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DENTO-LEGAL GREY AREAS IN PROSTHODONTICS

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Prosthodontics accounts for a sizeable proportion of the caseload of indemnity providers around the world, and the UK is no exception to that. Indeed, because the UK (outside Scotland) has become by some distance the riskiest place in the world in which to practise dentistry, with litigation and regulatory challenges being well beyond the levels seen in any other part of the world – including the USA – it is both timely and apposite to be considering the dento-legal risks and "grey areas" in the field of prosthodontics.

This presentation aims to highlight some of the key issues and to raise some concerns regarding the current direction of travel.

Context

Some facts to set the scene and concentrate the mind:

- The average UK dentist is sued more often than dentists in any other part of the world. Indeed, more than twice as often as the average dentist in the US, and 60% more often than dentists in California, Florida and New York State.
- The average UK general dental practitioner is 3-3½ times more likely to be sued than the average UK general medical practitioner.
- The likelihood of a UK dentist facing some kind of regulatory challenge (i.e. by the GDC) is much greater than for:
    - UK medical practitioners
    - Any other kind of registered healthcare professional in the UK
    - Any other dentists, anywhere else in the world

If we then look at the various areas of dentistry and ask ourselves what kind of procedure leads to what proportion of all the negligence claims in the UK, the league table looks something like this:

1 Endodontics
2 Crown and Bridgework
3 Periodontics
4 Nerve damage
5 Implants
6 Orthodontics
7 Veneers
8 Oral surgery

The two significant things to note about the UK picture compared to other countries are the prominence of:

a) allegations of a failure to diagnose and adequately treat periodontal disease; and

b) implant cases of all kinds.

These cases are moving steadily up the league table. So also are orthodontic cases and cases primarily involving veneers provided electively. Many cases are of course a combination of several different procedures on the above list and when compiling it, a case can be "apportioned" to a maximum of two categories. So it can only ever be a rough indicator of prevailing trends.

So any dentist undertaking prosthodontics procedures here in the UK is – at least, from a dento-legal perspective – carrying out some of the most high risk procedures, in the riskiest possible place in the world. Many of these procedures are more complex than might have been the case in the past and it would appear that a greater proportion of them are being carried out by general practitioners who have not undertaken any specialist training.

Add to that the underlying demographic factors and we have a recipe for real problems ahead. As we all know, the UK population is living longer and retaining more of their teeth into later life. The 'baby boomer' generation is also the 'heavy metal' generation and prosthodontics sits at the epicentre of most of the dentistry carried out on this group of patients both now and for the foreseeable future.

Implants

The number of implant cases has been increasing steadily for the best part of 15 years. These cases represent an increasing proportion of a significantly increased number of cases overall, and in terms of their size (average financial value) they have the added disadvantage of being much larger than the average case.

Broadly speaking, the cases are split in equal measure between problems associated with the surgical phase, problems linked to the restorative phase, and problems which either reflect an element of both, or which involve issues that can be traced back to poor case assessment, consent or poor communication (including at a referral interface).

Implants provide a perfect illustration of the main dento-legal concerns that arise within the wider field of prosthodontics, namely:

- Poor patient selection and case assessment, including inadequate / insufficient investigations and treatment planning
- Inadequate management of patient expectations – and in many cases actively fuelling these unrealistic expectations though marketing and promotional "hype"
- Practitioners taking on cases which are beyond their capability and perhaps not recognising the complexity of the case or being sufficiently experienced to recognise early enough, when they were getting out of their depth
- Deficiencies in the communication and consent process
- Operative failings
- Inadequate records and documentation

The GDC has visited the issue of implants on several occasions, even to the extent of having set up specific working groups to explore ways to regulate implant provision more effectively. The GDC has clearly been concerned about the number of cases and the issues that they were throwing up, not least in terms of the training and competence of those undertaking these procedures.

On each occasion to date – like many other regulators around the world – the GDC has concluded that its existing Standards guidance has sufficient provisions to address the main areas of concern, and it was illogical to make implants a "special case" requiring more specific and prescriptive controls. Whether or not this stance will continue in the face of the increasing number of implant cases remains to be seen, but in the meanwhile the Standards guidance is drafted so widely and in such generic terms that it is very easy for case officers and fitness to practise committees to conclude that aspects of treatment involving implants have fallen foul of one or more paragraphs of *Standards for the Dental Team*.

Confidence and competence

There appears to be quite a prevalent misconception amongst the UK dental profession that training (in virtually any form) is synonymous with competence. This is possibly due in part to the way in which specialist lists were first established in the UK in the late 1990s, but also to the fact that dentistry largely takes place in general (and specialist) practice. In any event it mostly takes place outside the hospital environment, while our hospital-based medical colleagues are more familiar with the principle of microcredentialling.

Dental regulators elsewhere in the world have already grasped this nettle and by way of an example, the Dental Board of Australia has helpfully expanded upon the principle of competence and explains that having been trained to carry out a procedure, and there being no legal or regulatory prohibition on undertaking it, is still only part of a much wider set of considerations that a practitioner should be mindful of. The Panel below provides some of this detail.

If, having taken the decision to go ahead with a procedure the end result is an undesirable or harmful outcome for the patient, there may well be questions asked about whether this adverse outcome could have been avoided and, in some instances, whether the practitioner was correct in having taken the decision to proceed. These questions frequently involve a detailed scrutiny of all aspects of that decision, carried out with all the well-known benefits of hindsight. While this may seem somewhat unfair to a clinician who is making these decisions in real time, it also serves as a timely reminder that we might as well ask ourselves these questions before the event rather than waiting for lawyers and other third parties to ask them after the event.

Panel

What should you think about before providing treatment?

When assessing your own individual scope of practice, you should ask yourself the following questions:

- Am I practising within the requirements of the Dental Board's registration standard?
- Have I completed the necessary education and training?
- Are there other legislative / regulatory frameworks that I need to consider (for example, other regulatory requirements that determine a dental practitioner's capacity to possess, prescribe / supply and administer medications, and perform radiographic procedures)?
- Does my professional indemnity insurance provide cover for the clinical procedure(s) being undertaken?
- Does my workplace allow the practice? Does my employer have any additional specific requirements (for example, supervision requirements, requirements for treatment planning and referral)?
- Have I undertaken the practice / procedure recently?
- Do I feel confident to undertake the practice / procedure?

If you answered 'no' to, or are unclear on, any of these questions, you should refer the patient to another dental practitioner who is educated, trained and competent to undertake the practice / procedure.

Extract from Frequently Asked Question 10, Scope of Practice Registration standard and guidelines, Dental Board of Australia, 31 October 2014.

Duty of care

Every practitioner owes a duty to every patient in whose treatment they become involved, to exercise a reasonable level of skill and care (the “duty of care”). Every registered healthcare professional has a personal duty of care which has a legal, ethical and professional/human dimension.

You should only ever undertake procedures that you are trained and competent to carry out (and obviously, which are not prohibited by law). It is not a sufficient defence to say that you were only following the demands of the patient or the instructions of your employer. If you have a reasonable belief that you are being asked to do something illegal or beyond your scope of practice or competence, then you should not allow yourself to be persuaded to do it. Similarly, even in situations where you would not be acting illegally or beyond your scope of practice, if you do not believe that you will be able to treat a patient safely and to an acceptable standard, then you should not be treating the patient at all.

A patient that you know well may create the dual risks of familiarity and complacency (‘I have treated this patient for years and there have never been any problems’), while on the other hand treating a relative stranger carries the risk that you don’t know enough about them, and they may present risks that you have no way of anticipating.

Consent

There is an inherent risk in any situation where the patient apparently consents to a procedure in full knowledge of the nature, purpose, likely outcome, risks and benefits of that procedure and of any alternatives, but then things don’t go to plan. It is quite commonly alleged that the patient’s consent was actually invalid because they should have been warned that there was a possibility of you not being able to complete the procedure to an reasonable standard, and had you warned them to this effect, they would never have agreed to allow you to carry out the procedure, and would have elected instead to have been referred to someone who was better able to undertake the procedure.

Another manifestation of this is seen if you are relatively inexperienced in carrying out the procedure in question (or are carrying it out for the very first time or even, for the first time without supervision or outside a training environment), and the patient is blissfully unaware of this fact. Are they aware (if relevant) that they could improve their prospects of a successful outcome, or reduce any associated risks, if they elect to have the procedure carried out by a specialist or a more experienced colleague?

Most dental professionals are uncomfortable with the notion that they might need to reveal their relative inexperience to a patient, not feeling the need to expose themselves to the potential embarrassment when they feel perfectly capable of carrying out the treatment.

The helpful question to ask yourself is that of what information you would like a member of your own family to receive, were they to be contemplating a medical procedure at the hands of one of our medical colleagues. Should not every patient be entitled to make a free choice from the position of being in possession of all material information that might affect that choice?

Another risk of treating a patient that you do not know very well is that it becomes more difficult to establish with any degree of certainty what facts and risks this particular patient would attach significance to and which might therefore be material to their decision as to whether or not to proceed.

Taking a wider view

Section 7 of the GDC's guidance *Standards for the Dental Team* contains the following statement:

Standard 7.2

You must work within your knowledge, skills, professional competence and abilities

7.2.1 You must only carry out a task or a type of treatment if you are appropriately trained, competent, confident and indemnified. Training can take many different forms. You must be sure that you have undertaken training which is appropriate for you and equips you with the appropriate knowledge and skills to perform a task safely.

7.2.2 You should only deliver treatment and care if you are confident that you have had the necessary training and are competent to do so. If you are not confident to provide treatment, you must refer the patient to an appropriately trained colleague.

7.2.3 You must only work within your mental and physical capabilities.

All this seems simple enough at first glance. But it gets a lot more difficult when the procedure in question is in broad terms something that falls within a practitioner's scope of practice, but in the specific situation of an individual patient, on a particular day, could be beyond their ability to carry out the treatment safely and to an acceptable standard.

On these occasions, working your way through the checklist below, asking yourself each question in turn, may be helpful.

Should I carry out this procedure?

1. Am I legally permitted to carry it out?

2. Have I been adequately trained to carry out? Was this a formal course of study from a reputable and authoritative provider, the duration, content/structure and provenance of which is likely to be recognised as being sufficient and appropriate for the purposes of achieving the necessary knowledge, understanding and competence? Would I be able to satisfy the GDC or a court of law that this was the case?

3. Am I sufficiently experienced in carrying out this procedure? How many times have I carried out a similar procedure, how recently and with what degree of success?

4. Am I in a position to assess the complexity and potential risks of carrying out this procedure in this specific situation, taking account of:

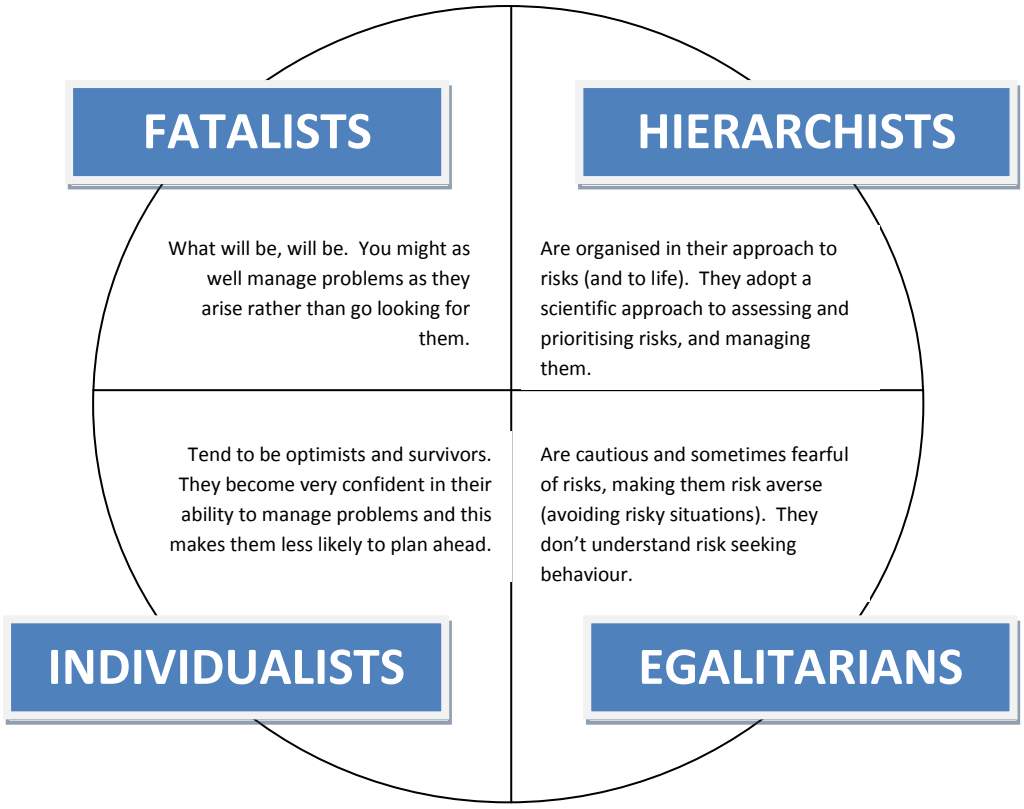
- *the patient in question*
- *the clinical situation*
- *the physical aspects of my working environment (the surgery facilities, the equipment and instruments, the lighting/access)*
- *the human aspects of my working environment (the competence and experience of the staff available to assist me)*
- *how the patient feels today*
- *how I feel today*
- *what fall-back (and/or support) I would have if I run into difficulties*
- *what alternative options exist – what else could I suggest? Is it possible that by postponing the treatment, my ability to carry it out to an appropriate standard on another occasion might be very different?*

5. In the light of all the above, am I still confident in my ability to carry out the procedure and complete it safely and to a satisfactory standard?

There is a lot more to the question of competence, then, than the bare bones of the GDC guidelines. Unfortunately, if you attempt a procedure and things don't go to plan, it might well be alleged (if a negligence claim were to be brought against you) that you could and should have been aware that the procedure was beyond your ability in the particular circumstances of that case, on that day, and taken the appropriate steps to refer the patient elsewhere or reschedule the patient.

Some practitioners are cautious by nature, while others tend to be more adventurous and perhaps less conscious of risks or more willing to disregard them. The danger for those in the latter group is that they may be a little overconfident on occasions, and too dismissive of the risks. The challenge - as always - is to find the right balance. Achieving that balance serves the best interests of the individual practitioner as well as that of the patient.

Professor John Adams of the Adam Smith Institute (in his 1999 book "Risky Business" - ISBN 1902737067, 9781902737065) suggests that each of us has a "default" approach to risk. The two groups on the left are essentially problem solvers and see no need to do anything until a problem arises. The two groups on the right anticipate and plan for risks in order to manage them effectively.



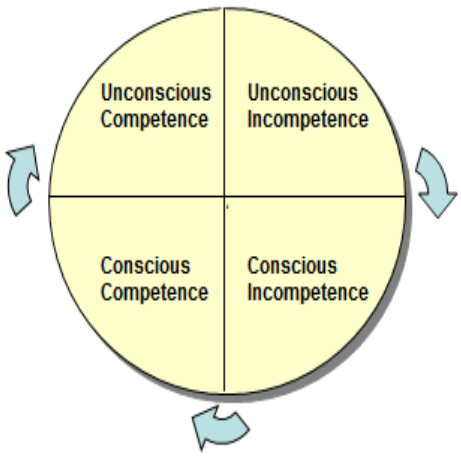
MALCOLM GLADWELL

In his best-selling book **"Blink! – the power of thinking without thinking"**, Gladwell explains the importance of intuition and being more trusting of our instincts. Healthcare professionals – like most highly trained experts in their chosen field – tend to have rigid systems and processes when making their decisions. Our many years of scientific training makes it even more likely that we will be vertical thinkers, always looking for evidence to support the decisions that we are about to make.

Gladwell has written other best-selling books – one of them **"Outliers**" in which he describes why it takes 10,000 hours of learning, diligent practice and repetition before one can become an expert in something. This is a daunting prospect for a new dental graduate.

MATTHEW SYED

His book **"Bounce"** echoes Gladwell's views on the value of practice and application. Syed believes that innate talent is not always necessary if you are prepared to put in the work and the hours. This is a very empowering prospect for anyone at the start of their career.



Whenever we start doing something for the first time, we will not (yet) be competent in carrying out that task. We may not realise this initially, but we move from this position of "unconscious incompetence" to one of "conscious incompetence", and then continue around the circle clockwise until (hopefully) we are competent without thinking too much about it. But see also the Kruger-Dunning effect (below).

DAVID DUNNING and JUSTIN KRUGER

Their work published in 1999 demonstrated that less skilled and less competent people tend to overestimate their level of competence and expertise, while those who are truly expert sometimes underestimate their true level of expertise. Socrates may have been quoted as saying that the one thing that he did know was that he knew nothing. But however improbable that sounds, it is important to understand a few basic things about training and competence:

- If an opportunity for the acquisition of knowledge and skill appears too quick and too easy to be true, it probably is.
- Be prepared to question the quality and substance of the further training that you seek.
- There are no short cuts to competence. There is no substitute for the investment of time, effort and (usually) money.
- Don't under-estimate the value of mentoring when you first try to apply a new skill. As soon as we undertake a new and unfamiliar procedure, or carry out a treatment for the first time, we become students again – no matter how capable or experienced we are in performing other procedures.

ROBERT BUNTING

Any new dental graduate is starting out on a long road of building their experience and extending and honing their skills. It is just not possible to be the "finished article" in any one area of clinical practice, let alone all areas – so during these early years there is a need to proceed with caution and circumspection. A revealing insight comes from the work of **Bunting and others**, who found that many complaints are triggered not just by the actual event(s) that tipped the patient over the edge into complaining (the "precipitating factors") – like an adverse outcome of some kind – but also because other things had already happened (the "predisposing factors") to create doubts and concerns. These predisposing factors included poor communication, a perceived lack of interest, rudeness or a lack of respect and it is significant that these are "people" issues that have little or nothing to do with clinical dentistry or the actual procedures undertaken.

In isolation, neither predisposing factors nor precipitating factors are generally sufficient to make a patient complain – it is the combination of the two that motivates the patient to take some kind of action rather than let things drop. There may be nothing wrong with the treatment, but a perception that there might be coupled with some people issues or misunderstanding, may be enough for the patient to decide to take things further. Good communication creates a better and stronger relationship between patient and clinician. Other dental team members can enhance (or detract from) this relationship, or help to compensate for less-than-ideal communication skills on the part of the clinician. Good communication right across the dental team, then, makes a major contribution to patient satisfaction. Happy, satisfied and appreciative patients:

- are less likely to complain; and
- are less likely to sue the dentist – even when mistakes occur.

For recent graduates and young dentists the message of Bunting's work is that in the years while you are building up your clinical skills, your best protection against complaints and claims being made against you is to work really hard at your communication skills – learning about verbal skills, how to use your voice in different situations, what to say and how, listening skills, non-verbal skills (body language), emotional intelligence, and perhaps advanced techniques like transactional analysis and neuro-linguistic programming (NLP).

But there are also lessons here for the more experienced practitioner or even for the specialist. Contrary to popular belief, even the best clinical skills do not provide automatic immunity from complaints and litigation.

Particular perils for the specialist

Perhaps surprisingly for some, specialists have their fair share of prosthodontics cases and in some respects are more in the firing line than the general (non-specialist) practitioner. There are several explanations for this, which are conveniently summarised in an article which is included as an appendix to this document. It is reproduced from Issue 43 of Riskwise UK, a publication for Dental Protection members.

Summary

Prosthodontics presents a host of dento-legal risks, which are compounded when the treatment is being carried out in the UK because of the heightened levels of litigation, complaints and regulatory scrutiny.

This should not lead to the conclusion that prosthodontics should be avoided, but instead should alert clinicians to the need for proactive risk management.

LEVITT Theodore ("Ted") Levitt was one of the architects and godfathers of marketing as it is understood and practised today. He argued that many businesses fail to see their product through the eyes of the customer because they are too internally focused. The more specialised and technical the business, the greater the danger that this will be so, and he advocated understanding the business that you are (really) in rather than the one you think you are in. He famously observed, at the time when the US railroad giants were forced to give way to the airlines – not just in terms of passenger traffic but freight traffic also – that:

"The railroads collapsed because they thought they were in the railroad business, when in fact they were in the transportation business."

There is a massive lesson for dentists in this statement. Many dentists and dental practices seem to believe that they are in the dentistry business, or the tooth business, or the implant or veneer business. In fact they are in the people business, and people buy people, long before they buy implants, bridges or veneers from them.

The most successful dentists treat people, not teeth.

Specialists: special risks?

Specialist practice and general dental practice are different in many important respects. But so also are the dento-legal risks faced by each group, and this is reflected in the number, type and magnitude of the cases that each group tends to generate. This article looks more closely at some of these differences and hopefully provides some food for thought amongst both generalists and specialists in various fields

Standards

While generalisations are often dangerous, it is fair to observe that cases involving general dental practitioners tend to feature a greater proportion of allegations which imply that the technical quality/standard of the treatment provided was deficient in some way. By and large specialists are more likely to get this aspect of patient care right because they are trained to be very good at what they do, and because they do it all the time. They build up a lot of experience too.

However, this higher level of expertise that comes with specialist status is a double-edged sword because in terms of their duty of care, the standard that the law (and the General Dental Council) expects of them - that of a specialist - is significantly higher than would be expected of a general dental practitioner.

Expertise and the competency trap

In his 1978 book '*Opportunities*', Edward de Bono - who by that stage had already introduced the world to the concept of 'lateral thinking' and came to be acknowledged as a leader and pre-eminent teacher of the art of thinking - spoke of the possibility of being trapped by intelligence, or trapped by expertise.

What he was suggesting was that there is an inherent danger in being particularly good at something, because it can close your mind to other possibilities and put you at risk of becoming complacent. As a result you simply remain very good, instead of looking for ways to become even better and achieving your full potential.

Since that time numerous people have referred, in many different fields, to 'Competency Traps' and this phrase is now in widespread use and applied in several different ways. In the context of a specialist in any branch of healthcare, the extra knowledge and experience of the specialist may give them an additional strength of conviction as to what represents the optimal treatment in a given situation, perhaps drawing from their in-depth knowledge of the current evidence base within their speciality. As a result they can be vulnerable in terms of the consent process if they fail to make the patient aware of the existence of other treatment options that they might wish to consider.

Clinicians are certainly under no obligation to offer or carry out treatment against their better judgment or which they consider to be not in the best interests of the patient - but nor are patients obliged to select from a restricted list of evidence-based options if they can find someone who is prepared to provide them with options that a specialist might not be willing to consider.

Partly for this reason, allegations of deficiencies in the consent process feature prominently in cases involving specialists, even where the treatment itself has been carried out to an acceptable standard.

Complexity

The first and perhaps most obvious challenge for specialists is that they may well be spending a high proportion of their time carrying out treatment that has been referred to them specifically because of its complexity.

They are often placed in the position of being the 'clinician of last resort' when other practitioners have tried unsuccessfully to deal with the patient's problems. The first question in the mind of anyone placed in this position – whether or not they happen to be recognised as specialists – should be to ask themselves why the previous treatment attempts have failed. The most tempting explanation is that the previous clinician(s) did not have the same level of knowledge and skill as the specialist - but this can also be a dangerous assumption if it leads the specialist to overlook other less obvious factors.

Patient expectations

These expectations of a successful outcome may be heightened because they know they are being treated by someone who is recognised as being expert in their field. Flattering as this may be, the patient's expectations must be contained within the realms of the achievable. The higher you allow the bar to be set, the more likely it becomes that you will finish up beneath it.

This calls for some very honest and direct conversations, to make sure that the patient is clear at the outset as to what can and cannot be achieved. It goes without saying that the records including any associated correspondence with the patient and any colleagues involved in the patient's care and treatment need to be sufficient to demonstrate that these conversations have taken place.

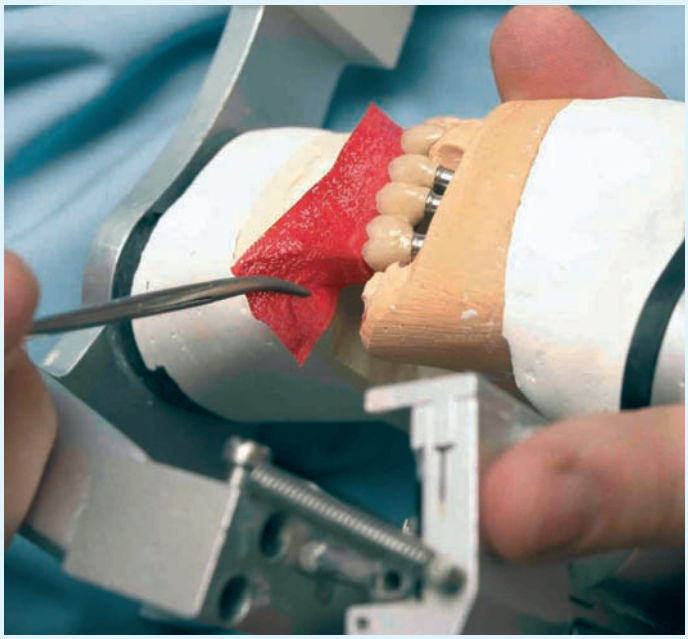
Another potential threat for specialists arises not from a claim in negligence, but from a claim based upon an alleged breach of contract. If you promote yourself as having skills that are greater than those of the average general dental practitioner, or imply that you can and will achieve better results than other dentists, you have similarly set the bar a lot higher in terms of the contract you are entering into with a patient. This risk is not, of course, restricted to specialists as general practitioners have also been known to claim or imply special expertise, knowledge and experience and in doing so, leave themselves open to the patient who later uses these claims to substantiate a breach of contract. See article on the latest GDC guidance about advertising on page 5.

Strangers

Specialists who rely heavily on referrals will often be treating someone very soon after meeting them for the first time, having had no previous relationship with them. It has long been recognised that there are particular risks associated with treating patients who we know little or nothing about. It is also well documented that one of our best sources of protection when things go wrong is the ability to draw upon any historic, positive relationship we have built up with a patient. But whereas a general practitioner might have months or years to build up a good rapport with a patient over successive courses of treatment, very few specialists enjoy this luxury.

Rapport

The word 'rapport' comes from a common French and Latin root meaning a close relationship or connection, especially of a harmonious or sympathetic nature. Many studies have shown that rapport is an essential prerequisite of a successful patient-clinician relationship in healthcare.The intimate physical relationship involved in healthcare raises the stakes in that patients feel safer and more comfortable and confident when they are satisfied that the person treating them is interested in them at a human level ('engagement'), and has their best interests at heart.



It is interesting to note that a surprisingly high proportion of claims arise out of the first course of treatment provided to a patient by a particular clinician. It is the combination of the complexity of the treatment, and the fragility of the short relationship that they might have had with the patient, that generates an extra risk for the specialist.

Consent

When meeting a patient for the first time, the clinician needs to make a judgement about the patient's competence and capacity to exercise their autonomy and free will in making decisions about their dental care. This can be difficult enough when treating longstanding patients and is fraught with risks when dealing with patients about whom we know very little. In any assessment of capacity there are a number of questions to ask:

- Can the patient understand the information being provided?
- Can a patient assimilate that information and appreciate its significance?
- Can the patient weigh up alternative options in a balanced and rational fashion?
- Can the patient make a decision?
- Can the patient communicate that decision in a clear and unambiguous way?

The patient and clinician may not share the same first language, and even when they do, the choice of words, phrases and any 'jargon' used may create a further barrier to effective communication and mutual understanding.

Because of their scientific training and clinical knowledge and experience, a specialist might find something perfectly simple to understand, while many patients who do not have such a background, may find it obscure and impossible to understand. On other occasions the sense is clear to the patient, but the relevance and application to their own personal situation is not.

It is no coincidence that almost every major case in the area of consent law has involved specialists of various kinds, rather than general practitioners. There is a message here for all specialists in terms of closing the knowledge gap between themselves and the patients they treat. It is in the nature of some specialities in particular that this gap in knowledge and understanding is huge and sometimes very difficult to close. As the complexity of the treatment increases, the potential consequences for the patient, if things don't go to plan, also increases and so does the triple challenges of;

a) having an up to date knowledge of the evidence base
b) understanding how it applies to the treatment being planned for each particular patient.
c) being able to translate what this evidence means for the particular procedure(s) being planned for this particular patient, in terms that are meaningful to the patient.

Another challenging aspect of the consent process when dealing with patients that we have only known for a short time, is that of deciding how much information we need to provide, and in what terms, in order for the patient's consent to be valid. From a dento-legal perspective, one of the most important requirements is the duty to warn each patient of possible limitations of treatment, and potential risks and complications. In doing so, we need to make another difficult assessment of what risks they might need to be made aware of.

Specialists: special risks?

Rogers v Whitaker

This question was conveniently described in a landmark Australian High Court decision in 1992 (*Rogers v Whitaker* 67 ALJR 47) in which the judgment stated

A risk is 'material' if in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

Similarly, consent cannot be said to be adequately informed if the patient misunderstands the information, perhaps because of the words used, or the way in which the information is imparted. At the beginning of the consent process the clinician has the advantage of knowing much more than the patient does, about what the procedure involves, about its risks, benefits, limitations, about alternatives and how they compare in each of these respects and also in terms of relative costs.

On the other hand, the clinician may also be at a similar disadvantage in knowing relatively little about the patient, and his/her life and personal circumstances. Meeting a complete stranger is never an ideal starting point for carrying out any clinical procedure, but it is inviting disaster when contemplating any procedure that carries significant risks for the patient.

The clinician must therefore ask the patient the right questions in the right way, at the right time, and needs to listen carefully to the patient's responses, in order to gain an insight into any additional information that this particular individual patient might require in order to decide whether or not to proceed. Any failure to elicit this information, if it might be material to the patient's decision, is more likely to be used to criticise the clinician, than to criticise the patient for not having volunteered the information without prompting. Patients, after all, may not understand why the information is even relevant, let alone important.

It will be obvious from the above that the less we know about a patient, the greater the risk that we will leave ourselves vulnerable to challenge in the consent process. For as long as the patient remains a relative stranger to us, the chances of us stumbling by chance upon the very information that has the greatest importance for that particular patient, are slender indeed, and that is the ever-present challenge for the specialist. This underlines the wisdom of doing as little treatment as possible in the early stages, while trying to find out as much as possible about the patient and proactively building up a relationship with them. This is easy enough for a general practitioner to do, but much more difficult for a specialist when asked to carry out a one-off, specific procedure.

The final consent pitfall for specialists to navigate themselves around is the allegation that the specialist has 'pulled rank' and has not treated the patient as an equal partner in the decision-making process, thereby abusing his/her position of trust and influence. The potential problem of any perception of arrogance or excessive control and influence being exerted by the clinician will be the charge that in adopting an authoritarian and paternalistic stance, the clinician has undermined the voluntariness and free choice that must be a feature of any valid consent to a healthcare procedure. Patients will generally attach a lot of significance to the advice given to them by people whose skill and expertise they respect and courts have shown themselves, time and time again, to be sympathetic to the patient who says that the clinician steered them too forcibly towards a particular decision.

The secret shopper

From time to time, specialists in some fields are likely to encounter the 'secret shopper' This is a patient who is seeking opinions from several different sources, sometimes to validate an opinion they have already received elsewhere, and on other occasions in the hope of finding someone who is prepared to tell them what they want to hear. Specialists should guard against being sucked into giving opinions or commenting on things that others are reported to have said or done. Wherever possible, specialists should develop the skill of being able to separate fact from opinion and to try wherever possible to get those facts and opinions direct from their source rather than second or third hand.

The referral interface

When a patient is referred to you for a specific procedure, it is not easy to have to explain both to the referring practitioner and to the patient, that you don't agree with the recommended treatment and are not prepared to provide it. Some of these decisions are clear-cut and straightforward while others may simply stem from the fact that you believe that a different treatment approach would have a better prognosis. But you should never allow concerns about potentially upsetting a valuable source of referrals, to influence you into doing something that you might later come to regret.

Shared care

Many specialists find themselves involved in multidisciplinary treatment of the same patient. Here the risk is that of breakdowns in communication, incorrect assumptions that somebody else is taking responsibility for something when they are assuming quite the reverse, and not least, important things falling through the cracks in between the various parties involved.

Identify all the involved parties at the earliest possible stage and with the patient's agreement, try to ensure that everybody is copied in on correspondence and kept aware of everything that is happening. Where joint consultations take place, detailed (duplicate) records should be maintained by all the involved parties rather than simply in the records of the clinician who might have been 'hosting' or leading the consultation.

Records

It is particularly ironic that it is the clinical records (or lack of them) that often prove to be the undoing of the specialist when faced with a complaint or claim. The impression is often given that the provision of the treatment itself is considered to be the 'main event' and the records are viewed as a burdensome and unnecessary administrative chore which merits as little time and energy as possible. This misplaced sense of priorities – especially in terms of the records kept of the communication and consent process - has resulted on many occasions in months or years of entirely avoidable stress and confrontation, for specialists whose actual treatment could have been defended very easily.

Summary

Specialists are, by definition, recognised as being experts in their field. But it is a misconception to believe that their special expertise protects them against being sued successfully. Even in the most competent and experienced hands, things don't always turn out as planned and it is on these occasions that any deficiencies in the consent process or the records can leave the specialist vulnerable.