

General Dental Council
Patient and Public Attitudes to Standards for Dental
Professionals, Ethical Guidance and Use of the Term Doctor

Research Report



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Executive Summary

1.	Background and Objectives	1
1.1	The General Dental Council (GDC)	1
1.2	Standards for Dental Professionals	1
1.3	Ethical Advertising	2
1.4	Use of the Term Doctor (Dr) by Dentists	2
1.5	Research into Public Attitudes	3
2.	Methodology & Sample	4
2.1	Qualitative Focus Groups	4
2.2	Sample Structure	4
2.3	Summary Quantitative Questionnaire	5
3.	Main Findings	6
3.1	'Trust' and the Need for Standards	6
3.1.1	Trust	6
3.1.2	Differences between key subgroups	8
3.1.3	'Distress purchases'	10
3.1.4	Awareness of the GDC	11
3.1.5	Complaints	11
3.1.6	Uncertainty and the need for standards	12
3.2	Standards	13
3.2.1	Guidelines vs Specific Procedures	13
3.2.2	Communication	14
3.2.3	Provision of evidence	15
3.2.4	Consulting the patient and Informed Consent	16
3.2.5	Guarantees and Quality Assurance	17
3.2.6	Qualifications and Registration	18
3.2.7	Costs	19
3.2.8	Maintenance of Qualifications	20
3.2.9	Other Standards (e.g. hygiene, confidentiality etc.)	21
3.2.10	Display and dissemination of standards information to the public	22
3.2.11	Summary and Key Sub-Group Differences	23
3.3	Ethical Advertising	24
3.3.1	Advertising (General Comments)	24
3.3.2	Patient and Public Preferences (Advertising)	26
3.3.3	Advertising Issues of Concern	28
3.3.4	Use of Terminology and the Word 'Specialist'	29
3.3.5	Key Sub Group Differences	31
3.4	Use of the Title Doctor (Dr.)	32
3.4.1	Patient and Public Preferences (Titles)	32
3.4.2	Use of the title Doctor (Dr.)	34
3.4.3	Attitudes to Enforcement	35
3.4.4	Key Sub Group Differences	35
4.	Summary, Key Findings and Conclusions	37
4.1	Summary and Conclusions	37
4.2	Key Findings	39

Appendix A: Focus Group Topic Guide
 Appendix B: Questionnaire & Results
 Appendix C: Mock Dental Ads

Executive Summary

George Street Research was commissioned by the General Dental Council to undertake some exploratory research amongst dental patients and members of the public in the UK. The research was designed to form part of the GDC consultation on Standards for Dental Professionals and Principles of Ethical Advertising.

The research explored patient and public attitudes to:

- What measures the GDC should take to update the current standards for dental professionals to ensure they are comprehensive, up to date and fit for purpose?
- What constitutes the ethical advertising of dental services?
- In what circumstances is the dentists' use of the courtesy title doctor (Dr.) appropriate?

A series of 12 focus groups was undertaken between 3rd and 11th November, 2010 with a cross section of 83 members of the public ranging between the ages of 18 and 70 from urban (London), non metropolitan urban (Bradford) and rural (rural Fife) locations and across socio-economic groups. Focus groups lasted up to 1½ hours and were audio recorded for subsequent analysis. Groups were structured to allow representation from three different patient types. These types were defined – and are referred to in the report – on the basis of the following:

- *Current patients* – respondents who had visited the dentist within the past year;
- *Lapsed patients* – respondents who had not visited within the last year but had done so within the last two years;
- *General public* – respondents who had not visited within the last two years.

The main findings to emerge from the research are as follows.

Trust in the Profession and the need for Standards

- A large proportion of respondents within the focus groups reported a mistrust of dentists in UK.
- A prevailing concern leading to this mistrust is the view held by some participants that dentists are not seen as just healthcare professionals but rather as businessmen. When undertaking treatment, especially in an emergency, patients and the general public spoke of how they feel at their dentists' "mercy". They could be told anything and would have to trust that it is correct. Moreover, as a "distress purchase", the costs of the treatment can lead to mistrust in terms of the patients being unsure of the necessity of the treatment.

- Patients and members of the public have concerns about the equality of treatment from dentists in terms of NHS vs Private patients. The prevailing perception is that, as an NHS patient, one is likely to receive a substandard level of service when compared with private patients within the same practice.
- The effects of this equality of treatment issue are manifested in a number of different ways, including:
 - Reluctance to make complaints – NHS patients are reluctant to ‘make a fuss’ for fear that they will be forced to lose their place within the practice;
 - Lapsed patients (most likely NHS patients) do not visit the dentist regularly as they are often discouraged by their dentist from doing-so;

Standards for Dental Professionals

- Trust emerges as the overarching issue for patients, which the GDC strategic review should consider. In order to do so, patients and the public highlighted three key criteria that need to be met:
 - I. **Communication** – patients want to know in advance how much their treatment will cost and why;
 - II. **Evidence** – a majority of patients will want an explanation of why certain treatment is recommended, what the benefits will be if undertaken and what the drawbacks will be if not;
 - III. **Informed consent** – patients want a balanced view of their options before proceeding with treatment.
- The most significant issue relating to standards that arose from these discussions was that of communication. Whilst important in its own right, communication appears to underpin every other issue and concern arising in the discussions and its importance cannot be overemphasised in the standards review. As one respondent said:

My dentist is very good; he will explain everything to me. Without even asking he goes to great lengths to make me feel comfortable in what he is doing and why he is doing it and what I should do to try to prevent any problems.

(Female, ABC1, 40-55, Bradford, Lapsed Patient)

- Those who were positive about their dentist’s ability to communicate effectively with them as adults also appeared more trusting of the profession as a whole.

- Ineffective communication contributed to a majority of respondents' negative experiences. Most related to what patients should expect in terms of:
 - The cost of treatment before it was carried out;
 - The level of pain from impending treatment;
 - The reasons for why the treatment is being carried out.

They should be obliged to consult with you on any treatment before it happens; and anything that would incur a charge... So whether it's just a clean... afterwards you get the bill and... you've actually consented to that treatment for that amount of money and that's it.

(Male, ABC1, 18-39, London, Current Patient)

- Respondents felt that it was imperative that when possible and practical to do so, dentists should provide evidence of the need for recommended treatments.
- Evidence of qualifications and registration with the GDC, clearly displayed in practices could be beneficial to reassure patients when visiting a new dentist.

Being registered with a governing body – you know, it makes you feel confident. When you see that, you know, rather than somebody just practising without anything.

(Male, 18-39, C2DE, London, General Public)

- The majority of respondents agreed that some level of informed patient consent was important. The nature of informed consent means that patients felt that they should be given a fair and balanced assessment of the situation and are put in a position whereby they understand and verbally consent to any treatment. This is especially important in the context of the “distress purchase”.
- Lapsed patients and the general public are likely to be less used to routine treatments and check-up. Whilst the dentist may consider the purpose of these treatments to be self evident, there is a need for full disclosure and transparency, supported by an explanation of why it is being recommended or administered.
- Respondents felt that they should be given “guarantees” on treatment being carried out. Therefore, if repeat treatment is required within a certain timeframe, the dentist should cover the cost of this.
- Whilst costs per se cannot be regulated by the GDC, respondents were positive about transparency about costs for treatment – for example, prominent displays of treatment costs in practices to manage expectations when expensive procedures are being undertaken.

- There was widespread expectation that dentists' skills should be (and will be) kept up to date (e.g. through CPD); this was considered to be important.

I have heard people say... 'don't go to the dentist in [named village], he's older; and he's old-fashioned'. Do they keep up their standards, and do they have to go on refresher courses, do they actually have to prove that they're keeping ahead?!

(Female, ABC1, 40-55, Rural Fife, General Public).

- Respondents also felt that standards should take into consideration registration with protecting vulnerable group schemes, hygiene and cleanliness, and confidentiality of patient records.
- There was widespread agreement that having information on standards made available to patients and the public would be beneficial. Outlining the key principles of standards, and what should be expected from dentist appointments, may go some distance to addressing mistrust of the profession and fear of these appointments.

Ethical Advertising

- Ethical advertising appears to be an important issue. This could be due to the increased promotion of expensive, and what are viewed by some patients and the general public as unnecessary treatments. This may feed into and/ or reflect concerns about dental care professionals being viewed as much as businessmen as healthcare professionals.
- Advertising examples which were seen as credible and trustworthy were those which displayed:
 - Quality Assurance (e.g. BDA approved and / or registration with various other professional bodies);
 - Confirmation of General Dental Council registration and registration number(s);
 - Availability of NHS places;
 - Information on the specific qualifications of the practice's dentists.
- Awareness of GDC specialist lists was limited, however most felt that to be a specialist there would be an expectation of some additional qualification and that the vast majority of treatment administered would be within that field.

[To be a specialist] they must have gone through their qualifications or their exams – whatever it is - but then if they can say. 'I have done a

thousand dental implants in the last ten years'. That's fine, that's a statement of fact. Shouldn't concern me...

(Male, 40-55, ABC1, Rural Fife, General Public)

- On balance, the majority of respondents agreed that using the term 'specialist' when not registered on a GDC specialist list was misleading.

Specialist implies that they're the best person... You would have to justify that

(Male, 40-55, ABC1, General Public, Rural Fife)

It's like I do a lot of DIY at home.... It doesn't make me a DIY specialist because I've been doing it for ten years!

(Male, 18-39, C2DE, London, General Public)

Use of the Title Doctor (Dr)

- There was a relatively high degree of confusion about when dentists are entitled to use the courtesy title Doctor.
- This was evident from an exercise introduced, as part of the focus groups, to test responses to the use of the term Doctor. All respondents appeared naturally drawn to those names which appeared more qualified or 'grander'. This meant there was a natural pull to names which displayed:
 - The title 'Dr.'
 - Letters after the name relating to qualification, e.g. BDS, MDS
 - Terminology which respondents were unfamiliar with and which looked impressive

Well I would assume that a doctor of dentistry has got more qualifications than a Mr.

(Male, 40-55, ABC1, Bradford, Current Patient)

They've got further qualifications from standard dental work. So they could be Mr and Mrs... but saying 'Dr' you know they're a step above.

(Female, 56-70, C2DE, Current Patient, Rural Fife)

- Subsequent to the exercise, the GDC Ethical guidance consultation on the use of the term Doctor was outlined and the context set.
- Almost across the board, patients and the public agreed that if a dentist uses the title Dr and is not qualified to do so this is very misleading.

I mean I could call myself HRH but I am not. It's a similar thing isn't it?

(Male, C2DE, 56-70, Bradford, Lapsed Patient)

- The vast majority of patients and the general public were adamant that dentists without a PhD or medical degree, who present themselves as a “Dr”, should be subject to disciplinary procedures.
- 73 of the 83 surveyed felt that the GDC should take some form of action against such practitioners. The extent of feeling was so strong in some, that they felt these individuals should be “struck off” the GDC’s register.

Key Findings

- The research supports the GDC’s current ambition to provide an up-to-date and relevant set of standards outlining the key operating principles for dentists in the UK.
- There is a need for the GDC to raise its profile amongst the general public and patients. The development of these standards provides the opportunity for to do this. The information included in the new standards should be clear and comprehensible for the general public and patients.
- The standards need to strike an appropriate balance between specific instructions (e.g. health and safety) and guided principles (e.g. communication).
- Standards information should be made available in healthcare related waiting rooms: i.e. dentists’ practices, doctors’ surgeries and hospitals.
- It is important that the GDC produces information for patients that outlines what they should do if concerned about treatment they have received or want to complain. It should make clear the process for raising the issue with the dentist if appropriate, or with the practice, or with the GDC.
- In terms of advertising:
 - Dentists should provide information on their registration with the GDC (including registration numbers where possible);
 - Practices should include logos of any other professional bodies with which they are registered or through whom they have accreditation;
 - Practices should display whether or not NHS patient spaces are available.
- Dentists and practices should not advertise themselves as specialists in any area where no such specialist list exists.

- The Consultation on the GDC Ethical Guidance needs to consider the views expressed by patients and the general public on the use of the term Doctor. These were that:
 - There is considerable confusion about the circumstances in which the use of the term Doctor is employed by Dentists;
 - Patients and the general public were of the view that Dentists should not be permitted to use the courtesy title “Dr.” except where a medical degree or PhD is held. Those using the title “Dr.” without relevant qualifications should be subjected to disciplinary action.

1. Background and Objectives

1.1 The General Dental Council (GDC)

The General Dental Council is the regulatory body for practicing dental professionals in the UK, with the principal aims of protecting patients through the effective regulation of dental professionals, promoting confidence in the profession and being at the forefront of healthcare regulation. This is achieved through the core activities of the organisation which include:

- Registration of qualified dental professionals;
- The establishment of dental practice / conduct standards;
- Quality assured dental education;
- Dissemination of up-to-date information to the profession;
- Helping patients with complaints about a dental professional;
- Working to strengthen and ensure patient protection;

All dentists and dental care professionals¹ (DCPs) in the UK need to be registered with the GDC to practise. Key information about all registrants is made available on the GDC website through a series of registrants' lists, separated by area of operation.

1.2 Standards for Dental Professionals

The GDC standards guidance is a code of behaviour that registrants agree to abide by and is a key means of not only protecting patients, but also protecting registrants by making it clear what is expected of them. The core guidance is the *Standards for Dental Professionals* booklet and this is supported by six supplementary documents, all of which are available in hard copy and on the GDC website.

The standards were prepared in 2005/2006, before DCPs were required to register, and a strategic review of the standards is now being undertaken. The comprehensive standards must be patient centred, reflecting patients' interests and concerns, and must be accepted by DCPs and dentists alike. It will therefore be important to have an up-to-date and in-depth understanding of the needs, concerns

¹ In 2008, dental nurses and dental technicians in the UK joined clinical dental technicians, dental therapists and dental hygienists in having to sign up to the GDC register of dental care professionals

and expectations of patients and the wider public, to help inform the GDC's strategic review of Standards.

1.3 Ethical Advertising

When GDC registrants are placing advertisements for the services they are providing, they are required to adhere to the Council's ethical guidance, as per the aforementioned *Standards for Dental Professionals*. A current GDC consultation on the principles of ethical advertising highlights the following three principles of the guidance as being of particular relevance in relation to advertising:

- *Work within your knowledge, professional competence and physical abilities*
- *Do not make any claims which could mislead patients*
- *Justify the trust that your patients, the public and your colleagues have in you by always acting honestly and fairly*

Within this context, it is again important for the GDC to understand the attitudes and expectations of patients and the wider public with regard to advertising of dental services. In particular, the Council wishes to gauge the importance of advertising / publicity material in influencing selection of dental care and providers, expectations of reliability, integrity and honesty of advertising and the potential impact of misleading or ambiguous claims on perceptions of, and confidence in, the profession.

1.4 Use of the Term Doctor (Dr) by Dentists

The ethical advertising guidance, on which the GDC is currently consulting, would include policy on the use of the term Doctor (Dr) by dentists. For the last 15 years dentists have been able to use the title of Doctor and GDC policy has stated that dentists would not be prosecuted for calling themselves 'Dr'² unless they did so in a misleading way. However, the current GDC proposal is that the use of the term Doctor (or the abbreviation Dr) by Dentists should be limited to practitioners who have a PhD or who are medically qualified and registered Doctors.

The GDC already has robust quantitative research evidence that patients and the wider public are unaware that the term Doctor is used by some dentists as a courtesy title, and that most patients consider this to be misleading. This study revealed that 41% of patients and members of the public perceived the term to indicate a PhD in

² It is against the law, for a dentist or DCP to use any title or description 'reasonably calculated' to suggest that (s)he has a professional status or qualification other than one which is indicated against his/her name in the register; however, cases alleging misuse of titles, descriptions or qualifications by dentists or DCPs can be dealt with through GDC fitness to practise investigatory/disciplinary processes.

dentistry with 37% perceiving it to reflect a medical degree – only one in ten recognised this as a courtesy title only³. Sixty six per cent did not think the term should be used as a courtesy title by dentists that are not necessarily qualified medical doctors, whilst 58% viewed the use of the term as misleading.

1.5 Research into Public Attitudes

George Street Research was commissioned by the GDC to carry out some independent research amongst patients and the wider public in order to inform the key regulatory policy issues outlined above.

1.6 Research Objectives

The specific objectives of the research can be summarised as follows:

- Explore what measures the GDC should take to update the current standards for dental professionals to ensure they are comprehensive, up to date and fit for purpose, relevant
- Obtain feedback on the ethical advertising of dental services.
- Gain insight, and understanding of public attitudes to dentists' use of the courtesy title doctor (Dr.).

³ *Public/patient understanding of Types of Dental Professionals*, DJS Research, August 2009

2. Methodology & Sample

2.1 Qualitative Focus Groups

A programme of 12 focus groups was undertaken between 3rd and 11th November 2010, across three regions, with patients and members of the public. The focus groups lasted up to one and a half hours and were moderated by Jo Fawcett (Managing Director), Sue Granville (Director) and Neil Costley (Research Manager) at George Street Research; who worked closely from a Topic Guide drafted in collaboration with the project team at the General Dental Council. The final draft of the Topic Guide used is appended to this report (Appendix A). All groups were audio recorded for subsequent analysis.

2.2 Sample Structure

Respondents were grouped according to three specific categories according to how recently, if ever, they had visited a dentist:

- Current patients – those who have visited the dentist within the past year
- Lapsed patients – those who have not visited within the last year but have done so within the last two years
- General public – those who have not visited within the last two years.

The following table outlines the relative demographics of each group and their various locations.

Group	Respondents	Location	Date
1	Current, 18-39, ABC1	London	Wed 3 rd Nov
2	Lapsed, 40-55, C2DE	London	Wed 3 rd Nov
3	Lapsed, 56-70, ABC1	London	Thurs 4 th Nov
4	Gen Public, 18-39, C2DE	London	Thurs 4 th Nov
5	Current, 40-55, ABC1	Bradford	Wed 10 th Nov
6	Lapsed, 56-70, ABC1	Bradford	Wed 10 th Nov
7	Lapsed, 18-39, C2DE	Bradford	Thurs 11 th Nov
8	Gen Public, 40-55, C2DE	Bradford	Thurs 11 th Nov
9	Current, 56-70, C2DE	Fife	Tues 9 th Nov
10	Current, 18-39, C2DE	Fife	Tues 9 th Nov
11	Gen Public, 40-55, ABC1	Fife	Thurs 11 th Nov
12	Gen Public, 56-70, ABC1	Fife	Thurs 11 th Nov

As shown in the table above, the groups were administered in London (Urban), Bradford (non metropolitan urban) and rural Fife (rural) in recruiters' homes, hotels and meeting rooms. All respondents were given £40 for attendance at the groups.

2.3 Summary Quantitative Questionnaire

A short, self-completion, summary questionnaire was issued to all respondents at the end of each group which they were asked to complete. It is important to note that these questionnaires were completed after extensive discussion and debate and give an insight into how the discussion and debate informed attitudes. These results are designed to show the extent to which there was agreement towards the issues raised, having had the opportunity to discuss and debate them, before answering the survey.

A copy of the questionnaire and the results are appended to this report (Appendix B). Throughout this report, we have highlighted the key findings from this summary questionnaire to support the arguments presented. The results are indicative of the views of the focus groups and should not be interpreted as statistically representative of the UK population.

3. Main Findings

This section of the report highlights the main findings arising from the focus groups. The first section outlines public attitudes to standards for dentists and the value and importance. Following this, the report reflects on participant views on the content of the standards before detailing findings on the various issues associated with ethical advertising and courtesy titles used by dentists.

Throughout the report quotes have been used, where relevant, to support the arguments raised. Additionally, key findings from the survey (see Appendix B), distributed at the end of the meeting are reported to add some further evidence of participant attitudes. Though the focus groups were recruited to be broadly representative of the UK population, it is important to note that George Street Research is not presenting these as statistically robust at a UK population level (based on 83 responses received).

Throughout the report respondents are referred to by their 'patient type' and for the benefit of clarity, these are defined as follows:

- Current patients – respondents who had visited the dentist within the past year;
- Lapsed patients – respondents who had not visited within the last year but had done so within the last two years;
- General public – respondents who had not visited within the last two years.

3.1 'Trust' and the Need for Standards

3.1.1 Trust

A large proportion of respondents within the focus groups, reported a mistrust of dentists in UK. A prevailing concern, leading to this mistrust is that dentists are no longer necessarily viewed as healthcare professionals, but rather businessmen – this was especially true of those who, as an NHS patient, had visited dentists who offer private treatment.

[When I last went to see my dentist] it was all about the sell and not necessarily about the caring. And I didn't really feel he was being that

careful either.... I didn't feel that comfortable with him. I tried another one – him, I didn't have the best experience with either. Again, I'm NHS and he was straightaway to me about the private options I could get.

(Female, C2DE, 18-39, London, General Public)

Furthermore, whilst it might be assumed that comparisons of dentists would be with doctors, other healthcare professionals and other professionals such as lawyers, many respondents currently draw comparison between dentists and the traditional 'rogue trader' within the manual work sector – plumbers and mechanics in particular.

Some of them are in it for the love – for the love of the profession – and some of them are in it for what they can get. It is like a plumber when they have that secret filming thing you know? A plumber comes around to fix something and breaks something else. I know it sounds silly 'cos that is a plumber and this is a dentist but it is the same sort of scenario you know...? I think years ago that was the case: whatever a dentist said was what was. Now it has become more of a money making thing. There is more competition out there you know? I still think people will just take it, whatever a dentist says they will just believe them...

(Female, 18-39, C2DE, London, General Public)

In addition to some sense of mistrust on the basis of over-paying for unnecessary work, a significant proportion of respondents in all regions were able to share their experiences where something had gone wrong in previous treatments.

I didn't have any fear as a child. As a child I used to go quite regularly but as a young adult I had a bad experience with one and I got a mouth infection and what I was charged for that was unbelievable and what I was charged to put it right was completely unbelievable so I won't go anywhere near them unless I seriously have to.

(Male, 40-55, C2DE, London, Lapsed Patient)

For these respondents, their anecdotes were commonly attributed as the root cause of fear of dentists and the consequent unwillingness to return to visit the dentist. Three current patients, in different areas, reported sending their children to a different dentist to themselves in the hope of not passing on their fear to their children and thus hoping to avoid perpetuating the problem.

I actually hate [dentists]. I have always made sure that my children go to a different dentist from me so that I never have to go for a check up before or after... I had a very bad experience as a child with a dentist who didn't

believe in anaesthetic whatever. I am absolutely terrified to be honest.

(Female, 40-55, C2DE, London, Lapsed Patient)

All of these personal experiences and concerns, which inform and drive levels of trust and confidence in the profession, may be exacerbated by media coverage in the recent past of malpractice, dentists operating without licenses and other negative coverage.

There was [a practice] up here opened up in [Rural Fife]... and it was fully booked as soon as it opened. Apparently [the dentist] was practising without a proper license as well – he got closed down!... It's very hard to know who to trust.

(Male, 40-55, ABC1, Rural Fife, General Public)

The dental sector in the UK needs to address these underlying issues of substance in order to win back the trust and arguably the respect of patients and the general public.

3.1.2 Differences between key subgroups

Putting these factors together, the intensity and reasons for a sense of mistrust of dental professionals in the UK appear to differ slightly between the key segments surveyed through this project.

- **Current patients** appear to have a slightly less prevalent mistrust of dentists (although mistrust is still evident) – this is partially because they do not always share the fear displayed by lapsed patients and the general public. Current patients participating in the groups were less likely to have had a bad personal experience with a dentist and as such, their mistrust was more likely to be focused purely on the cost of treatment.

I think I trust the profession; obviously it's a regulated profession. They are professionals. But I have been ripped off by a dentist before, so I've had to change. Although I can still trust the profession...!

(Male, ABC1, 18-39, London, Current Patient)

Younger current patients particularly appear to trust their own dentists and to a lesser extent, the dental profession in the UK. This is indicated by frequent revisiting (every 6 – 12 months); as a result, many current patients were less engaged with the topics in the groups; there was an expectation that standards and regulation are in place and – until they encounter a problem – these

individuals are unlikely to have major concerns beyond cost.

My dentist is lovely, I trust him... I have been going since I was 2 or 3 years old.

(Female, ABC1, 18-39, London, Current Patient)

However, it should be noted that even current patients – especially older individuals – have their concerns and levels of mistrust; often based on previous bad experiences; either orally or financially.

I mean I've had many problems; one of the dentists that I used to go to, because I had crowns and one of the things I didn't want was false teeth... And because of the dentist, what happened with the dentist, I ended up with losing a tooth... And I ended up having to get two false teeth in. I didn't have an option.

(Male, C2DE, 56 - 70, Rural Fife, Current Patient)

- **Lapsed patients** were more widely represented by NHS patients and a majority considered themselves to have a dentist. Their lack of regular visits tended to be on the basis that NHS patients are often discouraged from biannual check-ups unless they wish to be seen as a private patient. For many, mistrust appeared to be attributed to concerns about equality of treatment: that patients will be treated one way as an NHS patient and another way as a private patient. For many this seemed unfair as, ultimately, the treatment should be dependent on the symptoms and not the status of the patient, and will be administered by the same professional, whether NHS or Private. A small number of respondents recounted their experiences of dentists offering to administer treatment as a private patient, or allowing the issue to remain untreated if they remained as an NHS patient.

I find that with the national health it is very much in and out as it is not cost effective for them and they give you a limited time... I have had experience on both sides (private and national health).... Private is very expensive, if you have private dentistry you can get a lot more done.

(Female, 40-55, C2DE, London, Lapsed Patient)

- Those classed as '**General Public**' showed the most significant levels of mistrust of dentists. Many had encountered very bad experiences when they were young. Most lamented a lack of NHS spaces. Some suggested that when being treated as a private patient, a dentist's recommendation for treatment could often not be trusted since it might be motivated by commercial gain. Ironically, the reverse was felt to be true when being treated as an NHS patient in that a lack of

recommended treatment by an NHS dentist was thought to reflect a limited commercial reward for the dentist in undertaking treatment. There was a strong degree of mistrust amongst this group – many saw visiting the dentist as a last resort, only when oral pain was ‘unbearable’ – some even reported choosing to go to hospital before consulting a dentist. The key implication here is that, due to their mistrust of the profession, many of these individuals are likely to ignore symptoms requiring treatment and only seek help when deemed absolutely unavoidable.

I would trust a doctor, but I wouldn't trust a dentist.

(Male, 40-55, ABC1, Rural Fife, General Public)

A small number of respondents amongst the general public simply saw no value in visiting a dentist unless there was more urgent work required.

They're very good at what they do, but... I don't go to the doctors when there's nothing wrong with me, so if there's nothing wrong with my teeth then there's no point in going.

(Male, C2DE, 18-39, London, General Public)

3.1.3 'Distress purchases'

Within the context of mistrust, it is also important to consider the circumstances under which treatment is often sought and administered. This is especially important when considering emergency treatment or reactive treatment, rather than preventative. Treatment undertaken in this way (most commonly amongst lapsed patients and especially the general public) could be classed as a distress purchase. Most often, the treatment is required there and then and with one of a limited number of providers in the locality. As such, many described how they feel at their dentists' 'mercy', whereby they could be told anything and would have to trust that it is correct.

You are at their mercy: you're there with your mouth open and they could say a price or what you need done, and it's sort of impractical and inconvenient to say let me shop around. If it's anything else like a car, you shop around. You've got to have trust in the dentist... otherwise you're just going to say 'yes' to them...

(Female, 18-39, ABC1, London, Current Patient)

3.1.4 Awareness of the GDC

Throughout the groups, it was evident that awareness of the General Dental Council was very low. Whilst one or two respondents from each group seemed to be aware of the GDC per se, none were aware of the role of the GDC or that they exist for the protection of patients.

3.1.5 Complaints

Interestingly there were a number of experiences shared during the groups of treatments 'going wrong' – e.g. contracting infections during root canal treatment and being given a high dose of antibiotics. No respondents however had taken any issues further and complained or sought out a complaints procedure. Some reported returning to their dentist and requesting amendments to their treatment, but none reported looking to a regulator or third party for assistance or support.

I suppose it's just one of those things. If I were paralysed or something, God forbid, then obviously I would have taken it further, but I did obviously come out of the temporary paralysis!

(Female, C2DE, 18-39, London, General Public)

There appear to be a number of reasons why respondents choose not to take their problems any further.

1. There is concern amongst NHS patients that if they make a complaint they will be unable to maintain their place within the practice. There is a concern that to complain would be to mark oneself as a 'troublemaker' and therefore it is perhaps not worth raising the issue.

I did want to [complain] but I wondered who can I complain to. If I complain at reception or ask top man comes in then maybe then somehow there may be undermining there may be T for trouble. Then whenever I come and he sees the card he will know that this guy is trouble.

(Male, 40-55, C2DE, London, Lapsed Patient)

2. Often the pain is the main priority and therefore, as a distress purchase, there is simply a need to get it sorted. When fixed, complaining can seem like a long and arduous process and, as the situation is resolved it seems easier to simply move on. This is especially true of private patients who can more readily choose to go elsewhere in the future.

3. In light of the lack of awareness of the GDC, respondents expressed uncertainty as to whom they should report the issue. Addressing it with the dentist directly can be confrontational and it is often difficult to return to the source of the problem. There was also a reticence to report any issues to the practice as there were concerns that the complaint would simply disappear and not be dealt with properly.

On account of the lack of awareness of the GDC, and concerns about the personal consequences of making a complaint, and lack of clarity about the correct place to make a complaint, it could be argued that many potential complaints are going unreported to Dentists, the General Dental Council and the Dental Complaints Service – again, possibly contributing to the growth of mistrust in the profession.

3.1.6 Uncertainty and the need for standards

The issues outlined in the report highlight the importance of this current strategic review of standards and of how dentists present themselves through advertising and through courtesy titles. Uncertainty amongst the general public, together with mistrust and arguably cynicism show the need for clearly established and relevant standards.

It's dodgy when you start making a profit out of people's health.

(Male, 56-70, ABC1, Rural Fife, General Public)

They are trained individuals aren't they and you just have to put your faith in them and you don't know what you are doing, and so you just hope it comes out all right.

(Male, 18-39, C2DE, Bradford, Lapsed Patient)

Overall, there was a general acceptance that dentists should be operating to some form of standards, although there was limited awareness of any current standards in place and the topic was not top-of-mind.

Irrespective of patient type, there was strong support in the groups for the production of standards in dentistry; 82 of the 83 respondents surveyed agreed that *dentists should be subject to a set of minimum standards outlining a code of behaviour* (68 agreed strongly). The remaining one respondent answered '*don't know*'.

The following paragraphs discuss areas that respondents felt should be covered by standards.

3.2.1 Guidelines vs Specific Procedures

There was some division of opinion in the extent to which standards should be a set of minimum operating guidelines or a comprehensive set of rigid rules. For some, there was a preference that dentists should almost be going through a checklist at each appointment, whilst others took a more pragmatic approach and felt that rough guidelines would be sufficient, assuming the principles were adhered to. In the summary questionnaire, 31 of the 83 respondents felt that minimum guidelines were sufficient, whilst 49 felt that specific instructions were more appropriate.

A discussion from one of the focus groups would suggest that actually in some instances, both approaches are appropriate. If guidelines are too specific, some argued that their dentist could run the risk of appearing 'robotic' which ultimately eliminates the personal touch. On the other hand, there are certain processes and protocols which can – and arguably must – be made very specific; these related principally to more pragmatic things such as hygiene, health and safety etc.

If they all fill out instructions, so to speak, as opposed to guidelines... they're going to lose the personal touch.... They're going to be parrots: it's all just the same thing. They know they have to follow these instructions.

The scientific stuff I would say instructions, definitely; that needs to be structure; procedures in doing whatever. But as far as on a personal level, the guidelines are probably appropriate.

(Male and female, C2DE, 18-39, London, General Public)

If you make it an absolute, then...! It's... I think it would be difficult to adhere to that.

(Male, ABC1, 40-55, Rural Fife, General Public)

3.2.2 Communication

The most significant issue relating to standards that arose from these discussions was that of communication. Communication is important in its own right. Moreover, it appears to underpin every other issue and concern arising in the discussions and its importance cannot be overemphasised in the standards review.

It was evident from all the groups that for some patients and the public, the prevailing fear and mistrust of dentists, contribute to a need for reassurance at all stages of a visit to the dentist; particularly in relation to pain, duration of treatment and cost. Previous research carried out by George Street Research, for the GDC⁴, with dentists themselves confirmed the findings in this research that patients need to be reassured in these key areas during check-ups and treatment.

Those who were positive about their dentist's ability to communicate effectively with them as adults also appeared more trusting of the profession as a whole.

My dentist is very good, he will explain everything to me. Without even asking he goes to great lengths to make me feel comfortable in what he is doing and why he is doing it and what I should do to try to prevent any problems. I have no complaints on that score.

(Female, ABC1, 40-55, Bradford, Lapsed Patient)

Communication affects patients' views and experiences at every stage from entrance into a practice, through to consultation, treatment and payment. Respondents frequently spoke of their need to be told what was happening for reassurance and for management of expectations. This means in terms of:

- Cost of treatment before it is carried out
- Level of pain to be experienced and reassurance surrounding this
- Why the work is being carried out

⁴ GDC Revalidation Stage 1 Feasibility Study

Maybe explain what they're doing. I mean one of the dentists that I had a problem with about eight years ago... I have a problem with thinned enamel much because I was paranoid and was brushing my teeth so much. And he kept sort of shooting water at them which I was obviously in pain over, but without explaining - just turning around and putting local anaesthetic... but no explanation as to what he was doing.

(Female, C2DE, 18-39, London, General Public)

In addition to this, many respondents commented on foreign nationals operating in the UK who they feel do not have a full grasp of the English language. For these respondents, there was a desire that dentists' can express themselves clearly in English to ensure that they can effectively convey what is happening.

I really, really think that it's atrocious when you can't understand your... dentist and you can't understand what on earth they're saying and they look at you as though you've got six heads! A good understanding of spoken English is... a total necessity.

(Female, ABC1, 56-70, General Public)

The importance of communication is a key factor in allaying potential mistrust and patients' fear. This is achieved, at least in part, through management of expectations, reassurance and a clear explanation of what is happening and why.

3.2.3 Provision of evidence

When considering visits to the dentist and treatment, respondents were quite clear that there was a need to provide certain types of evidence to justify the treatment being recommended. This flows naturally from the preceding discussions on communication and indeed on mistrust. As an example, one respondent recounted a dentist suggesting his 5 year old daughter required a filling. Uncertain of the necessity, he took her to see another dentist for a second opinion who was adamant that the work was not necessary. This was not an isolated example, as illustrated below, but effectively highlights the mistrust of the profession and the need to provide some level of justification for why treatment is recommended.

They give you half a dozen fillings when you don't need them...I mean so is that something that a standard needs to be introduced on in terms of whether it is justification?

(Male, 56-70, ABC1, London, Lapsed Patient)

I think there's quite an awful lot of evidence of work that's being done on unnecessary root filings... I think quite a lot of that goes on. I think there's a lot of unscrupulous dentists and good ones, but there seems to be less and less ... doing National Health work, and I think it might be because the rate of pay they get for National Health work is quite small...

(Male, 56-70, ABC1, Rural Fife, General Public)

Respondents spontaneously cited their appreciation for situations when a dentist talks them through the problem, shows the problem (e.g. through an X Ray) and outlines the recommended solution. Although many will not necessarily understand the issue or be able to discern the relevant treatment, the care and courtesy added to the apparent transparency appears to increase trust and reassurance. Again, this reassurance applies to the benefits of undergoing the treatment and that the ensuing charges are justified.

3.2.4 Consulting the patient and Informed Consent

Whilst the provision of justification for treatment has the potential to bridge the divide between patient and practitioner, respondents felt the need to develop this further. Respondents commented on the need for dentists to approach treatment through a more thoroughgoing consultation with patients and to acquire informed consent before carrying out significant work – in some cases, respondents felt this should be the case for any work undertaken at all. This was informed by a number of actors including the emotional state of patients, together with the impending costs of accepting treatment.

Some – not me, particularly, but some people might not care about the stains on their teeth!

(Male, 18-39, ABC1, London, Current Patient)

The implication here is that even 'routine' work might be deemed unnecessary in the mind of the patient – this was most likely to be mentioned by lapsed patients and the general public who are less used to the routine work of a check-up, scale and polish, for example. Whilst the dentist may consider the issue to be self evident to some, there is a need for full disclosure and transparency of treatment, supported by why it is being recommended or administered.

They should be obliged to consult with you on any treatment before it happens; and anything that would incur a charge... So whether it's just a clean... afterwards you get the bill and... you've actually consented to that treatment for that amount of money and that's it.

(Male, ABC1, 18-39, London, Current Patient)

One respondent commented that each time she visits the dentist there is concern throughout the whole appointment about what the final bill will be on exit. The main issue is that there is no prior warning about what treatment is being administered and what the associated costs are, thus producing anxiety.

My dentist kind of does this thing now where he says, 'I'm going to give you a clean and I'm going to give you this and that, and then you go out and they say '£60 please!' And you feel like going to go back in and say, 'I didn't ask you to clean or anything – it's just a check up so I can go home!'... I think it's misleading. It is beneficial, but I think he should give me the option and say, 'do you want me to clean your teeth' etc. rather than just doing the work! And when I get out I have a hefty bill to pay.

(Female, 18-39, ABC1, London, Current Patient)

The nature of informed consent does not mean that patients would expect to be signing a contract confirming their willingness to receive treatment, but rather that they have been given a fair and balanced assessment of the situation and are put in a position whereby they understand and verbally consent to the work. This is especially important in the context of the 'distress purchase' as mentioned earlier in this report. Respondents commented on the need to have the situation explained to them as much as possible and be presented with the recommended treatment and its benefits, together with the risks of not undertaking the treatment. A clear outline of what the costs would also be at this stage is essential. Following this process will allow patients to rationally consider their options, feel like they have been treated fairly and could lead to increased levels of trust.

3.2.5 Guarantees and Quality Assurance

Respondents spontaneously commented on their frustration when dental treatment 'fails' within a close timeframe to when the work was carried out. Personal experiences included common issues such as a filling falling out, to more serious issues where infections were contracted during treatment. For some, there was recognition that everything will not work perfectly all the time, but there was concern that it is patients and their wallets which bear the brunt of these failures. Many expressed concerns that they felt powerless if a dentist carries out some expensive treatment and it fails or needs to be re-administered within the next year or so (or even longer in the case of very expensive treatment). Many felt strongly that a standard needed to be implemented which sees certain work 'guaranteed'; especially for treatment over a certain cost threshold.

I mean you pay a dentist to do a service. You don't pay a doctor for a service. You don't go and offer him money for what you're about to get, so it's totally different if it's a doctor to a dentist. A dentist you would expect them to do a standard of work the same as a plumber or anybody else who's doing any work or providing a service that you're paying for; and it should be guaranteed as well. I think there should be some sort of law out there... I think there should be a general guarantee that it should last x-amount of time or you don't have to pay.

(Male, C2DE, 40-55, Bradford, General Public)

Again, communication and management of expectations here continues to be an issue. Very often, if the dentist were able to say, now if you experience this, we will need to fix it, or this will only last for X years etc., that way people are prepared.

It could be very expensive. You could walk away and in 6 months time it could give you trouble and you could have visit after visit and never have satisfaction. With regular items you can take them back and complain up to 3 or 4 years in some cases, but where do you stand with dentistry?

(Male, ABC1, 56-70, Bradford, Lapsed Patient)

Whilst the issue of guarantees would exist outside the remit of the GDC, for both NHS and private patients, there is a need for the standards to acknowledge the extent to which patients feel powerless when it comes to this issue. When discussing what it means to 'put patients first', respondents felt that providing some level of guarantee would fit into this category.

Management of expectations is essential; this is perhaps comparable with, for example, 'possible side effects' warnings on medicine bottles, whereby patients are informed of possible things which could go wrong and what to do if they do. For the dentist to acknowledge issues and offer to sort them out, free of charge, if they fail within a certain timeframe, would allay many patients concerns.

3.2.6 Qualifications and Registration

Whilst awareness of the GDC was low, there was some understanding and expectation that dentists would be subject to a degree of scrutiny and regulation. As such, respondents commented on the reassurance provided by practitioner credentials – extending from certificates on the wall, to letters after the name, to explicit outline of the registrant's GDC number.

Being registered with a governing body – you know, it makes you feel confident. When you see that, you know, rather than somebody just practising without anything.

(Male, 18-39, C2DE, London, General Public)

Whilst not necessarily top of mind, the fact that qualifications are ‘taken for granted’ would suggest the need for a standard to be in place here to ensure that potentially vulnerable new patients are provided with reassurances of their dentist’s eligibility to practise.

It has been known that people have come from abroad as immigrants and say that they are dentists or doctors and they are not really so that should be tightened up.

(Male, 56-70, ABC1, Bradford, Lapsed Patient)

3.2.7 Costs

Although the GDC is unable to have any influence on how much a dentist charges for treatment, it would be remiss to ignore the issue of money in this report. Indeed, it was the single biggest issue for many respondents. Respondents did make a distinction and acknowledge that ‘vanity treatments’ which are mostly deemed unnecessary – e.g. teeth whitening and other cosmetic dentistry – would be expensive and there were no concerns with this, due to the voluntary nature of undertaking this type of treatment. Nevertheless, as discussed in section 3.3.1, active promotion of cosmetic dentistry fuels perceptions of the profession being overtly commercially focused.

A good example from the focus groups of effective warning of charges related to the display of charges on practice walls. Respondents were really positive about the three banding system and outlined of what treatment was available within each banding.

There is at the dentist I go to – and there’s a list of all the charges for NHS treatments which is really good. It tells you exactly what you are going to get for £45, exactly what you will get for £198. You don’t see that in every dentist’s do you?

(Female, 40-55, C2DE, London, Lapsed Patient)

Whilst private dentists may not wish to publicly display their charges, the effects this could potentially have on patient trust may be high. A display of charges would effectively manage expectations, which is especially important for members of the

public seeking treatment after considerable time away from the dentist.

3.2.8 Maintenance of Qualifications

Awareness of any particular schemes relating to continuing professional development (CPD), updating of qualifications or other courses was not widespread, however the majority of respondents assumed that something was already in place.

I assume that there is a programme of events that keeps them up to date like doctors do and going on retraining courses. I just naturally assume that if there is a 20 year old dentist that is newly qualified and a 60 year old dentist that is coming to the end, that the 60 year old dentist will have learnt the new techniques.

(Male, 40-55, ABC1, Bradford, Current Patient)

Whilst these assumptions were in place, there was widespread agreement that some level of CPD activity was absolutely essential. Nevertheless, many respondents in the groups expressed concerns that older, more experienced dentists may actually be more of a 'risk' due to old fashioned practices.

What is quite interesting is that the dentist who has 30 years experience, unless he gets retrained or goes on courses, who is to say he is in touch with the latest practises...?

(Male, 40-55, C2DE, London, Lapsed Patient)

This would suggest that dentists should be doing something to reassure patients of experience and of up-to-date techniques – something the GDC currently does through compulsory CPD for dentists. This is also a key aspect of current plans for Revalidation for Dentists, which the GDC is recently consulted on.

I think the thing is as well – you know, you're talking about checking on dentists' work. I have heard people say... and I've heard people saying 'don't go to the dentist in [named village], he's older; and he's old-fashioned'. Do they keep up their standards, and do they have to go on refresher courses, do they actually have to prove that they're keeping ahead?! And the rest of it. I think that kind of puts you off as well.

(Female, ABC1, 40-55, Rural Fife, General Public).

3.2.9 Other Standards (e.g. hygiene, confidentiality etc.)

There was a range of other standards discussed in the focus groups which respondents felt should be included and would already be included. Many of these felt were 'common sense' issues and self evident and therefore in-depth discussion was not widespread, although all were touched upon. These included the following:

- I. **Registration** with some form of **Protecting Vulnerable Groups (PVG) scheme** for those who will be dealing with children or other vulnerable groups.

Respondents – especially those with younger children – felt that it was essential that dentists and DCPs dealing directly with children and other vulnerable groups, would be registered with the appropriate protecting vulnerable groups scheme. There was a general expectation that this would already be in place; however, as with other standards, the provision of this information in practices would be beneficial.

Certainly [I would] expect police checks... I've never really thought about it. I trust him so I'm happy for my children to go there.

(Female, 18-39, ABC1, London, Current Patient)

- II. **Hygiene and cleanliness** in the practice were considered of utmost importance – no respondents in the groups expressed concerns over hygiene in practices they had visited in the past.

There was a widespread belief amongst current and lapsed patients and the general public that dentists, as with other healthcare professionals, would be subject to specific clinical health and safety procedures; this ranged from frequent washing of hands and use of gloves and masks, through to ensuring machinery and practices were suitably sterilised and clean. Health and safety was a standards issue which respondents believed should and would involve specific instructions, rather than guidelines.

The scientific stuff I would say [there needs to be some specific] instructions, definitely. That needs to be structured; procedures in doing whatever.

(Male, 18-39, C2DE, London, General Public)

- III. In terms of **confidentiality**, respondents agreed that looking after confidential information was important. It should be noted that many felt the records held by

dentists would not be the sort of thing they would be concerned with; nevertheless, compliance with Data Protection is always of key importance.

- IV. A large number of respondents felt that dentists should be regulated about their **timekeeping**. Patients were frustrated at being left in the waiting room, especially when they themselves are likely to be penalised for being late for an appointment. This proved most frustrating because of having to take time away from work, sometimes having to travel and occasionally being late for appointments due to circumstances outside of the patient's control.

NHS patients, in particular wanted to be given more time in the dentist's chair when appropriate. The prevailing attitude for many was that, unless you were being seen as a private patient – and thus of more potential profit to the dentist – there was a degree of 'production line' treatment; whereby the dentist appears keen to end the appointment as quickly as possible. Again, this is an equality of treatment issue.

With a private dentist, I think they give you more time and more options and they are there to kind of give you more of their expertise than an NHS dentist would.

(Female, 40-55, C2DE, London, Lapsed Patient)

- V. Only a minority of respondents felt it was important to provide **a dentist of the same gender as the patient** – a small number of female respondents felt this was important.

3.2.10 Display and dissemination of standards information to the public

There was widespread agreement that having information on standards made available to patients and the public would be beneficial. Outlining the key principles of standards, and what should be expected from dentist appointments, may go some distance to addressing mistrust of the profession and fear of these appointments by effectively providing a yardstick to measure performance.

Current and lapsed patients spontaneously said that displaying this information in dental practices would be beneficial for them. Displaying information in dental surgeries alone however is unlikely to attract the general public to return to the dentist and therefore, this would suggest the need to disseminate the information more widely – for example in other healthcare related waiting rooms such as hospitals and GP surgeries. This would also suggest the need for raising the profile of the General Dental Council in the public eye.

Respondents commented on the need to test dentists against these standards and to make the information available publicly – some discussed the possibility of a ‘mystery shopping’ exercise to assess the extent to which dentists were meeting the minimum operating criteria. Further, respondents spoke of online reviews similar to those found on the website *Trip Advisor*. Interestingly, a small number of respondents who worked in regulated professions were very much against this idea on the basis that they were unfair and one bad review could ruin a practitioner’s livelihood.

3.2.11 Summary and Key Sub-Group Differences

The issues raised above were commonly held across all groups and show the need for a comprehensive set of standards across the dental profession in the UK. Respondents’ attitudes would suggest that if an appropriate set of standards is produced and adhered to, trust in the profession could conceivably shift. A majority of respondents, irrespective of socio-economic grouping, gender, previous and current use of dentists, hold some level of concern about the cost of dental treatment, mostly borne of frustration at a lack of choice and availability of NHS spaces, together with concerns of being coerced into unnecessary treatments. Whilst little can be done by the GDC itself about the former (NHS spaces), improvements to communication, provision of evidence and level of consultation would go some distance towards bridging the gap between dentist and patient.

The general public represent those who could be considered most vulnerable in the sense that there is often a very strong fear of the dentist, highlighting the need for effective communication and reassurance throughout. Lapsed patients sometimes share the fear of their general public peers however treatment as an NHS patient seems to be their major concern with the profession which has led to mistrust, whilst current patients were more mixed in their attitudes and concerns.

In terms of what standards should be included and developed, there were no notable differences between groups and types of respondent. The table below summarises the proportions of respondents who felt certain issues were important in the consideration of standards development.

Issue	No.
Consulting with patients on choice of treatment	78
Ensuring confidentiality of patient information	65
Treatment of children	65
Display of information relating to qualifications / regulation	65
Providing the opportunity for feedback / to make complaints	55
Time-keeping	49
Ability to provide a dentist of the same gender as the patient	18

3.3 Ethical Advertising

The second issue to be discussed in detail at the focus groups was ethical advertising for dentists and dental practices; this formed part of the GDC public consultation on the draft Ethical Advertising guidelines. The groups assessed use of the term specialist and alternatives, how practice and dentist information is advertised and ways to maintain trust and quality assurance for the public; this included how dentists' names and qualifications are presented. Attitudes to advertising are important in terms of gauging trust in the profession in the long-term. As a prompt, respondents were shown a series of 'mocked-up' dental advertisements presented in various ways – a copy of the ads used is appended to this report at Appendix C.

3.3.1 Advertising (General Comments)

In general, when it comes to advertising in, for example, *Yellow Pages*, local news and other publications, respondents were often unable to say specifically what they are looking for. When searching for a new dentist most said that they would principally go on word of mouth recommendation and a practice which was reasonably local to them. This meant that required information was usually limited to a named contact, telephone number, web / postal address and whether there are NHS spaces available. Once prompted with the stimulus materials, a much more in-depth discussion of the issues ensued.

Initially, a high proportion of respondents in the groups struggled to recall any dental advertising they had actually seen in the recent past. When discussing the issue a little further, many commented on recent increases in advertising for cosmetic dentistry alone. This raised an interesting point in perceptions of the profession. As previously mentioned, many commented on a feeling that dentists are more businessmen than healthcare professionals. An increase in active promotion of expensive, and what are traditionally viewed as unnecessary cosmetic treatments, appears to be fuelling this issue further albeit, as previously noted, that respondents recognise the voluntary nature of having cosmetic treatment undertaken.

Cosmetic stuff – whitening of teeth and stuff. I've seen a lot more of that recently.

(Male, 18-39, C2DE, London, General Public)

This advertising of cosmetic dentistry, fuelling perceptions of dentists' focus on commercial interests at the expense of healthcare per se, appears to be compounded by dentists promoting cosmetic treatments during check-ups and other treatments.

I do notice though that every time [my children] go [to the dentist], especially the older girls, they say "have you thought about teeth whitening? Have you thought about that?" They don't do that in the NHS but in the private ones they tend to plug more the cosmetic side... Well I think that they have got lovely teeth and there is nothing wrong with them and now they say to me "Mum I think I will get it done when I am 21" They have sowed the seed. I am not very happy about it but what can I do?

(Female, 40-55, C2DE, London, Lapsed Patient)

3.3.2 Patient and Public Preferences (Advertising)

Of the mock advertising materials shown, in all groups, the most widely preferred ad was for 'The Bridge End Dental Surgery' as shown in the picture below. The following paragraphs outline the reasons for this.


Private and NHS places available

The Bridge End Dental Surgery

All our staff are registered with the General Dental Council and our practice
British Dental Association (BDA) approved

Dr. Rowan Clark, BDS, PhD
Dentist and Orthodontics Specialist
General Dental Council Registration Number: 123456789

Call us now:
Visit us at:

GENERAL DENTAL COUNCIL 

3.3.2.1 Approved and Quality Assured

Whilst awareness of the GDC, and of professional Dental associations such as the BDA, was low across the groups, respondents maintained that branding from any professional associations or regulatory bodies was a very positive thing to display. This is especially important when considered in the context of patient mistrust and need for reassurance. Awareness may have been low, but there was an expectation that such bodies exist and as such, including any relevant information of which bodies practitioners are registered with, supported by or endorsed by adds reassurance.

I like how they've put the General Dental Council and the BDA...

(Male, C2DE, 56-70, Rural Fife, Current Patient)

It does add a certain gravitas.

(Male, ABC1, 40-55, Bradford, Current Patient)

3.3.2.2 Registration with the General Dental Council

Similar to the point above, but more specifically related to the GDC, respondents were very positive about the phrase: *'All our staff are registered with the General Dental Council and our practice British Dental Association (BDA) approved'* in addition to the inclusion of the GDC registration number listed under the dentist's name. Many commented that this was reassuring and added a strong degree of credibility to the advertisement in addition to 'looking professional'. One respondent commented that the inclusion of the registration number would be the sort of thing they could look up if they were uncertain or were looking for further information.

Get the registration number as well. You'd think you could look at like on the Internet you get a check-up and more information about it, you know?
(Female, C2DE, 56-70, Rural Fife, Current Patient)

You can get that number anyway, I'm sure but it's reassuring that it's there to see.
(Male, ABC1, 18-39, London, Current Patient)

3.3.2.3 Availability of Places

Respondents were also positive about the information relating to whether or not NHS spaces were available, though some were cynical about whether or not this claim would be legitimate.

It says private and NHS available. The fact that it says 'available' it's a bit more welcoming. Yeah, chances are he does have space on his list...
(Female, 18-39, C2DE, General Public)

3.3.2.4 Presentation of Name

Use of titles and terminology will be dealt with in section 3.4 of the report. However, on a more general level respondents appreciated the inclusion of the dentist's name on the advertisement

I like the inclusion of the doctor's^[sic] name there... it makes it more personable as well.
(Male, 18-39, C2DE, London, General Public)

Respondents were also positive about how the dentist's name was presented: that is, title, qualifications, registration number and areas of operation.

3.3.3 Advertising Issues of Concern

Respondents in the focus groups tended to be highly 'literal' and therefore there was a significant amount of weight placed on what the advertising was promoting. Although this may not appear to be of immediate salience to the GDC, there are perhaps some interesting findings to be drawn from this.

A majority in the groups were highly averse to advertising relating to cosmetic dentistry. For most, this type of treatment was deemed as expensive and unnecessary and there appeared to be concerns over what dentists in the UK would be focussing on. Again, this relates strongly to the issue of dentists operating primarily as businessmen rather than healthcare professionals. Whilst few objected to the practise of cosmetic dentistry, and recognised that cosmetic treatment is voluntary (see section 3.2.7) many were strongly off-put by it being the principal focus of a practice.

**SMITH GALLAGHER
COSMETIC DENTAL PRACTICE**


'Achieve the perfect smile from only £99'
Come in for a **free** consultation on all cosmetic work

We have a special interest and wealth of experience in all forms of cosmetic dentistry including:

- Teeth whitening
- Dental Implants
- Teeth straightening
- Veneers
- Smile Makeovers

**No obligation
No appointment necessary**

Call us on [REDACTED]

In the case of the example above, respondents frequently commented on the lack of any reference to healthcare treatments.

The first one makes so much emphasis on the cosmetic... Free consultation straight away [arouses] suspicions.

(Male, 56-70, ABC1, Bradford, Lapsed Patient)

As was the case discussing standards, respondents also raised concerns over the presentation of costs information. In the 'Smith Gallagher' example, a large number of respondents felt that the term 'from £99' was not credible or trustworthy. There was a prevailing attitude that upon consultation, recommended treatment would be significantly more expensive.

I mean, it is car sales. Buy a car for a minimum of £8995. It's £99; it's teeth whitening; it's all cosmetic. The only one that mentions anyone's qualifications really is the second one [Bridgend].

(Male, 40-55, ABC1, Bradford, Current Patient)

A high proportion of respondents also spontaneously commented on a general dislike for perceived frivolous or insincere advertisements, on the grounds that they 'cheapen' the perceived importance of dental care. Whilst a small proportion liked the example, the advertisement below attracted negative comment on this basis.

MICHAEL SIMPSON DENTAL TECHNICIANS
'Time for new dentures? Say cheese!'

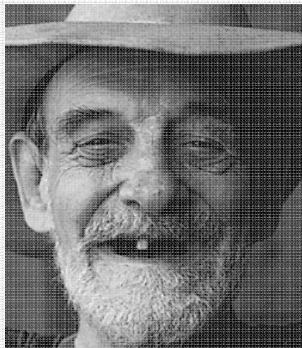
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3.3.4 Use of Terminology and the Word 'Specialist'

In terms of the presentation of information, a considerable degree of time was spent discussing terminology and the circumstances when it could be considered to be misleading. One potential issue is use of the term 'specialist' when the practitioner is not registered on a specialist list for the discipline, e.g. cosmetic dentistry, where no such specialist list exists

The majority of those participating in the research were unaware of the nature of specialists in the dental sector and of specialist lists. The only respondents aware of specialist dentists were those had previously been referred to see a specialist, or those for whom a family member had been referred (e.g. a child to an orthodontist). No respondents in the groups were aware of a wide range of specialist 'types'.

When discussing the term 'specialist', most felt that this would signal some further qualification level to that of a 'normal' dentist or at least that this area makes up the majority of that practitioner's work. There were no evident differences of opinion or awareness at sub-group level.

It's like I do a lot of DIY at home.... It doesn't make me a DIY specialist because I've been doing it for ten years!

(Male, 18-39, C2DE, London, General Public)

If I went to my dental practice and they said Dr So-and-so in the room next door specialises in that. He mainly does cosmetic work rather than something...! I would look for someone who was doing, you know, the majority percentage cosmetic work... that to me would be 'specialist'.

(Male, 18-39, C2DE, London, General Public)

When discussing presentation of a practice or practitioner as 'specialist', there was some debate between respondents. There was an agreement that a standard practice dentist whose work is primarily constituted of non-specialist treatments, should not claim to be a specialist in any area, unless they are technically qualified to do so. The emergence for example of the cosmetic dentistry market, however makes for a very interesting discussion. Presenting oneself for example as a 'cosmetic specialist' has the potential to be considered misleading in light of the fact that no such specialist list exists. However, it is important to note that no respondents spontaneously raised any objection to any references to, for example, 'cosmetic specialist' or 'specialist denturists'.

There was a degree of ambivalence, and at times confusion, when discussing this issue in the groups. For some presentation of oneself as a 'specialist' when no such list exists would be misleading and therefore should not be allowed. For others however (a minority across the groups), there was a feeling that if the vast majority of that practitioner's work is made up of that particular type of treatment, then advertising themselves as a 'specialist' could perhaps be perceived as accurate.

If you have the experience and you have been doing it then why shouldn't you be allowed to [call yourself a specialist]?

(Male, 56-70, ABC1, London, Lapsed Patient)

That's fine, but specialist implies that they're the best person... You would have to justify that.

(Male, 40-55, ABC1, General Public, Rural Fife)

In the summary questionnaire, more than half of all respondents (43 out of 83) **disagreed** with the statement *dentists should be allowed to describe themselves as 'specialist' on the basis of experience, even if no such specialist list exists*. Twenty-six respondents agreed with the statement. This shows a split in the extent to which use of the term specialist is misleading however the balance of opinion would suggest that it is.

It depends on how they do it. If it's... 'I am a specialist in...' then they must have gone through their qualifications or their exams – whatever it is - but then if they can say. 'I have done a thousand dental implants in the last ten years'. That's fine, that's a statement of fact. Shouldn't concern me...

(Male, 40-55, ABC1, Rural Fife, General Public)

When discussing appropriate substitutions for the term 'specialist', respondents were undecided as to what the most appropriate terms would be. Whilst most agreed that 'special interest' was acceptable, there were concerns that this terminology does not actually suggest any form of expertise.

Special interest – I have a special interest in my local football team that doesn't make me an expert on it.

(Male, 40-55, C2DE, London, Lapsed Patient)

3.3.5 Key Sub Group Differences

Overall, there were no evident sub-group differences, although some current patients appeared less *concerned* about the issue than others.

3.4 Use of the Title Doctor (Dr.)

It is important to note before outlining the main findings relating to courtesy titles, that dentist use of the term 'doctor' was not a top of mind issue amongst respondents. Overall respondents focus on issues relating to the cost, duration and any pain associated with dental treatment and give little thought to any titles used, perhaps based on an assumption that any titles used are fully justified. However, after some discussion around the topic, the issue became quite provocative and evoked a lively discussion. To stimulate discussion, respondents were presented with a series of names and asked to select their preferences in terms of how each name was presented and why.

There was a very mixed response and some confusion when respondents were asked, unprompted about the use of the term Doctor. A small number of respondents were under the impression that all dentists automatically qualified to use the courtesy title, whilst others were aware – or assumed – that this should only apply to those with a medical degree and / or a PhD. There was a large proportion which was simply unsure what to think.

3.4.1 Patient and Public Preferences (Titles)

It is perhaps not surprising that, given the nature of dental treatment, all respondents appeared naturally drawn to those names which appeared more qualified or 'grander'. This meant there was a natural pull to names which displayed:

- The title 'Dr.'
- Letters after the name relating to qualification, e.g. BDS, MDS
- Terminology which respondents were unfamiliar with and which looked impressive

'Well I would assume that a doctor of dentistry has got more qualifications than a Mr'.

(Male, 40-55, ABC1, Bradford, Current Patient)

They've got further qualifications from standard dental work. So they could be Mr and Mrs... but saying 'Dr' you know they're a step above.

(Female, 56-70, C2DE, Current Patient, Rural Fife)

When considering the context of mistrust and fear of the dental profession in general, one would perhaps have expected that patients and the public will have a natural preference for the title doctor, over any other. By respondents own testimony, the term carries with it a certain gravitas, which suggests a high level of qualification and of skill. When presented with show cards displaying the same name but with the title Doctor rather than Mister, respondents were naturally drawn to those with 'Dr.'.

I like the one with all the qualifications... and the 'doctor' reassures me more.

(Female, 18-39, ABC1, London, Current Patient)

It is important to interpret this finding with a degree of caution as patients and the public are unlikely to choose a dentist in this way. However, when considering the context of patient choice evaluation, it suggests that there could be a naturally inflated sense of trust when being examined by a dentist with the title doctor. As such, any instance of discovering that a dentist is using the Doctor title when not appropriately qualified to do so is likely to impact adversely on patients' and the public's trust in the profession as a whole.

Whilst letters appear to add a strong degree of credibility to a professional's abilities and qualifications for some, for others, perceived 'meaningless terminology' or a full presentation of degree qualifications (e.g. Bachelor of Dental Surgery) were unengaging and perhaps viewed as 'overkill'.

[I like] the use of the initials... They've got all their qualifications there you can see.

(Male, 40-55, ABC1, General Public, Rural Fife)

Within the current patients groups, there was often less engagement with this topic – a product of the slightly higher levels of trust felt towards the profession. Lapsed patients and general public – notably more mistrusting of the profession – were more engaged in general with the subject. Irrespective of levels of engagement, there was a natural propensity to prefer names presented as doctor and with letters after the name.

It was evident in the groups that there is confusion about the circumstances in which the term doctor and letters should be used and it is important to note that current patients were no more aware of the issue than lapsed patients or the general public.

What between the Dr and the Mr? I don't understand enough about medical qualifications. If you are an orthodontic surgeon, well I don't know. I know other surgeons called Mr. I don't know what the hierarchy of dentistry is. I don't know what the difference is between a Dr and Mr of dentistry?

(Female, 40-55, ABC1, Bradford, Current Patient)

Dentists they are doctors I know that for a fact... They are they are all called doctor.

(Female, 56-70, ABC1, London, Lapsed Patient)

They should be able to call themselves doctor.

(Male, 40-55, ABC1, Rural Fife, General Public)

The extent of public and patient confusion and uncertainty with respect to this issue would suggest the need for the GDC to clarify its position on the issue – and this may have knock-on impacts on the standards review.

3.4.2 Use of the title Doctor (Dr.)

For the last 15 years dentists have been able to use the title of Doctor and GDC policy has stated that dentists would not be prosecuted for calling themselves 'Dr'⁵ unless they did so in a misleading way. However, the current GDC proposal is that the use of the term Doctor (or the abbreviation Dr) by Dentists should be limited to practitioners who have a PhD or who are medically qualified and registered Doctors.

In one of the groups, a respondent highlighted the importance of the issue in reference to the drugs which can be prescribed by dentists, which potentially has relevance to the standards review.

I thought dentists are automatically doctors... because they can also give you a prescription if they find something, you know, to do with the back of your throat, they can prescribe and they can also then refer you on to a hospital.

(Female, 18-39, C2DE, London General Public)

⁵ It is against the law, for a dentist or DCP to use any title or description 'reasonably calculated' to suggest that (s)he has a professional status or qualification other than one which is indicated against his/her name in the register; however, cases alleging misuse of titles, descriptions or qualifications by dentists or DCPs can be dealt with through GDC fitness to practise investigatory/disciplinary processes.

The above statement highlights the need to ensure full transparency on this issue in terms of what a dentist's qualifications are and indeed what they are entitled to do under that qualification. This is also important to consider in the context of patient consent and effective communication as some patients and members of the public may be reluctant to accept prescriptions or certain types of pain relief if being treated by someone who does not have a medical degree.

Upon prompting in the groups that dentists do not qualify as doctors without a PhD or medical degree, most were adamant this should not be allowed.

I mean I could call myself HRH but I am not. It's a similar thing isn't it?
(Male, C2DE, 56-70, Bradford, Lapsed Patient)

Almost across the board, respondents agreed that if a dentist uses the title Dr and is not qualified to do so this is very misleading – in fact in the summary questionnaires, only 7 of the 83 respondents felt that this should be allowed. Seventy-three respondents said they should not be allowed to use the title.

The strength of feeling demonstrated by respondents suggests that there is a view that dentists who do not hold PhDs or medical degrees should be stopped from using the title. Whilst a small number were apathetic towards the issues, the vast majority felt this was highly misleading and should not be allowed.

3.4.3 Attitudes to Enforcement

This intensity of concern fed into attitudes toward enforcement by the GDC of use of these titles. Seventy-three respondents (out of 83) from the summary questionnaire agreed that the GDC should be taking action against those falsely declaring themselves to be doctors. In all groups, either all respondents or a large majority of respondents who completed the summary questionnaire felt that the appropriate punishment would be to take disciplinary action against those dentists. It is important to note that in the context of the discussions this view was held most strongly by those with a greater level of mistrust of dentists in the first place – especially general public and lapsed patients.

3.4.4 Key Sub Group Differences

The balance of opinion on this issue was strongly in favour of the GDC's proposals to take action against any practitioner erroneously presenting themselves as 'doctor'. Only a small number of respondents felt that this was acceptable practice – these were respondents with no real engagement with the topic; whether current patients

who have no issues with their dentist and no previous bad experiences, or general public with no intentions of visiting a dentist again and no particular reason to be concerned.

4. Summary, Key Findings and Conclusions

4.1 Summary and Conclusions

The research appears to confirm the need for the GDCs strategic review of standards with a focus on publishing an updated set of Standards that take into account patient and public priorities. This would appear to be especially important for ‘lapsed patients’ who – although most still intend to visit the dentist – appear concerned at how they are treated when undergoing NHS treatment and the ‘general public’ who are mistrusting and highly fearful. On the surface, the concerns of ‘current patients’ appear less pronounced, but there are still levels of concern and cynicism; these are mostly based on costs. One of the main concerns is the perception that dentists have become more business and money focussed, rather than healthcare focussed.

4.1.1 Standards

In taking forward the standards review, and standards development, it is important to bear in mind the circumstances in which treatment is administered, especially for lapsed patients and the general public. In the context of a ‘distress purchase’, those undergoing treatment are in a particularly vulnerable position, concerned about both the pain (current and ensuing) and the impending costs of the treatment. Therefore, it is perhaps not surprising that the need for comprehensive standards is underpinned by patients’ need for reassurance. The key areas suggested by respondents, which should be considered for inclusion in the standards framework, include, most importantly:

- Communication;
- Provision of evidence: both in terms of qualifications and registration, and for why certain treatment is recommended;
- Consultation on treatments and the acquisition of informed consent;

Other key issues, of slightly lesser importance, which should also be considered, include:

- ‘Guarantees’ on treatment and some level of quality assurance;
- Information relating to how much treatment is expected to cost;
- Maintenance of professional qualifications through continuing professional development (CPD);
- Hygiene, cleanliness and Health and Safety;

- Treatment of children and other vulnerable groups; and
- Maintenance of confidentiality of patient records.

Whilst the extent to which patients and the public will invest time in reading detailed dental standards documentation remains inconclusive, there was a general acceptance that widespread publication of these standards would be expected. Indeed, the production of a simple leaflet and more detailed information which addresses the concerns of lapsed patients and especially the general public could play a role in restoring an element of trust in the profession. Highlighting what patients should expect from dental appointments could, for some, encourage a return to preventative dental treatment.

4.1.2 Ethical Advertising

An increase in awareness and demand for cosmetic dentistry in the UK is reflected in the visibility of dental advertising. The majority of respondents were unable to recall much specific advertising they had seen relating to dentistry in recent months, other than that relating to cosmetics.

Advertising information that is valued by patients and the general public in the UK, should be credible and trustworthy. It needs to:

- Demonstrate Quality Assurance (e.g. BDA approved and / or registration with various other professional bodies)
- Confirmation of General Dental Council registration and display of registration number(s);
- Availability of NHS places (if applicable);
- Information on the specific qualifications of the dentists themselves.

On balance, the majority of respondents agreed that using the term 'specialist' when not registered on a GDC specialist list was misleading. Although awareness of GDC specialist lists was limited, most felt that to be a specialist there would be an expectation of some additional qualification and/or that the vast majority of treatment administered would be within that field.

For around a third of respondents involved however, there was a feeling that if a dentist solely / primarily carries out, for example, cosmetic treatment, has years of experience and has undergone specific training, then they could be entitled to use the term 'specialist'.

Whilst terms such as 'special interest' are not seen as misleading, there were some concerns that this does not actually convey any level of expertise in the field. Use of the term specialising attracted a mixed response – on balance a slight majority would agree that this is acceptable, providing the practitioner only or mostly operates in the relevant field.

4.1.3 Use of the Title Dr.

Respondents appeared naturally drawn to dentists whose title was 'Dr.' as this conveys a level of competence and experience which 'Mr' or 'Ms' for example, do not. As such, the vast majority of respondents were adamant that those presenting themselves as a 'Dr.' without a PhD or medical degree should face sanction, with 73 of the 83 surveyed agreeing that the GDC should take some form of disciplinary action against such practitioners. When discussing what the consequences should be, some respondents spontaneously commented that dentists should be "prosecuted" or "struck off". There were no evident differences of opinion between the various subgroups about the need for disciplinary action.

4.2 Key Findings

The findings from the research support the GDC's strategic review of standards and its objective of providing an up-to-date and relevant set of standards outlining the key operating principles for dentists in the UK. There can be little question that trust is a key issue for the patient/professional relationship. The following paragraphs outline our key findings based on the results of this research project.

4.2.1 Standards and Communication

The research would suggest the need for the production of an updated cohesive set of standards, written in a way which is easily understood by patients and members of the general public. The development of these standards also presents two further opportunities: to raise the profile of the General Dental Council and to provide some positive information about dentistry in the UK for use in the media.

There is a need to ensure that the standards strike an appropriate balance between specific instructions (e.g. health and safety) and guided principles (e.g. communication). An approach that combines the strengths of both approaches may be most appropriate.

4.2.2 Publication and Information

It is essential that the information included in the new standards is clear and comprehensible to the general public⁶. In order to reassure patients of what they can expect from dental care, it is important that this information outlines what patients should do if they are concerned about treatment they have received or wish to complain.

4.2.3 Dissemination of Information

Respondents stated that a natural place to display this information would be in dental practices; however this is unlikely to have the necessary presence to reach the general public who are one of the most important groups to reach in terms of encouraging the restoration of trust in the profession. Therefore, it would be sensible to ensure that standards information is made available in other healthcare related waiting rooms, e.g. doctors' surgeries and hospitals. Furthermore, providing this information to patients who are applying to join a particular practice might be a useful exercise.

4.2.4 Revalidation and standards compliance

Some patients and the public want to be re-assured of a professional's continued fitness to practice. As part of revalidation, dentists could be 'tested' against these standards. This information should be made available publicly – some respondents discussed the possibility of a 'mystery shopping' exercise to assess the extent to which dentists were meeting the minimum operating criteria.

⁶ The GDC's 'Smile' leaflet* may provide a useful exemplar for standards publication i.e. an accessible, succinct, attractive piece of literature which clearly outlines what patients should expect from an appointment with the dentist.

4.2.5 Advertising

Key findings arising from the research that the GDC may wish to consider as part of the Ethical Advertising guidance include:

- Dentists should provide information on their registration with the GDC (including registration numbers where possible);
- Practices should include logos of any other professional bodies with which they are registered or through whom they have accreditation;
- Practices should display whether or not NHS patient spaces are available;
- Dentists and practices should not advertise themselves as specialists in any area where no such specialist list exists.

4.2.6 Use of the Title Dr.

In light of the fact that there is a strong degree of public and patient confusion around dentists' use of the courtesy title doctor, the GDC would want to consider these views as part of its response to the Ethical Guidance consultation. Once explained, the prevailing view of patients and (informed) members of the public, is that dentists should not be permitted to use the courtesy title 'Dr.' except where a medical degree or PhD is held. Moreover, those purporting to be a 'Dr.' without relevant qualifications should be subjected to disciplinary action.

APPENDIX A



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6520 GDC Focus Groups **Topic Guide**

The following question areas have been developed to provide a framework for discussion. All relevant topic areas should be discussed and covered at some stage during the group session, but should be addressed in such a way that facilitates a relaxed and natural flow of conversation.

Introduction / Background (10 mins)

- Introductions and recap on the aims of the discussion i.e. *we are carrying out some work for the General Dental Council looking at some important issues related to dentistry in the UK.*
- Remind respondent of MRS Code of Conduct which ensures full confidentiality and anonymity for all respondents;
- When was the last time you visited a dentist and how would you describe your commitment to visiting the dentist and why; (if not visited at all what are the barriers);; to what extent do you feel going to the dentist is important / unimportant and why;
- What are your views on dentistry in the UK; **is it a profession that can be trusted** – if so, why, and if not, why not; how have these views affected your likelihood to visit a dentist;
- Have you heard of the General Dental Council before; if so, what experiences have you had with them before and if not, what do you think they do;

[MODERATOR TO READ OUT] The General Dental Council (GDC) regulates the practice of dentistry in the United Kingdom, Its aim is to protect dental patients. All dentists and dental care professionals (DCPs), both NHS and private, are required by law to be registered with the GDC in order to work in the United Kingdom. There are 94,000 dentists and dental care professionals registered with the GDC. The GDC was established by parliament and is wholly independent of the government and the National Health Service.

In addition to registration, as outlined above, the GDC protect the public by:

- helping patients and where appropriate investigating complaints about dental care
 - setting standards of dental practice and conduct
 - assuring the quality of dental education
 - ensuring professionals keep up-to-date with skills and knowledge
-
- Have you ever had a problem with a dentist before; if so what was the nature of that experience and how, if at all, was it resolved;

Standards for Dental Professionals (25-30 mins)

- What industries can you think of which are not regulated; what are the implications of this; what are the main benefits of regulation in terms of **'trust'**; probe fully
- (if relevant) when visiting the dentist, to what extent do they trust the opinions and actions of the dentist and why; how should this feature in the standards;
- How aware are respondents about patient safety and quality of care issues (probe for specific issues);
- To what extent do you feel that dentists should have set 'standards'; what do standards mean to you as a patient/member of the general public;
- How should these standards be reviewed, monitored, enforced and why;
- What are the key factors against which dentists should be judged in terms of best practice standards: e.g. Communication, hygiene, appearance, cost of treatment etc. (WRITE KEY FACTORS ON FLIP CHART)
- For each of these factors what would you describe as the key factors for a dentist to be performing to the highest standard: Probe fully for;
 - Communication (probe)
 - Hygiene
 - Appearance (Don't probe too much NB GDC cannot influence this)
 - Charges / cost of treatment
 - Any others
- How important are each of the following and how would you expect each to be displayed in real terms:
 - Putting patients first
 - Ensuring confidentiality of information
 - Time/timekeeping
 - Provide opportunity for complaint / feedback
 - Treatment of children
 - Consultation / choice of treatment
 - Gender / choose a same sex dentist
 - Provide information on / introductions for others involved in your treatment (e.g. nurses etc)
 - Provide information on qualifications / registration
 - Justify the treatment they have provided at a visit

- Where would you expect to find information on dentist 'standards'; should there be information for the public on this and why; how should they be accessed/used;
- To what extent can the establishment of set standards develop patient trust in the profession and why; should they be accessible to patients and the public;
- To what extent should they be minimum guidelines and to what extent should they be comprehensive guidance and how do you see this working in practice;

SCENARIOS – TO BE USED TO PROMPT DISCUSSION IF AND WHEN REQUIRED

Scenario 1: You have relocated and you are searching for a new dentist for you and / or your family, how would you decided about which dentist to visit (recommendation, word of mouth, research etc) would you do to ensure the practice / dentist was appropriate for you? What reassurances would you is looking for to ensure confidence and trust in the dentist / practice?

Scenario 2: You have been suffering significant pain in one of your teeth and are worried that it will require some painful and potentially expensive treatment and so decide to make an emergency appointment with the dentist. Talk me through the visit to the dentist on this occasion (*assume you need to undergo treatment*) – from arriving at reception, to being seen by the dentist, the treatment itself and post treatment. How do you feel at each stage and what are your expectations.

Scenario 3: You have been to visit your dentist and have come away with some concerns about the practice, in terms of meeting a set of minimum standards; you have come away feeling uncomfortable about going back to the practice in future, where would you go for more information about what to do next and what information would you be looking for; what would be your next course of action and why;

Ethical Advertising (20 – 25 mins)

- What pieces of advertising have you seen in recent months for anything related to dentistry; Prompt if struggling:
 - Yellow pages
 - Local newspaper
 - Banners outside surgeries
 - Advertising for teeth whitening / cosmetic dentistry
 - Surgeries advertising NHS or other spaces
- Where was this advertising seen and what was the nature of it; what drew your attention to the advertising;
- When you last chose/if you were choosing a dentist, how did/would you go about it; What sorts of advertising would you be looking for, what would be the key messages a surgery would have to impart to attract your interest;
- What restrictions would you expect to be placed on dentists and surgeries in their advertising to ensure accuracy and trust;
- How would you decide what was a justified claim in a dental advert and why; what would you do if you felt you had seen a misleading/ambiguous claim on an advertisement; what should the GDC do;
- Look at these examples of some dentist advertising – which do you feel would be most trustworthy and which are least trustworthy and why; which are most appealing for you and why; How do you feel about use of the following terms and phrases and why;
 - ‘Specialist’, what does this say to you;
 - ‘Special interest’;
 - Orthodontist
 - Smile/Cosmetic Specialist
 - Denture Specialist
 - What terms in these ads are confusing or strange and why;
 - Do you understand them?
- Are any misleading? Do they affect your trust, choice etc? [Probe on use of ‘specialist’ in the context that to be a ‘specialist’ you need to be certified in one of 13 specific disciplines]
- Should dentist ads have GDC branding or links to the GDC website / contact details; if so why, and if not, why not; if advertising has GDC branding / links, what would this suggest to you; would it look like the GDC has ‘endorsed’ the ad;

Use of the term Doctor (Dr.) by Dentists (up to 20 mins)

CUE CARDS EXERCISE

- I'm going to show you some names and I would like you to imagine that this is the name of your new dentist, each name will be presented in 3 different ways and I would like you to tell me which is most appealing to you and why, but also what your expectations would be in terms of the qualifications and expertise of that practitioner:
 - Miss Clark; Miss Clark, Dental Care Practitioner; Miss Clark, Dentist
 - Dr Smith; Mr Smith; Dr Smith, BDS
 - Dr Jameson, BDS – Bachelor of Dental Surgery; Mr Jameson, BDS – Bachelor of Dental Surgery; Dr Jameson BDS, BSc (Hons), PhD
 - Dr Brown, Specialist Cosmetic Surgeon, Mr Brown, Cosmetic Surgeon, Mr Brown, Cosmetics
- What is your understanding of titles which can be used by dentists; (If you have a dentist) How do you address your dentist; how would you refer to him/her outside the surgery;
 - Do you use the term Dr or Mr / Mrs / Ms etc.;
 - If don't know, what title would you expect a dentist to have and why;
- If your dentist used the term Doctor, what expectations would you have about his/her qualifications and training and why;
- Should all dentists be entitled to use of the term – irrespective of whether they have a medical degree or PhD – and why/why not

MODERATOR NOTE: explain the GDC rule about use of the term Doctor – courtesy title only
NB in the rest of Europe and other countries such as the States, when people have studied for 5 years a dentist they do qualify as a 'Dr'.etc

- Would you prefer to you use a dentist with the title 'Dr' or 'Mr'/'Mrs' and why; if you have a dentist, do you know what their title is; do all dentists have the same title;
- How do you feel about the use of the term Dr. (in light of the information that this is a courtesy title only); what are the key implications of this; how does this equate with other professions, e.g. if a teacher used the term 'Dr', but did not have a PhD;
- What action should the General Dental Council take – if any – of dentists who use the title Dr., but have no PhD or medical training and why;

Conclusions - What actions should the General Dental Council be taking to ensure that the profession is one which is seen as 'trustworthy'?

Appendix B: Summary Questionnaire & Results

APPENDIX B



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General Dental Council Summary Questionnaire

Many thanks for participating in these important focus groups we are carrying out on behalf of the General Dental Council. Having taken some time to discuss the issues, we would like to ask you a few short questions to assess your views on the subjects raised.

Q1. To what extent do you agree with the statement: ‘Dentists should be subject to a set of minimum standards outlining a code of behaviour’? PLEASE TICK ONE ONLY

Strongly agree	68
Agree	14
Neither agree nor disagree	-
Disagree	-
Strongly disagree	-
Don't Know	1

Q2. Should these be ‘guidelines’ or a set series of specific instructions? PLEASE TICK ONE ONLY

Guidelines **39** Specific Instructions **41** DK **3**

Q3a. Which do you feel are the most important factors which dental standards should address? PLEASE TICK ALL THAT APPLY IN COLUMN A BELOW

Q3b. And which do you feel are the least important factors which dental standards should address? PLEASE TICK ALL THAT APPLY IN COLUMN B BELOW

	A Most Imp	B Least Imp
Consulting with patients on choice of treatment	78	1
Ensuring confidentiality of patient information	65	9
Time-keeping	49	22
Providing the opportunity for feedback / to make complaints	55	9
Treatment of children	65	2
Ability to provide a dentist of the same gender as the patient	18	54
Obtaining patient consent	68	5
Display of information relating to qualifications / regulation	65	5
Something else (please write in below)	9	3
.....		
None of the above	-	10
Don't Know/no reply	2	8

Q4. To what extent do you agree with the statement: ‘Dentists should be allowed to describe themselves as a ‘specialist’ on the basis of experience, even if no such specialist list exists’? (For example, there is no specialist list for cosmetic dentistry; should dentists experienced in cosmetics be allowed to describe themselves as ‘a specialist’?)

Strongly agree	11
Agree	15
Neither agree nor disagree	12
Disagree	19
Strongly disagree	24
Don't Know/No Reply	2

Q5. Which of the following words or phrases would you support the use of, in replacement of the term ‘specialist’? PLEASE SELECT ALL THAT APPLY

Specialise in...	31
Experts in...	26
Leaders in...	4
Experienced in...	40
Dedicated to...	14
Other	3
Don't Know/No Reply	5

Q6. Do you think all dentists should be allowed to use the courtesy title ‘doctor’ (Dr.) irrespective of whether or not they have a medical degree or PhD? PLEASE TICK ONE ONLY

Yes 7 No 73 DK/NR 3

Q7. Should the GDC take any disciplinary action against a dentist using the term Dr. when they do not have a PhD or medical degree?

Yes 73 No 7 DK/NR 3

THANK YOU VERY MUCH FOR YOUR TIME

Appendix C: Advertising Materials

APPENDIX C



GEORGE STREET
RESEARCH

24 Broughton Street
Edinburgh EH1 3RH (UK)
Tel; +44(0)131 478 7505 Fax; +44(0)131 478 7504
Email; info@george-street-research.co.uk
VAT No: 502 484862

Registered Office:
St Paul's House
Warwick Lane
London EC4P 4BN (UK)
No: 2364135

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No obligation

No appointment necessary

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All our staff are registered with the General Dental Council and our practice British Dental Association (BDA) approved

Dr. Rowan Clark, BDS, PhD
Dentist and Orthodontics Specialist
General Dental Council Registration Number: 123456789

Call us now: [REDACTED]
Visit us at: [REDACTED]

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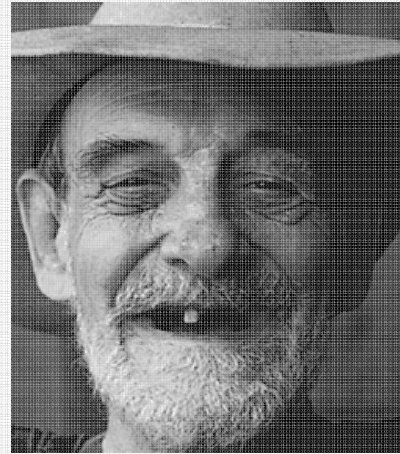
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Or visit our website [REDACTED]



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