Report on findings from public and patient engagement on the Duty of Candour

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The General Dental Council

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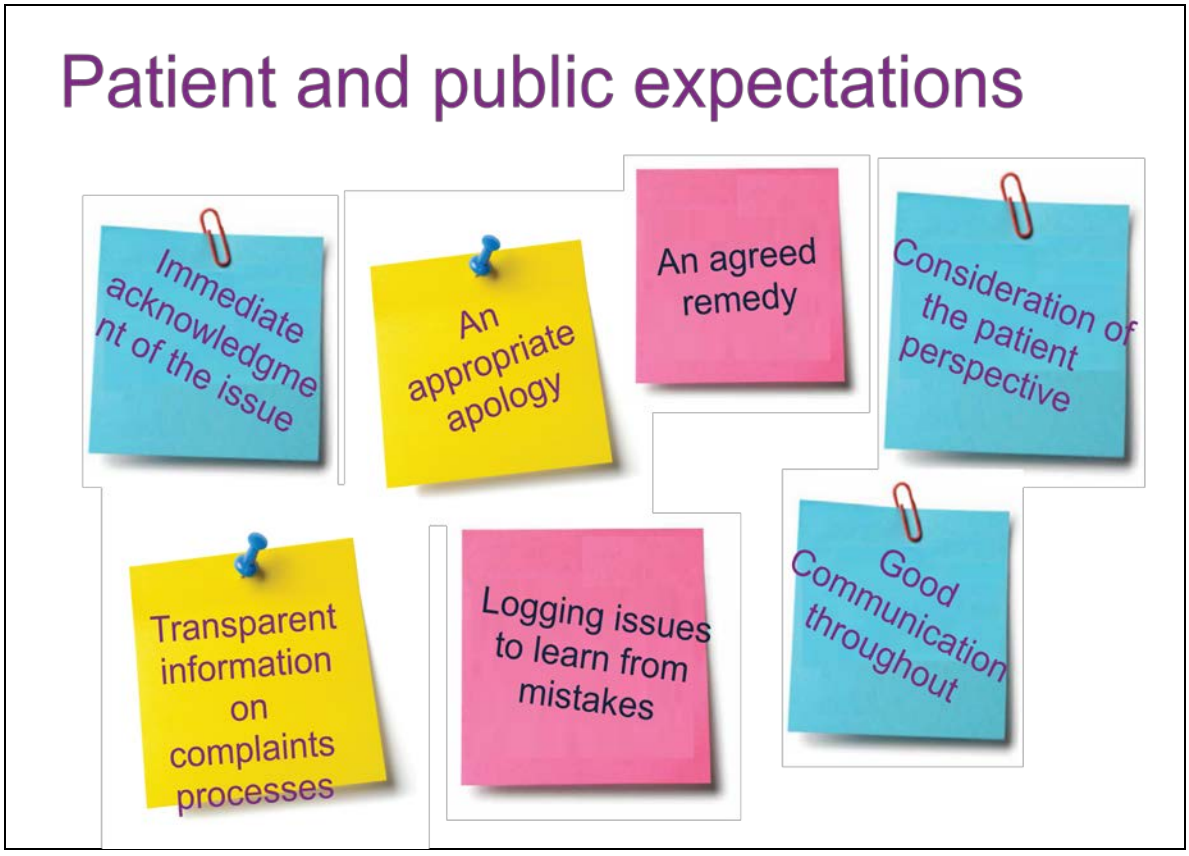
1. Executive summary

The GDC is currently reviewing its Duty of Candour guidance, the primary document that sets out the behaviours and values expected of dental professionals when things go wrong with dental treatment or care.

In order to inform the consultation process, the GDC identified a need for engagement with patients and the public so that it could gather some initial understanding of the public perspective on this issue. Two two-hour group discussions were conducted in London and Glasgow, with members of the GDC's Word of Mouth Patient and Public Online Panel, during the week beginning 1st February 2016. In total 24 participants attended the sessions.

In terms of patient and public expectations, the themes emerging from each of the discussions were very consistent and are summarised below:



2. Background, objectives and approach

2.1. Background and objectives

After considering evidence from the Francis Report and other reviews, the Government decided to take forward a statutory duty of candour for health and care organisations in England. Rather than introduce a statutory duty for individual health and care professionals, the Government recommended that the professional duty of candour should be strengthened through changes to professional codes and guidance.

In response to this, the GDC has recently consulted on new draft guidance for registrants on the Duty of Candour.

In addition to consulting with key stakeholders and registrants, the GDC has recognised that it would be useful to ensure that public and patients are directly engaged in the development of the guidance. The GDC's Word of Mouth online panel was identified as an appropriate vehicle to undertake this engagement.

The objectives of the exercise were as follows:

- To understand in-depth views and expectations of patients and public when things go wrong with treatment or care.
- To gather feedback from a broadly representative mix of members of the public with regard to these issues.

2.2. Approach

An extended group discussion (lasting two hours) was chosen because it would allow participants time and space to explore the complex issues relating to the Duty of Candour.

Two group discussions were conducted; as follows:

- London on the 2nd February 2016
- Glasgow on the 4th February 2016

Recruitment

Participants were recruited to match a pre-agreed specification. In total 24 people attended (12 participants in London and 12 in Glasgow.) The majority at each session was recruited from the GDC's online patient and public panel - Word of Mouth. A small number of participants (three in London and two in Glasgow) were recruited purposively to ensure the required mix by demographics and life-stage.

The specification was designed to be broadly reflective of the UK population as a whole, with reference to the following criteria:

- Gender

- Age group
- Ethnic background
- Working status
- Social grade
- Family composition (i.e. whether they have dependent children in the household)

In addition, recruitment sought to ensure a mix of participants by recent dental experience, including whether or not they had experienced any issues with their treatment or care. The profile of attendees at the discussions is provided at Appendix A.

Design and facilitation

The discussion content was designed to ensure that participants were given an opportunity spontaneously to discuss their views and experiences, prior to being asked to consider specific questions. Scenarios were used in order to present participants with realistic hypothetical case studies that would bring the discussion to life. A range of examples was used, reflecting a mixture of relatively minor and more serious issues or problems.

The final agendas for the workshop sessions and hand-outs are attached at Appendix B.

Facilitation at the discussions was undertaken by Community Research. The sessions were audio-recorded and fully transcribed with the permission of the participants.

All participants were asked to complete an evaluation questionnaire at the end of the session; the results of which are outlined in Section 4.

3. Key findings

The discussions referred to a series of scenarios. Where specific scenarios are referred to in the report a link is provided to the scenario in question.

3.1. Expectations of dental professionals when things go wrong

Informing the patient

A fundamental principle identified by participants was that dental professionals should bring mistakes to the attention of patients if they, themselves, have not identified a problem. This was seen as a basic 'duty of care.'

> *"You would hope that the dentist would do that, you would hope that they would have the honesty...to put their hand up and take it, ring the patient and bring them back..." (London participant)*

This was felt to be particularly important for children and vulnerable patients who may not be able to identify or articulate what is wrong.

> *"What if it was your kids they were doing it to and not you? You've got more chance of getting away with it with drilling the wrong tooth. If it was your child's tooth, if it was an eight year old or something and they made the mistake, there'd be more chance of them getting away with that kind of [thing]." (Glasgow participant)*

However, this duty did not extended to 'near misses'. There was a widely held view that, although problems should be recorded internally to allow for learning from potential mistakes, patients did not necessarily need to be informed if they had not been affected and/or no mistake had actually been made. In fact there was perceived to be associated harm in informing patients who could be made to worry unnecessarily as a result.

> *"I'd think they should be honest to someone but not necessarily the patient, you'd think." (Glasgow participant)*

Importance of an apology

There was strong and very clear consensus about the importance of an apology when things go wrong with treatment or care. There was a firm belief that this should include a clear acknowledgement of what has happened and some form of expression of regret. Most felt that the apology should be immediate but others felt that under some circumstances it should be delayed, for example when a patient is in pain, since they might be less receptive to such communication from the dental professional at that point in time.

The importance of getting the tone of the apology right was mentioned, both in terms of when and how the apology is given and also the actual wording of any written apologies. For example, some felt that in some case an apology should be given in person, in a private setting. It was stressed that consideration should be given to the wording to ensure that the apology comes across as being sincere rather than one aimed at deflecting or preventing the patient taking the matter further.

> *"The apology feels like 'we're going to give you the money to make sure you go away, we don't actually care about you'." (London participant)*

> *"If it's a real person to person apology, rather than a professional one, then you would probably take it more [seriously]." (Glasgow participant)*

For minor issues, such as the situation outlined in Scenario 2 when the dentist was running late and there was a small accident, this could be a simple verbal apology:

> *"I thought we'd just expect the apology and help to mop you down and things. Nothing… just sort of acknowledging there has been something and help you deal with it but not too much, kind of thing." (London participant)*

> *"Getting an [written] apology might make you think it was a more serious mistake than perhaps it necessarily was." (Glasgow participant)*

For more serious issues, participants expected a staged process - a verbal apology, followed by a written apology. For some issues, it was felt important to have something in writing both for the patient and to ensure that some form of internal recording of issues is taking place.

> *"I think the dentist needs to put down in writing what he acknowledges the mistake he's made, rather than a casual sort of 'oh, I'm so sorry about this' verbally." (London participant)*

For very serious issues, participants expected an apology from the dental professional in question and also a more formal apology from the surgery or clinic. There was a belief that any apologies relating to errors with charging should also be in writing to avoid any confusion, even if the amount involved was relatively small.

Participants stressed that the apology should also include a suggested remedy:

"You've got to apologise with an indication of what you're going to do about it as well. So accept responsibility and also show how you're going to go about rectifying the damage." (Glasgow participant)

"I think you'd want to know what's happened and what's going to happen." (Glasgow participant)

Participants also made the point that any written apologies should be formal, but should in plain English, avoiding any unintelligible jargon.

"We all talk in jargon according to our various workplaces and when you're talking to a client or a patient you have to think and put it into different words sometimes than what you'd say to a colleague. And you need to be careful what you say, that it's clear." (London participant)

Remedying the situation

In relation to issues that are minor, participants would not expect any further action other than an immediate apology. For more serious issues, participants would expect an apology but also reassurance that the situation has been resolved. An appropriate remedy could take a number of forms, depending on the particular circumstances, for example:

- In the case of Scenario 1 relating to breach of confidentiality, participants call for the practice to demonstrate that the issue has been resolved and will not happen again (to them or another patient). There was much emphasis on the need for **retraining of staff and/or reviewing of internal processes**, as well as **informing the patient** what steps the practice had already taken or is planning to take to prevent such an issue recurring.

"I think it would be for the practice to then contact you and say we apologise for this, she's been informed of the guidelines, she's been sent for training maybe on what breach of confidentiality is etc." (London participant)

"I think probably yes, because where it's a question of competence you want to know that, I suppose, it's been addressed if there's an issue where a dentist needs to be looked at so they're not going to go and do that to somebody else again." (Glasgow participant)

"So it would be nice to know that the process allows us to find out what actually happens." (London participant)

- In cases relating to treatment going wrong, participants tended to want either the **treatment putting right for no additional cost** or, in more serious cases, some form of **financial compensation**. This was particularly evident in relation to Scenario 4 where the dental professional had filled the wrong tooth, because participants were concerned about future costly treatment resulting from the error:

"Maybe the compensation could be in the form of the practice agreeing that any further treatment needed on that tooth would be free of charge because they were responsible." (London participant)

"I think definitely compensation because by doing a deep filling you've damaged that tooth, which is going to require a lot of future treatment. It could result later on to a crown, eventually to root canal and eventually to the whole tooth being removed. So you need compensation for any future treatment that's going to have to be made on the tooth." (London participant)

"[Scenario] number 4 is actually a very very serious case because it's more of medical negligence. You can't make a mistake like that. And definitely compensation... that's without question." (London participant)

Some felt that, in addition to compensation in some form, the patient should be offered the opportunity to go to an alternative dental professional if trust has broken down with the original dentist.

In all cases, participants wanted a **quick** remedy; to be **passed on to someone who could deal with the problem** if the individual dentist or clinic was unable to do so; and to be involved in the decision making process i.e. to **discuss and agree** the remedy, rather than having it imposed upon them.

Legal action

Participants indicated the importance of an apology in terms of preventing the situation from escalating. An appropriate apology and offer of a remedy could mean that they would not take recourse to a legal solution even in the event of a serious issue:

"If it's a fairly minor thing and you know it was their fault, and they don't apologise, you just feel even more angry. Which makes you even more inclined to make a deal out of it." (London participant)

"So we would expect just the bare minimum, so an initial apology, perhaps a brief explanation, 'awfully sorry, something came up earlier on which has caused me to be 15 minutes late'...because we've all been in situations

where that hasn't happened and you start to see the red mist, you start to almost brew on it and things just sort of snowball. So, yeah, it needs to be nipped in the bud." (London participant)

"I think if they're really apologetic you're perhaps less likely to complain, less likely to take it as far." (Glasgow participant)

However, participants were very conscious of the challenges associated with saying sorry in terms of the association with an admission of legal liability. This was raised spontaneously in the discussions and there was a presumption that dental professionals might be deterred from apologising because it is seen an admission of guilt.

"That's the culture of the health service, from the top, not from the bottom, 'don't say anything' " (London participant)

"The trouble from the litigation point of view, they are instructed really… to say very little." (London participant)

"I suppose there's a fine line though between an apology conversation and a complaints conversation, because that must change the balance the minute the word 'official complaint' is used." (Glasgow participant)

Whilst patients said that they would like this situation to change and for dental professionals to proffer apologies more readily; there was also a sense from the discussions that they might well see an apology as additional ammunition for a legal case if it came to that.

"I think us, as clients, we would rather they were more open with us and say 'there's been a little bit of a cock up, we're very sorry but we are going to try and deal with it as best we can'. I think we'd rather... they were dealing with it rather than just going 'I can't touch it because of [legal constraints]'" (London participant)

There was also some evident confusion about the difference between raising a complaint with the GDC and pursuing a legal case, with some participants conflating the two.

Participants also indicated that their response to an apology and suggested remedy would depend on a number of factors, including some that are out of control of the dental professional:

- The patient's own personal and financial circumstances.
- Their fear of / an anxiety about dentists.

- Their personality (and their general assertiveness/combativeness/ tendency to complain.)
- Their degree of choice in terms of access to alternative dental professionals and treatment.

One key factor mentioned that is much more within the dental professional's control, is the relationship with the patient. If there is a rapport and good communication between the professional and patient, then some participants indicated that they would be more inclined to accept an apology and not take things further.

> *"So I think a lot depends, we've not really spoke about the relationship you've got with your dentist, which I think it's important..... If you know you've got a good dentist you will forgive." (Glasgow participant)*

> *"It probably depends whether you know your dentist. Somebody you've been going to for a long time may probably just apologise." (Glasgow participant)*

A documented, systematic, transparent procedure for complaints

There was a call for clear, transparent information for patients on processes when things go wrong.

> *"We would hope that the actual practice would be completely transparent and tell you your options for remedies and also speaking to the GDC. They would actually give that information to you, they wouldn't sort of close in sort of thing and go quiet, they would be very transparent and say here's the full range of information, these are your options, have this leaflet." (London participant)*

> *"I think, for me, the more open they are and the more honest, the less likely to complain officially I would be. Whereas if I thought that they were covering something up or not really properly sorry then that's probably when I would complain." (Glasgow participant)*

- One Glasgow participant suggested that the form at the end of treatment could include information on what to do if there is an issue (but others felt that they would be unlikely to read this.)

> *"Why doesn't that form you fill in at the end, when you sign the thing, does that have a tick box or 'was there any issues, minor/major/nothing'? Because you always get to sign a form at the end." (Glasgow participant)*

There was a recognition that dental practices or clinics may find it difficult to be completely open about processes relating to raising complaints or concerns but that this was felt to be extremely important.

> *"It's human nature for dentists to try and get away with it anyway rather than follow the correct procedures, 'I'll get away with this if I can'." (Glasgow participant)*

> *"I think there's a chance that they'd try to cover it up, just because it is bad enough to complain about and get compensation." (Glasgow participant)*

- Several participants gave examples of not being helped to navigate the complaints process by their own practice:

> *"I felt as though he trimmed it [tooth] too much and really and truly there was nobody to complain to, there was no accountability. So I went back to speak to the head receptionist and she was telling me they'd get back to me but they still never got back to me regarding my complaint." (London participant)*

There was a general presumption that the complaints process would start locally and then have details on how to escalate the issue if necessary.

> *"Yeah, the process would start internally and then…because it may be something that can be sorted out at ground level fairly simply." (London participant)*

Although not part of the explicit objectives of this research[1], one London participant also spontaneously raised the issue of the importance of practices having clear information provided to staff about how to raise concerns about colleagues or other members of staff.

A requirement to report issues internally and to the GDC

In terms of dealing with treatment or care that has gone wrong, there was an assumption that processes would be put in place to review issues to check that they have been resolved and in order that a pattern of recurrent problems is not allowed to develop. There was a focus on practices demonstrably learning from mistakes.

There was also a belief that issues should be systematically reported to the GDC.

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[1] Although the work on candour is very closely aligned to that on raising concerns, the latter was not explicitly explored in the research as the duty of candour is owed to the patient and raising concerns must be done with an employer, contracting body or regulator.

"Maybe not individual dentists, but as a practice that you'd be expected to submit a report saying we've had this many complaints this year, this many have not been resolved." (London participant)

"I assume that most dentists do at some point get complaints but is there a monitoring system for the amount of complaints, and is there a point when you would step in, when you go we're hearing too much going on here'?" (Glasgow participant)

Putting themselves in the patient's shoes

Much of the discussion was about dental professionals demonstrating that they appreciate the personal nature of the service that they are providing and putting themselves in the patient's shoes when dealing with the aftermath of things going wrong.

"I guess the issue with customer service in this environment, because it's very personal to us. It's not like you're going shopping and you're buying something that goes wrong...So they need to accept that it's very important to us because it is us, it's not our things, it's us personally. It's more important for us to get a response back immediately saying 'okay, we're not really accepting responsibility but we're going to take ownership of any issues and deal with it as we should do'. And that's my point, that's it's immediately with the people in the room and then it's at practice level and then the GDC. But it's the ownership, we want them to feel like they've taken ownership of any issue and not just gone 'oh, I'm sorry' and not meant it." (London participant)

"It also goes down to the same care, like patient care, listening to what the patient has to say, asking questions, having surveys. Even at the practice, getting information from them so they can give their opinion and express themselves." (London participant)

In the instance of Scenario 2 whereby the dentist was running late, some participants suggested that the dental clinic could contact the patient's employer and explain the situation if this would be appropriate. This was seen as the clinic thinking about the issue, however minor, from the patient perspective.

Actions before treatment

Some of the draft GDC guidance on the Duty of Candour relates to actions that the dental professional can take before treatment starts to help ensure that a patient understands their treatment and the associated benefits and risks so as to help avoid potential problems.

Whilst this was not covered explicitly in the discussions, it was implicit that participants felt that this was extremely important. In the discussions relating to Scenario 5 (confusion over the cost of treatment) and in other actual examples of perceived mis-selling and poor treatment given by participants, it was clear that they expect a balanced and transparent discussion about their treatment at the start of the process and that this helps to establish a good relationship. As indicated, the relationship between dental professional and patient was felt to be key to how the patient would then respond if, and when, problems arise.

3.2. Considerations for GDC

Participants were not shown the draft guidance on the Duty of Candour at the sessions. Instead, they were encouraged to talk about the key themes and to discuss what is important to them without being prompted by the guidance. The research affirmed the importance to patients of the following:

- A quick acknowledgement of the problem.
- An appropriate apology, with consideration given to the setting, format and tone.
- The offer of a remedy which is discussed and agreed with the patient.
- A robust internal procedure for the monitoring of issues.
- The importance of the dental professional putting themselves in the patient's shoes when things have gone wrong, so that they consider the situation from the patient perspective.

Notion of proportionality

With regards to the notion of a proportionate response to an issue there was wide agreement amongst participants about what would be a proportionate response to the various scenarios discussed. However, there were a small number of people at both groups who tended to see issues as being more serious than others and, therefore, as warranting a more involved remedy.

For example, in Scenario 2, relating to the minor incident of the dental professional running late and some mouthwash being spilt, most felt that an immediate apology and help with mopping up would be appropriate. However, some felt that the dental surgery should go further and help with dry cleaning costs and travel expenses back to work.

Similarly, with Scenario 1 relating to the breach of confidentiality, the majority felt that the appropriate response would be an apology and retraining for staff. Only one participant felt that the member of staff should be dealt with more severely.

Legal liability

One participant summed up the issue of dental professionals potentially being deterred from making an apology by the threat of legal action as follows:

> *"You need to put the patient first rather than worry about what's going to happen to you as a dentist." (Glasgow participant)*

Throughout the discussion, it was clear that this issue stimulated much debate and whether or not legal action might be pursued depended on a number of factors. Whilst many participants indicated that an appropriate apology would mean that they would be far less likely to take an incident further, there was also a clear association in participants' minds that an apology is an admission of guilt.

Raising awareness of the complaints process

A general theme, which has arisen in other research with patients and public for the GDC and others, is the relatively low level of awareness of how to complain about poor treatment or care. Participants tended to feel that the individual dental practices and the GDC could be doing more in this respect.

> *"And also it's hard to retrieve information about dentistry. At least with hospitals and healthcare you know that their regulators are the CQC that go to monitor these hospitals and care homes but, when it comes to dentistry, there's not much information out there." (London participant)*

> *"Yeah, it's good to know there is someone there but I think it should be better publicised because, when I had bad treatment, I didn't know who to complain to. It's not really publicised very well." (Glasgow participant)*

There was some uncertainty at the London group whether private dental professionals were covered by the standards and Duty of Candour guidelines and a belief by some that they would be able to 'do what they like.' There was a call for it to be made clear to patients that all dental professionals were bound by the regulations regardless of whether they work in the NHS or not.

4. Evaluation questionnaire results

An evaluation questionnaire was distributed to all participants at the end of each session. There was a high level of satisfaction, with all participants indicating that they agreed with the statements.

The results in summary are as follows:

Workshop	**London**	**Glasgow**	**Total (%)**
I enjoyed taking part in the event			
Strongly agree	9	9	18
Agree	3	3	8
Neither agree nor disagree	-	-	-
Disagree	-	-	-
Strongly disagree	-	-	-
Everyone was given a fair chance to have their say			
Strongly agree	10	11	21
Agree	2	1	3
Neither agree nor disagree	-	-	-
Disagree	-	-	-
Strongly disagree	-	-	-
The event was well organised and structured			
Strongly agree	9	10	19
Agree	3	2	5
Neither agree nor disagree	-	-	-
Disagree	-	-	-
Strongly disagree	-	-	-

Some example comments from the feedback forms are provided below:

> *"It was insightful. I was able to learn more about the GDC. I think this will help improve services and bring more accountability to these health professionals." (London participant)*

> *"Discussion was open, there was sufficient time and opportunity for everyone to consider the scenarios and voice their opinion." (London participant)*

> *"Keep up the good work and best of luck for the future research." (London participant)*

"It was good to hear other people's opinions and experiences. The facilitator allowed everyone the opportunity to participate. It was well facilitated." (Glasgow participant)

"Very friendly group, everyone open and honest with their opinions and encouraged to be so…..Interesting discussion with very good scenarios to contemplate. I would be happy to take part in any future session." (Glasgow participant)

"Open, informal and friendly. This made the exchange of ideas easy and the session was very informative." (Glasgow participant)

Appendix A – Participant profile

The demographic profile for the sessions is shown in the table below:

	London	Glasgow
Gender		
Male	6	6
Female	6	6
Age		
18-35	4	4
36-64	5	6
65+	3	2
Ethnicity		
White	9	10
BME/mixed	3	2
Socio-economic group		
AB	6	3
C1/C2	2	4
DE	4	5
Working status		
Employed	8	5
Student	-	3
Retired	3	2
Unemployed	1	-
Other	-	2
Dependent children		
Yes	3	4
No	9	8
Frequency of dental visits		
I go regularly	11	11
I don't keep track	-	-
I only go when I need to	1	1
Type of care		
NHS that I paid for	8	4
NHS that was free	-	7
Private	3	1
Both private and NHS	1	
Experienced any issues with dental care or treatment		
Yes	4	4
No	8	8

Appendix B – Discussion agenda and handouts


Discussion groups agenda


Handout A.pdf


Handout B.pdf


Scenarios for moderator.pdf

Appendix C – Scenarios

Scenario 1: Breach of confidentiality

You go into your dental surgery for a routine appointment. The dental nurse checks your name and, when she realises who you are, offers her condolences for the loss of your brother who has recently died. As there has been a family falling out, you were not aware of his death and are very upset about hearing about his death in this way.

The dental nurse explains that your brother also attended the same surgery and she was not aware of the family dispute.

Scenario 2: Late running and minor accident

You attend the surgery for a routine check-up. The dentist is running very late and you are kept waiting for some time which is inconvenient because you have to get back to work. After your treatment, when you are still in the dentist's chair, the dental nurse manages to spill the mouthwash all over you. This means that you'll have to go home to get changed and will make you even later for work.

Scenario 3: Mistaken identity

You attend for a booked filling and the dentist is running 20 minutes late. When you go in, the dentist seems a bit distracted and rushed. He apologises for running late, quickly checks your notes and asks the nurse to pass him the local anaesthetic to numb your mouth.

He begins by putting a gel on your gum on the right hand side, which seems strange as the filling is going to be on the left but you assume that he knows what he’s doing. However, he then injects the right hand side and, before your mouth goes numb, you ask him whether he will be numbing the left as well.

The dentist looks at you in surprise and turns to check your notes on the computer screen. It then becomes apparent that he has numbed up the wrong side, because in his haste he has called up the notes for another patient with the same surname and first initial as you, but a different first name.

Scenario 4: Misreading a radiograph

You have a nagging toothache at the back of your mouth. You have recently moved to a new area and attend your new dentist for the first time. She carries out a check-up and you have x-rays taken. Studying the x-ray, she recommends that you need a deep filling on your back tooth which she can do there and then. You discuss the different options, and agree to have a mercury filling. As part of the discussion, the dentist warns you that because it is a deep filling, the discomfort could persist for a couple of days.

Four days later, you still have the pain and it is not improving. You go back to the practice and the dentist, on looking again at your notes, realises that she has mistakenly filled the wrong tooth.

Scenario 5: Treatment costing confusion

You have been seeing your dentist for numerous appointments lately as you have needed to get some complex dental work done on numerous teeth. When you had initial discussions with your dentist and made a treatment plan, you were given a printed out plan with all the items of cost itemised.

As you have been having the treatment over numerous appointments, you haven't paid much attention to the costing as you have been paying it bit by bit. The treatment was completed smoothly without any issues, and now you have fully paid for all your treatment. A few weeks later you come across the initial treatment plan and you notice that the total cost you paid according to your bank statements is more than the amount that you were initially quoted for. You approach the dental clinic.