might cover:

- Corporate social responsibility
- Dealings with customers and supply chain
- Environmental policy & actions
- Rules for personal and corporate integrity

In a similar way to leadership, the ethical tone of a business comes from the top. If the owner of the business does not set an ethical example then it is probably impossible to expect employees to be ethical in their business dealings. A well-defined ethics code of practice along with an outline of related standards of expected conduct provides the framework for ethical, moral behavior within a business.

Since 2003, the Institute of Business Ethics has annually surveyed the perceptions of the British public to ethics in business. The latest face-to-face survey was conducted by Ipsos MORI among a representative sample of 991 British adults (aged 16 years and above) as part of its Sustainable Business Monitor Survey in September 2012. The results report that around half (48%) of British adults say they believe that British business is behaving very or fairly ethically in terms of its behaviour and decisions following good principles. However, of these only 3% said they think business is behaving ‘very’ ethically. This is a substantial decline from the previous year – down ten percentage points from 58% in 2011. The 2012 proportion is similar to the all-time low of 47% in 2003 (when the survey was first conducted).

“Being good is good for business” Dame Anita Roderick

Research indicates that the integrity demonstrated by a business can have a positive effect on that business’ bottom line. The challenge for any business is to not only believe and voice its’ ethical principles, but to also practice them in all business transactions. The old adage that “what you sow, you will reap” also supports this premise.

Business stories:

It’s all about the profit margin – no, it’s not
It’s a jungle out there – no, it’s not
If I don’t do it, the practice down the road will – be authentic and ethical
References:


General Dental Council (2008) Guidance on principles of management responsibility

General Dental Council (2013) Preparing for Practice – Dental team learning outcomes for registration

Institute of Business Ethics

Kramer, SN (1959) History begins at Sumer, New York: Doubleday


Additional Reading:

General Dental Council Guidance:

- Principles of Ethical Advertising, March 2012
- Escalating and raising concerns
- Involvement with a Dental Body Corporate, February 2009
SESSION Ten

Revision
ASSESSMENT

We will be running a revision session where we will work through some questions like those listed below and where we will be ready to clarify any points in the course material that you may not have understood.

Examination format

You will sit an unseen exam which will contain multiple-choice questions and extended matching sets (which are a sophisticated version of multiple-choice). Like multiple choice you are not asked to construct the answers yourself but you are expected to identify the right/wrong answers.

For your information, here is a selection of example exam questions:

Multiple Choice question:

What ages of children is the Gillick test applied to? (Select the most appropriate answer: 1 mark)

A: Minors under the age of 16 years
B: Minors under the age of 18 years
C: Minors aged 16 and 17 years of age
D: Minors under the age of 17

Extended matching set questions:

The following are situations where a practitioner may be justified in breaching confidentiality, they are:

A. Disclosure with the patient’s consent
B. Disclosure within health care teams
C. Disclosure in the patient’s medical interests
D. Disclosure in the public interest
E. Disclosure in connection with legal proceedings and in accordance with statutory requirements
F. Disclosure for the purposes of teaching, research or audit.

For each of the following cases, select the most appropriate justification for disclosure of confidential information?

1. Mr. Westhill is detained in a secure mental hospital having killed two people and severely injuring another five people in an arson attack. However, Mr. Westhill is believed to be no longer a threat to the public and is to be released into a low security institution. Mrs Preston is Mr. Westhill’s dentist and after treating his toothache he confesses to her that he is making a bomb and asks if she has any matches. Mrs Preston believes that Mr. Westhill is still a very dangerous individual and would pose a significant risk to the community if released. Mrs Preston wishes to report what Mr. Westhill said to her, to the authorities to prevent Mr. Westhill’s release back into the community. (SELECT 1 JUSTIFICATION)

2. Mr. Reynolds is contacted by the police after they find a dental appointment card with his name and practice address on in a house where a terrorist attack has taken place. The police say they believe the card belongs to the suspected terrorist who is responsible for the crime. Which of the above justifications for breaching confidentiality is relevant to Dr. Reynolds in this case? (SELECT 1 JUSTIFICATION)
It should be noted that many of the exam questions are linked to a particular case study. In this way, it is very similar to the work that is done in the small group discussions.

If you fail the first sit in Health Care Ethics and Law, re-sits will take place in the August examination period.

Resit

In the unfortunate event that you fail the first attempt at the examination, we will hold a revision session in the week before the re-sit exams in August. It is your responsibility to find out when this session is timetabled BEFORE leaving the University at the end of the summer term. One of us will be available to see you either on the day that the examination results are released or the day after However you may have to make an appointment to see us. Please bear in mind that University Regulations prevent us from showing you your exam script. We can only discuss the exam with you in general terms.

QUESTIONS
An questions during the revision period please use the e-course discussion board (Ethics home page) OR contact Dr K Hill 0121 237 2810; k.b.hill@bham.ac.uk or Prof D White 0121 237 2765 d.a.white@bham.ac.uk
SMALL GROUP TEACHING
SMALL GROUP TEACHING: CONSENT

LEARNING OBJECTIVES:
During the discussion, students will begin to develop their capacity to:

- collaborate productively
- reason critically and creatively in the decision-making process
- empathise with other persons’ points of view
- identify their own strengths and weaknesses as group members
- refine and/or modify their opinions based on the group discussion

Case Study 1
Wes, a thirty-five year old unemployed male arrives in the accident and emergency department at one in the morning on a Sunday. He is accompanied by his wife and a police officer. He is 'known' to the local police and is extremely drunk. You are called out of bed at two am to see him, having just completed a 15 hour day and had around 8 hours sleep in the last 48 hours.

From Wes, his wife and the police officer you establish that he was involved in a fight at his local working men’s club, where he received facial injuries. Radiographs reveal a broken lower jaw that requires surgery to repair; otherwise his jaw and perhaps his life are at risk (his life is in no immediate danger). You tell Wes that you wish to admit him to a ward and will operate in the afternoon to reduce his jaw fracture. He is adamant that he will not stay in hospital and he demands to be taken home. Despite pleas from his wife and the police officer, he refuses to change his mind.

Questions
1. When Wes refused surgery whilst drunk, was this a autonomous decision?

Options do you….

❖ Wash your hands of the case – if he is so stupid as to get drunk, get into a fight and then refuse help, that's his look out and not your problem.
❖ Get him to sign a disclaimer saying that he absolves you and the hospital of any blame and let him go.
❖ Forcibly detain him until he has sobered up, sedate him and take him to theatre for surgery.
❖ Let him go home and ask his wife to bring him in for a review appointment the next day where you can try again to persuade him to have surgery.

2. If Wes had agreed to surgery then, would this have been a valid consent? Would it have mattered if his consent was valid, would you have still gone ahead?
3. Would you have been right to operate against his will under the ‘doctrine of necessity’?
4. If Wes had been in immediate danger would this have changed things?
5. If he had not returned, would that have been the end of things as far as your responsibilities lay?
6. How would you assess the distinction between coercion and persuasion with regards to Wes?
Case Study 2
Ivy, a 73-year-old woman attends as an emergency during an evening session. She has not been to the dentist for several years, as she has no teeth left. She has brought her husband with her.

She complains of an ulcer on her tongue that has been present for some time. Looking at this, you suspect mouth cancer and offer to refer her to the hospital the next day for it to be looked at. Not wanting to alarm her unduly, you do not mention cancer, as it could be something else.

She flatly refuses to attend hospital, saying she would rather die. You therefore take a small piece of the ulcer for pathological examination (biopsy) and review her 3 days later.

3 days later you review her with the results. As you suspected, she has an aggressive form of mouth cancer. You tell Ivy and her husband that the ulcer is ‘serious’ and needs specialist treatment. Again, she refuses referral to hospital and leaves the surgery without resolution of the impasse.

Questions
1. Was Ivy’s refusal to be referred for treatment autonomous?
2. Should you have told her that she had cancer and would die unless she got treatment? The prognosis was poor in any event. Many surgeons are very open about cancer e.g. ‘I’ve been asked to see you about your cancer’.
3. Should you have forcibly taken her to hospital at the first or second appointment?
4. Was telling her GP about your findings a breach of confidentiality?

Case Study 3
Alan, a 10-year-old attends your surgery with his mother. On examination you see that his teeth are seriously overcrowded and uneven. The only treatment option is to remove four of his adult teeth and to fit a fixed-brace. Alan is pleased about your suggestion and tells you that he has been teased at school recently about the appearance of his teeth. However, when you attempt to discuss the treatment with Alan’s mother she reacts very differently and states that you if you attempt to remove any of Alan’s ‘perfectly healthy teeth’ it will be over her dead body.

1. Do you need Alan’s mother’s consent to carry out this operation?
2. How might your situation be helped if Alan’s father was also there and he consented to the treatment but Alan’s mother still objected? (Assume that Alan’s mother and father are married)
3. How might your answer differ if Alan was 14 and quite mature for his age?
4. If you were offering the treatment privately, what ethical problems might you face if you tried to persuade Alan’s mother that the treatment was necessary?
LEARNING OBJECTIVES:
During the discussion, students will develop their capacity to:
* collaborate productively
* reason critically and creatively in the decision-making process
* empathise with other persons' points of view
* identify their own strengths and weaknesses as group members
* refine and/or modify their opinions based on the group discussion
* Review the three elements of negligence and apply them to the case studies
* Distinguish between negligence as a result of lack of information and negligence arising from incompetence, error, or lack of diligence.
* Distinguish between cases of battery and negligence

CONFIDENTIALITY RATING
For this small group session consider each of the situations described below and discuss and determine the most suitable description:

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<tr>
<td>0</td>
<td>No breach of confidentiality</td>
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<tr>
<td>1</td>
<td>Trivial breach of confidentiality</td>
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<tr>
<td>2</td>
<td>Significant breach of confidentiality</td>
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<tr>
<td>3</td>
<td>Serious breach of confidentiality</td>
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A  A friend of yours tells you something personal about him/herself 'in strict confidence'. You tell another friend of yours telling him/her to tell no one else.

B  Medical students discuss 'a case' in the hospital lift. Other people (strangers to the students) are in the lift.

C  A GP receptionist sees that a neighbour has had an appointment with the GP. Suspecting the neighbour is pregnant, and wishing to congratulate her, she looks in the notes.

D  You visit a friend of yours who is in the maternity hospital two days after she had a baby. On the door of her single room there is a notice: 'barrier nursing'. You ask the ward sister if you can go in the room. "Oh yes" she replies "she's a hepatitis carrier, but there is no risk".

E  Over supper, a doctor tells his/her spouse about some of the patients seen in clinic that afternoon, identifying some of these patients

F  In the 'clinical details' section of a blood form you write '?alcohol abuse'. The form is placed in a routine transparent envelope together with a blood sample. The porter who takes the blood to the laboratory notices that the sample is from someone he knows, and sees your 'clinical details'.
G. The phone rings on the ward. You answer it. The caller asks how a particular patient is doing. Since you know the patient, you tell the caller that the patient has pneumonia on top of chronic bronchitis and that IV antibiotics have been started. In putting the phone down, the ward sister asks who called. You don't know.

H. After finding the body of an infant of eight months' gestation, the police approached a GP for the names of his patients who were about eight months pregnant. The names are revealed.

I. Parents of a child who had been indecently assaulted asked the police to arrange for the suspect to have an AIDS test. The test results are then revealed.

J. The GP of a patient who discovers that she has breast cancer decides to tell the patient's pregnant sister that she (the sister) may be at risk also when the patient refuses to disclose the information because she is not talking to her sister.

K. You treat a colleague who has AIDS. He is a practising surgeon. You tell the Health Committee of the GMC.

L. A patient tells a university psychiatrist that he is going to kill his ex-girlfriend who has dumped him for another guy. The Psychiatrist tells the police.

M. A 14 year old girl tells her GP that she has been assaulted at home. The girl desperately wants her family to stay together and begs the GP not to tell anyone. The GP phones social services.

Based on your considerations above can you now provide a definition for trivial, significant and serious breaches of confidentiality? On what basis were your definitions made? Does the distinction matter? Include legal and ethical justifications.
Case 1

Susan is claiming damages against you alleging negligence in her dental treatment. She underwent wisdom tooth extraction, performed by you, in September 1990. It is alleged that:

(1) She lost feeling in her lip and gum due to nerve damage during the extraction, that you had been negligent in failing to recognise that the extraction would be extremely difficult, had failed to warn her of the possible complications of the procedure, with the high and foreseeable risk of nerve damage and consequent paraesthesia, and alternative treatments which were available.

It is also alleged that you should have terminated the extraction when it became difficult. She is claiming that she would not have consented to the procedure if she had known of the foreseeable risks.

Questions

1. Do you think this claim of negligence is a fair one? Is it a claim for negligent treatment or negligently obtained consent?
2. Work through the three elements of consent to see whether the claim would succeed or not.
3. Do you think Susan should be entitled to any financial compensation if you are found negligent?
4. Do you think it is reasonable to expect dentists to terminate treatment when problems arise and make an urgent referral?
SMALL GROUP TEACHING: TRUTH-TELLING AND WHISTLE BLOWING

LEARNING OBJECTIVES:

During the discussion, students will develop their capacity to:

* collaborate productively
* reason critically and creatively in the decision-making process
* empathise with other persons’ points of view
* identify their own strengths and weaknesses as group members
* refine and/or modify their opinions based on the group discussion

Case Study 1
Oscar is the senior partner in the practice where you are conducting your vocational training. One Monday morning Oscar turns up to work appearing very dishevelled and smelling strongly of alcohol. He appears to be drunk but you are not certain. Oscar’s first patient that morning, Sarah, suffers from severe dental anxiety and has a history of running out of the surgery before and even during treatment. Oscar goes into his surgery and prepares to see Sarah; he still seems to be drunk and certainly very shaky. Sarah arrives and proceeds to the surgery to see Oscar. Within minutes screaming can be heard coming from the surgery. You rush in alarmed to see Oscar physically restraining Sarah in order to treat her when she is clearly terrified. Oscar also appears to be attempting to administer a sedative to Sarah without her consent.

Questions
1. You have long suspected that Oscar abuses alcohol but you still cannot be certain. He is an influential and well-respected member of the profession. How should you manage the situation?
2. Sarah has a history of irrational behaviour in the surgery. Consider what your actions would be, knowing Sarah had not consented to a sedative.
3. Would your answer differ in any way if Sarah had not shown any distress and appeared satisfied with her treatment?

Case Study 2
Carol attends your surgery with her son Mark. Carol tells you that Mark has not been to the dentist in some time and he has been experiencing pain. You examine Mark and take some radiographs to try to locate the source of his pain. On examining the radiographs you identify some deep decay on a back molar that needs urgent treatment. You explain this to Mark and his mother who both ask you to treat it immediately. As you drill the tooth you can see no sign of decay. You drill further until the hole is quite deep but still cannot find any decay. On examining the radiographs again you realise that you looked at the radiograph back to front and have drilled the opposite tooth that was healthy.

Questions
1. Do you tell your patient and his mother of your mistake or just fill the tooth and then work on the correct tooth?
2. Would your answer differ if you had made the same mistake but this tooth also had decay?
3. How would you act if you were the nurse and had observed the dentist making this error?
SMALL GROUP TEACHING: Poor Performance

Case Studies – Poor Performance

1). The Case of the Reference Request

A former dental hygienist who was dismissed due to poor quality work, absences, and lateness related to her drinking problem, informs you that she has applied for a position at another dental practice and has already given your name as a reference. She desperately needs a job (she is a single parent with three children), and she asks you to give her a good recommendation and not mention her drinking, which she assures you is now under control. She also asks you to say that she voluntarily left the company to address a family medical crisis, and that the company was pleased with her work. You like this person and believe she is a good worker when she is not drinking. You doubt that she really has overcome her drinking problem, however, and you would not recommend your own practice take her back.

- What do you say to this woman?
- What do you say to an employer who calls you for a reference?
- What if the prospective employer was a friend?
- Suppose the problem was a theft?
- Suppose she had asked you to be a reference prior to supplying your name to her prospective employer?
- What values are at stake? Do some of the values conflict with one another?

2). The Case of “It’s just a bit of harmless fun!”

Joanna couldn’t believe her eyes when she checked Facebook this morning. A new page, “FT Confessions,” had just been created, and one of the first “confessions” was about her! Someone shared a story where she had gotten really drunk last week and did a few things she wasn’t proud of. Granted, she wasn’t mentioned by name, but it was a unique enough situation that everyone she knew would recognize it as being about her.

Joanna had heard about other Foundation Training schemes starting pages like this, where people message the page administrator their secrets, hook-up stories, dirty deeds, and anything else that they would want to share anonymously. Joanna initially thought these pages were hilarious, and even “liked” the ones from other schemes just so that she could be entertained. However, now that she was reading something about herself, she felt embarrassed and upset. Already it had 50 “likes” and counting, and several of her friends tagged her in the comments so that she would see it. To make matters worse, the post was anonymous, so she had no way of knowing who was spreading the story around.

The other FT’s told Joanna to laugh it off; it wasn’t that big of a deal. Even she had to admit that the story was objectively pretty funny, and most of the other posts on the page were relatively harmless as well. On the other hand, she could envision how people would take advantage of the anonymity and could potentially cause somebody real harm.

Unfortunately it didn’t stop there and a photo appeared on the page. There were several people in the photo and Joanna wasn’t easy to spot, however she was visible. A few
days later one of the patients at Joanna’s practice called to complain and wished to be transferred to another dentist’s list.

- What are the issues here?
- What is likely to happen next?

3). The case of the referral to a colleague

Your hygienist confides in you because she has concerns regarding the treatment plan provided by an associate at your practice. The patient is new to the practice. He is a 44 year old smoker who has not been to the dentist for 5 years.

When the hygienist looks at his mouth she notes that there are large supra-gingival calculus deposits, and plenty of stain on the teeth. The gingivae do not appear to be inflamed but do appear fibrotic, with a rolled edge and she suspects there is sub-gingival calculus present. The treatment plan from the associate says 1 x 15 min scale and polish. There are no radiographs, no periodontal indices and no oral hygiene advice has been given to the patient.

She questioned the treatment plan provided by the associate because she thinks it is inadequate to be able to treat the patients periodontal disease and the dentist told her not to worry because all the patient wants is a bit of a clean up before he goes on holiday.

- Is the treatment plan adequate? If not, why not?
- What should you do?

Case 4 – Don’t tell

A patient who is HIV positive tells you of his condition but asks you not to record it in your records and not to tell your dental nurse because he is dating her best friend.

- What should you say to the patient?
- What should you record in your records?
- What should you say to your dental nurse?

Case 5 – Tales from overseas

You are an Associate in a large multi-chair practice. You joined the practice four months ago. Every year a dentist from Scandinavia joins the practice for the summer period to help whilst holidays are taken. She is 71 years old and fit and healthy. However, one of your colleagues tells you that he has told the receptionist that none of his patients are to be seen by this dentist, you wonder why. After the dentist has left and returned home you are concerned that three of your patients have returned to see you and it is obvious that the treatment they received was of a poor standard.

What should you say to the patients?
What should you say to the practice owner (the dentist may wish to return next year)?
SMALL GROUP TEACHING: Business Ethics

Business Ethics

Case Studies

1. Fair recruitment

Janet has been a practice principle for about two years and has been doing very well. About a month ago, she decided she needed to hire a practice manager. After interviewing several candidates, she decided to hire the best one of the group, Andrew. She called Andrew on Monday to tell him he had got the job. They both agreed that Andrew would start the following Monday and that he could come in and fill out the necessary paperwork at that time.

On Tuesday, of the same week, a friend of Janet's called her to say that she had found the perfect person for Janet. Janet explained that she had already hired someone, but the friend insisted. "Just meet Kira. Who knows, maybe you might want to hire her in the future!" Rather reluctantly, Janet agrees. "All right, if she can come in tomorrow, I'll meet with her, but that's all." "Oh, I'm so glad. I just know you're going to like her!" Janet's friend exclaimed.

And Janet did like her. She liked her a lot. Janet had met with Kira on Wednesday morning. She was everything that Janet had been looking for in a practice manager and more. In terms of experience, Kira far surpassed any of the candidates Janet had previously interviewed, including Andrew. On top of that, she was willing to bring in systems of her own which would only increase business. All in all, Janet knew this was a win-win situation. But what about Andrew? She had already given her word to him that he could start work on Monday.

And yet she only had the money to take on one person at this point. Clearly, the best business decision was to hire Kira. But what about the ethical decision? If the practice did poorly or Andrew couldn't provide enough support, the practice would suffer. As a result, Janet's patients and family would suffer. Money was already tight, what with two boys in college. And yet she knew Andrew also had a family he was supporting. Plus, he had been so enthusiastic about starting to work.

Obviously, Janet has a problem - an ethical problem. Should she hire Andrew (whom she'd already given her word to) or Kira (who was obviously the best person for the job)?

Questions like these touch on our deepest values. Depending on who you would ask, you would get strong arguments for both decisions. This is what we mean when we talk about "grey" area. So what is the answer?

In thinking about your answer there are three questions that might be helpful:

- **Is it legal?** - will you be violating any criminal laws, civil laws or company policies?

- **Is it balanced?** - is it fair to all parties concerned both in the short-term as well as the long-term? Is this a win-win situation for those directly as well as indirectly involved?

- **Is it right?** - most of us know the difference between right and wrong, but when push
comes to shove, how does this decision make you feel about yourself? Are you proud of yourself for making this decision? Would you like others to know you made the decision you did?

Most of the time, when dealing with "grey decisions", just one of these questions is not enough. But by reflecting on all three, you will often times find that the answer becomes very clear.

2. Realistic Expectations

A 45 year old female patient is referred to your ‘Smile Clinic’. She requests a ‘complete make over’ of her anterior teeth. She has reasonably good periodontal condition. The upper right lateral has been root filled approximately 5 years ago, it is very slightly discoloured. The upper left canine is a little buccally placed and the patient has a Class 2 div 1 occlusion. She is adamant she wants all her anterior teeth (upper and lower) crowned or something similar. She is convinced her appearance is poor and she seems quite agitated when talking about her teeth. She tells you money is not the issue, she wants to look beautiful again.

What are the underlying issues here?

What questions do you need to ask before continuing with the consultation?

How could you proceed?

3). Case Study – Marketing in Aesthetics

Your practice advertises cosmetic solutions for patients unhappy with the appearance of their teeth. You have a website that shows a number of ‘before’ and ‘after’ photographs showing successful results. You attended a course some years ago over three weekends on smile design and you feel confident with the latest techniques.

A 55 year old male patient presents at the practice. He is very upset and complains that the veneers placed three years ago (to his upper lateral and central incisors) have now started to break down. The patient says that he was told by you that the veneers were a permanent treatment for his discoloured teeth and now they are breaking down. There is recession around the gingival margin of his upper left lateral incisor. He is experiencing pain from the upper right central incisor and the margin of this tooth is chipped. The patient is annoyed that he was told the treatment was permanent, he paid a considerable amount of money for the treatment and now he is in pain and the veneers are falling apart.

What are the ethical issues here?

What should have prevented this scenario?