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APPENDIX TWO: My reflections on 'honesty' and the meaning of 'misleading'

Introduction

The allegations are summarised by the GDC in the evidence schedule but in essence refer to specific criticisms of my clinical protocols and record keeping and the more serious charges accusing me of failing to tell patients when something has gone amiss. The accusations of dishonesty and misleading my patients need to be addressed, clarified and challenged.

Background

Two patients have undergone root canal treatments that led to perforations and it has led to criticisms of both my clinical protocols and record keeping and the failure to inform the patients of these adverse events in a timely manner, inferring that I have deliberately concealed information or failed to divulge the information in a timely fashion.

Honesty

My understanding of honesty brings me to the Latin honestas for honour, respectability, decorum, virtue, chastity, trustworthy and integrity. To simply put it, effectively not telling a lie.

Misleading

Misleading may be regarded as a diluted form of dishonesty, half-truth or simply withholding information. Giving the wrong meaning, idea or impression. At its worse, it is a lie and at the least, simply a fib to avoid causing unnecessary upset.

Ghosh

The Ghosh test concludes that dishonesty should be divided into objective and subjective components. Do third parties consider the behaviour or act as dishonest, and would the subject accused consider they themselves were being dishonest at the time? Was there an element of intention to be dishonest and deceive?

Communicating effectively with patients

Following the initial consultation with all our patients we consider the interview as a two- way process. We are collecting a mass of information regarding past dental and medical histories and trying to find what expectations the patient has.
We find out the language they use. We find out whether they are accurate and reliable historians.
We find out how emotionally they connect with their problems, or whether they view things in a rather mechanistic fashion. We have regarded ourselves as the dental sump of patients with long standing problems, very often compounded with being highly emotionally charged and labile.

I am no practitioner of neurolinguistics but I do attempt to mirror and match the language of a patient to make a connection. In return, I would like to think the patient is concluding that we are able to resolve their problems, that they can rely upon us to deliver and that they actually like us.

We have found that 85% of all new patients return for their prescribed treatment after their initial consultation. A fair number who do not, are often times, advised not to have treatment as it isn't in their best interests, eg. invasive and destructive procedures in adolescent subjects for misguided or trivial wholly cosmetic issues. We have to balance the oral health needs of our patients with their desired outcomes.

Communication is assisted by giving considerable time to patients for their consultations and treatments and encouraging feedback. Patient questionnaires are completed for that feedback and we pro-actively ask patients to be critical and find fault so that we can improve our service.
Our recent survey (APPENDIX THREE) has been most encouraging and highlighted our effectiveness with communication.
In one case this was highlighted when a patient gave us lower scores for lack of clear explanations. This led us to discuss the matter directly with her. This patient has an innate distrust of traditional medical protocols and medicines. This stems from experiencing the plight of her daughter who was diagnosed with a particularly aggressive form of leukaemia that she has attributed blame to "all the toxins in the environment".
Her daughter is particularly prone and susceptible to dental caries. We have prescribed daily fluorides to attempt to gain some control but these have been rejected by the Mother on the grounds that they are poisonous. When fluoride releasing fillings have been recommended, these again are refused for the same reasons. When protective fissure sealants were prescribed, these were rejected on the grounds that they contain oestrogen that could lead to hormonal influences.

Finally, I was restricted to the sole use of provisional materials as they contained natural botanicals including oil of cloves, despite their poor efficacy. After she expressed her lack of satisfaction with us we had the opportunity to conclude that we were not controlling the disease effectively in her daughter's mouth as the mother's concerns hampered and undermined all the science of my prescriptions.
We have now reached an understanding between ourselves to continue to do our best and at the same time respect the mother's wishes. It is to be noted that a suggestion that she sought future care with an "holistic amalgam free practitioner" immediately led to her breaking down and bursting into tears. She pleaded with us to keep her and her family on as she became even more distressed with the thought of going elsewhere. She considered we had become an integral part of her family.

When treating another patient, her conduct in the dental chair was one of restrained terror.
As with all frightened patients with anxiety states I have learnt to adopt a caring parent-vulnerable child mode of language to help reassure her. May I specifically point out; this is NOT a paternalistic approach but a caring approach. Non-emotive language is used at all times. We make everything appear calm and controlled without a hint of concern that may be picked up by the patient. Everything is reassuring and positive.
Although the patient subsequently accused me of "showing off" when treating her, I had my trainee nurse in attendance on both occasions, and this could not have been further from our thoughts. I am an experienced postgraduate educator, happiest when I am chairside, explaining the facts as demonstrated. In view of my trainee nurse's limited experience, having only joined us a few months earlier,

I would have been extremely detailed with the information verbalised with the patient. I consider on these occasions I effectively have an audience of two to keep informed.
At the conclusion of her appointment, the patient was very well informed of my clinical findings. It was clear that when I shared the difficulties we were having locating the third canal, and the eventual breach of the pulp chamber, she had become extremely distressed. It is at these times I find I have to make a call as to whether to proceed to the 'bitter end' and complete the treatment, or call an end to proceedings and arrange for the patient to come back later.
In this case I elected to complete the treatment at what turned out to be her last appointment, considering that if we failed to complete it could cause her even greater distress.
As she had been given the details during the appointment, it seemed eminently sensible to end on an upbeat note with my follow-up letter, which omitted making any reference to the challenges that we had experienced on the grounds that I was completely confident that the tooth was restorable and it could only lead to additional distress.
Quite understandably, my follow up letter, seen in isolation did not include these difficulties which led the GDC to conclude I had intentionally withheld and misled the patient.
Giving and obtaining consent is a process, not a one-off event. It should be part of on- going communication between patients and all members of the dental team involved in their care.
You should keep patients informed about the progress of their care. This patient had information and running commentary at each and every visit. I consider written reports are to be regarded as a continuum of that process and not to be seen in isolation. This was an error of judgement.
I consider we never show off to patients, but we do engage in banter and verbal distraction to entertain. Making a patient who is anxious laugh out loud is a great way of breaking the ice and getting them to forget where they are. It's a skill we are proud of.
Our controlled and unhurried methods calm our nervous patients and is a reassuring method of defusing tense times for them. In essence, if the world was falling around me, none of my patients would get a whiff of any of it. It's what I expect from any professional.
We may be accused of trivialising our roles but doctoring is far more than just fixing. It's about taking a patient on a journey of recovery. We have a duty of care to always end with positive news. Depressed patients do not heal. I have been inspired by the most talented clinicians who could bring hope and a smile to a patient with the news of terminal disease.
The patient accuses me of bullying her into a treatment strategy of prescribing the use of metal on a lower second molar tooth. It is noted that considerable explanations of the choice of materials available with the advantages and shortcomings of each were given on several occasions.
The need to preserve tooth structure and the viability of the nerve and the position of the tooth wholly out of sight from third parties was discussed to ensure what was in the best interest of the patient. You should take patients' preferences into account and be sensitive to their individual needs and values.
The patient never once contradicted me. Yet later, she accused me of denying her a tooth coloured restoration solely on the basis "she wasn't an opera singer" which had led to her humiliation and the charge of "bullying".
My recall of another patient was that of a tense professional lady who was always an accurate and reliable historian when describing her problems. She was predominantly crisis driven, restricting her visits to my clinic when driven by an acute dental crisis. This is reflected by her lack of attendance for a five-year period when she considered she had no problems, until another acute episode brought her back to us.

This attendance record tends to lead to a marked focus upon the presenting issue during those visits.
In other words, problem solving. The language between us was always adult to adult. Like many of my patients, she shared details of her personal and professional relationships at home and work, which has always led me to be reminded of the privilege of being a clinician.

My only awareness of a problem with this patient was when she wrote to us to say she was going elsewhere for her treatment and wanted her records sent to the other practitioner.

My reaction at the time was one of disappointment, expressed by myself and my clinic manager as we had become rather fond of her. Our conversations with the patient had become informal and easy. Allegations only became apparent after we had sent the copies of her records that led to accusations of withholding information.

Given my clear recording of an adverse event in her records, it is inconceivable that I had not informed her. However, after a period of 7 years, I would consider it wholly unprofessional and indecent to contradict her.

Action

You must treat patients with kindness and compassion. To be honest and act with integrity at all times.

As a young and very inexperienced junior surgeon in my first appointment in a district general hospital, I observed and witnessed a consultation given by the lead clinician in a maxillo-facial unit. The patient had oral cancer and the appointment was to break the news. The patient was accompanied by his wife who sat motionless and wholly mute
during the entire meeting. The patient was a retired engineer who appeared to want to know all the practicalities of the treatment that was to include surgery and radiotherapy followed by prosthetic rehabilitation. He left having shook hands with us both. The wife said nothing and avoided eye contact.

A little time later, I ‘clerked’ him into our ward the evening before the proposed surgery. His wife was carrying his case for the stay and I left them together to continue my ward rounds. Surgery went well, frozen sections reports from the pathologists implied we had cleared all the disease. The patient was returned to the ward for intensive nursing care.

After several days, the ward staff nurse noted she had not seen the wife during visiting hours. We made attempts to reach her by phone without success. After 24 hours I contacted the police due to my own concerns. It transpired the wife had not ‘coped too well’. On the day of her husband’s surgery, she had walked into the sea as it had become all too much to bear. She ended her life and changed mine forever.

I have been inspired by the most talented clinicians who could bring hope and a smile to any patient with the news of terminal disease.

Clinicians who also were all inclusive and engaged with family and friends of patients. All patients are told the truth but the considerate use of non-emotive language is essential to avoid causing distress at all times. When dealing with highly charged emotional patients, this is even more so as they start distressed. Anxieties must be managed and given equal emphasis as well as the disease itself. It is all about putting the patients first. I do not consider using non- emotive language as misleading any patient in anyway.

Providing an honest service is of paramount importance to myself and my team. We devote considerable time to our patients to ensure that we are never rushed.

There is never any sense of urgency or being rushed. We believe we have identified several areas of our record keeping that have led us to these accusations. The delay of processing radiographs had led us to not view the images until after a patient has been dismissed from the surgery. A new x-ray protocol now means we process all x-rays
before a patient leaves the surgery, and a report of those x-rays is shared with the patient and recorded in the notes before the patient leaves.

In addition, whenever information is shared with a patient, the simple entry ‘patient informed’ is added to the information recorded in the notes. Finally, we have adopted a discharge letter protocol for any patient who advises us that they are not continuing under our care, whatever the reason. A synopsis of treatment provided will be detailed and a copy of their clinical records will be added to ensure we facilitate continuity of care and can be seen to be open and transparent, and never find ourselves again being accused otherwise.