MFDS / MJDF PART 1 · MODULE 4 · LECTURE 16

Law & Ethics · GDC, Consent & Complaints

Dr Reham Ragab · with GDC **Standards for the Dental Team** and **Guidance on reporting matters to the GDC** (sections 1, 2 and 5)

EXAM-DAY SUMMARY

everything on this page → detail in §§ overleaf

THE GDC → §1

- Statutory regulator, **Dentists Act 1984** — duty to the public, not to registrants
- Council 12 = 6 dentists/DCPs + 6 lay
- 12 specialist lists (orthodontics not one of them)
- Functions: register · standards · education quality · protect patients & assist complaints

RETENTION FEES → §1

- Dentist £621 · specialist list £72 per specialty → both **31 December**
- DCP £96 → 31 July
- Examinable split = the deadline, not the amount

FTP GROUNDS & ROUTE → §2

- Grounds: misconduct (incl. private life) · deficient performance · adverse health
- Caseworker → Investigating Committee → FTP Committee
- IC ceiling = advice or warning — ✗ suspend, ✗ erase
- Committees: Performance · Health · Conduct (criminal convictions)

SANCTION NUMBERS → §2

- Erasure **5 yr** before restoration may be applied for
- Suspension 12 months · conditions 3 years · reprimand = no restriction, public record
- IOC: 18 months, 6-monthly review, any stage

NEGLIGENCE → §3

- Duty → breach → damage from that breach — all three
- Bolam 1957 responsible body · Bolitho 1997–98 logic check · Montgomery 2015 patient's view
- Criminal · contributory · vicarious liability
- Breach without harm ✗ negligence (may still be a GDC matter)

COMPLAINTS CLOCK → §4

- Acknowledge 3 working days · respond 10 working days (20 hospitals)
- Patient complains < 12 months of event · < 6 months of realising
- Delayed → update at least every 10 days (5.3.6)

COMPLAINT ROUTES → §4

- Local resolution → Dental Complaints Service → Ombudsman
- DCS: GDC-funded but independent, private only; panel 2 lay + 1 dental
- Ombudsman: last resort, independent of NHS and DCS
- Illegal practice = unregistered/erased/suspended doing dentistry, whitening, dentures, titles

REPORTING TO THE GDC → §5

- In force 1 Feb 2025 · Dentists Act 1984 ss 26B, 36M, 27, 36N
- §1 local first → GDC immediately if still concerned; cease practising if necessary
- §2 must = another healthcare regulator's FTP · **should** = other public-body findings
- §5 respond in full in time · tell indemnifier ASAP · co-operate + comply

RECORDS → §6

- Adults ≥ 11 yr · children to 25 or 11 yr, whichever LONGER · extensive work indefinitely
- Good records = good defence · radiographs · study casts · pre/post photos · PDP
- Patients ✗ own records → right of access; encrypt + back up

CONSENT → §7

- Implied = primary exam only · verbal = minimum for treatment · written for long/complicated plans
- Written mandatory for sedation + GA (3.1.6)
- Valid = informed + voluntary + capacity; discussion, not signature, decides validity (3.1.2)
- Self-consent from 16 · Gillick < 16 = sufficient understanding + intelligence

CAPACITY → §7

- No one consents for an adult lacking capacity at common law
- MCA 2005 → LPA; no LPA → best interests, to preserve life/health/well-being
- 6 steps: participate · circumstances · no discrimination · may regain? · consult · IMCA
- Final decision-maker = the treating clinician; relatives consulted, not consenting

STANDARDS NUMBERS → §8

- Nine principles, equally important, not ranked · must = compulsory, should = qualified
- 6.2.6 one other person for emergencies · 6.6.6 employer arranges two
- 7.2.1 trained + competent + confident + indemnified · 5.1.7 complaint records kept separate
- 9.3 tell GDC: criminal proceedings anywhere · other regulator's FTP · barred list

SAFEGUARDING → §9

- Red flag = history ✗ fit the injury · shifting story · delayed presentation
- Marks at front of wrists, hands, arms, neck, back
- Document → discuss with colleague → GMP → child protection advisor → hospital
- 4.3.3 inform social care or police · 8.5.2 know local procedures in advance

§1 The General Dental Council

KEY POINTS

Statutory regulator of the whole dental team under the **Dentists Act 1984** · Council 12 = 6 registrants + 6 lay · 12 specialist lists · duty owed to the **public**, not to registrants.

- **Status**: statutory regulatory body, created under the Dentists Act 1984 → regulates dental professionals across the UK
  - ✗ trade union · ✗ charity · ✗ NHS department — its duty runs to patients and the public
- **Council**: ★**12 members = 6 dentists/DCPs + 6 lay** → deliberate parity of lay representation
- **Specialist lists**: ★**12**
  - oral surgery · paediatric dentistry · prosthodontics · oral medicine · dental & maxillofacial radiology · restorative dentistry · endodontics · periodontics · oral microbiology · oral pathology · dental public health · special care dentistry
- **Registrant groups** bound by GDC standards: dentists · dental nurses · hygienists · therapists · orthodontic therapists · dental technicians · clinical dental technicians
- **Four core functions**: maintain a register of qualified dental professionals · set standards of practice, conduct and ethics · assure the quality of dental education · protect patients and assist with complaints
  - ✗ negotiating NHS contract values — not a regulatory function

Table 1 — Annual Retention Fee (ARF): amount and deadline

Registrant	ARF	Due by
Dentist	£621	31 December
Specialist list entry	£72 per specialty	31 December
DCP — nurse, technician, therapist, hygienist, clinical dental technician	£96	31 July

- **The examinable split**: the **deadline**, not the amount → dentists and specialists 31 December · DCPs 31 July
- **Specialist fee is per specialty**: dual list entry → pay twice

★ EXAM PEARL

Two traps in one section. **Orthodontics is not among the 12 specialist lists** as the lecture gives them — yet **orthodontic therapists** are a registrant group under *Standards for the Dental Team*: registrant title ≠ specialist list. And ARF figures are revised yearly — learn the structure and the two dates, check current amounts before quoting them clinically.

§2 Fitness to practise

KEY POINTS

Three grounds: **misconduct · deficient performance · adverse health**. Route: caseworker → Investigating Committee → FTP Committee. Only an FTP Committee (or the IOC, interim) can touch registration.

- **Grounds of impairment**: misconduct — professional **or personal** · deficient professional performance · adverse health, physical or mental
- **Misconduct reaches outside work**: private behaviour is examinable precisely because it can undermine public confidence even with no patient harmed
- **1 · Caseworker**: assesses whether issues are raised about the registrant's fitness to practise → the registrant may be made aware of the complaint and asked for case records
- **2 · Investigating Committee**: assesses all case information, including the registrant's response
  - three outcomes → no further action · advice or a warning · refer to a Fitness to Practise Committee ± the Interim Orders Committee
  - ✗ cannot suspend, ✗ cannot erase — its strongest outcome is a warning
- **3 · Fitness to Practise Committees**: hold the hearing and impose the sanctions

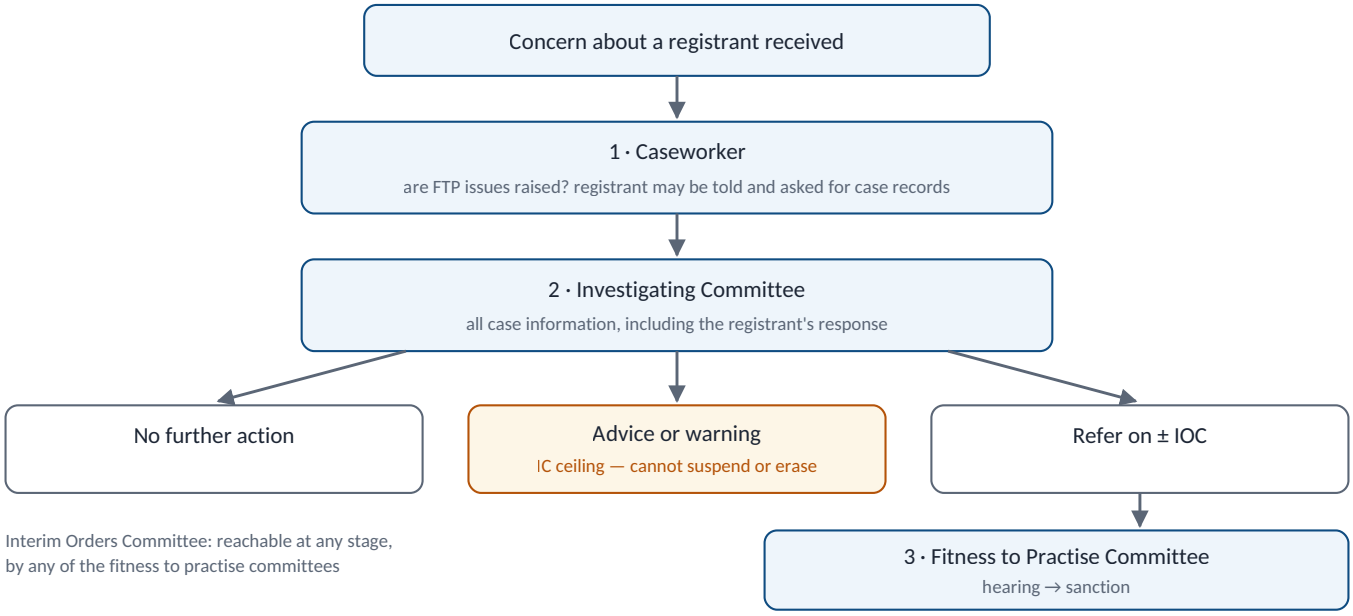

Diagram 1 — The FTP investigation route: caseworker screens, Investigating Committee decides, FTP Committee sanctions.

Table 2 — The three Fitness to Practise Committees

Committee	Remit
Professional Performance	Deficient professional performance
Health	The registrant's mental and physical health problems
Professional Conduct	Criminal convictions and major misconduct

Table 3 — Sanctions and their maxima

Sanction	Maximum
Erasure from the register	up to 5 years
Suspension from the register	up to 12 months
Conditions on registration	up to 3 years
Reprimand	—

- **Ladder to memorise**: ★**5 years erasure · 12 months suspension · 3 years conditions**
- **Erasure**: removal from the register → the 5 years is the **minimum before restoration may be applied for**, not a ban that expires on its own; restoration must be applied for and granted
- **Reprimand**: no restriction on practice → but stays on the register entry as a public record
- **Interim Orders Committee (IOC)**: statutory committee acting **before** a case concludes
  - grounds → public protection · the public interest · the individual's own interest
  - referral at **any stage**, by any of the FTP committees
  - powers → suspension up to 18 months **or** conditions up to 18 months, both with 6-monthly reviews · or no order

★ EXAM PEARL

Interim ≠ final. The IOC's **18 months** is a holding measure pending the substantive hearing; the FTP Committee's **12-month** suspension is the final sanction. Candidates routinely swap the two numbers.

§3 Negligence and medical law

KEY POINTS

Negligence = failure to exercise reasonable care in a professional capacity **resulting in harm**. All three limbs — duty, breach, damage caused by the breach — must be proved. A breach without harm is not negligence, though it may still be a GDC matter.

- **Definition**: failure to exercise reasonable care in one's professional capacity which results in a patient suffering harm

1. **Duty of care** was owed to the patient

2. **Breach** of that duty occurred
3. **Damage** to the claimant as a **direct result** of the breach → causation

Table 4 — Landmark cases in medical law

Case	Year	What it established
Bolam	1957	No negligence if a responsible body of other professionals would have acted the same way — expert-opinion based
Bolitho	1997–98	The judge may find the body of expert opinion cannot be logically supported, and rule against it
Montgomery	2015	Consent shifts from doctor-based judgement to the patient's perspective and best interests

- **One line each**: Bolam = the profession sets the standard · Bolitho = the court may override the profession if its logic fails · Montgomery = the patient decides what is material
- **Criminal negligence**: very serious, with aggravating factors → prosecuted, not merely sued
- **Contributory negligence**: the patient's own actions partially or wholly involved in the resulting damage → reduces the award
  - e.g. post-op instructions ignored → dry socket
- **Vicarious liability**: the dentist is responsible for the actions of staff and those acting under his or her direction → pairs with Standards 6.3.1, delegate the task never the accountability
- **Worked discrimination**: paraesthesia after a lower third molar, standard technique, risk warned of, deficit resolved → duty yes, damage arguable, **breach fails** → claim fails

★ EXAM PEARL

Correction to the slide. The lecture attaches the "understand – retain – use – communicate" test to *Montgomery*. That four-part test is the **Mental Capacity Act 2005** test of capacity. *Montgomery* is about **disclosure of material risks** — those a reasonable patient in that position would attach significance to. Keep the two apart.

§4 Complaints, public protection and illegal practice

KEY POINTS

Three categories: **concerns about a dental service · public protection issues · illegal practice**. Service complaints climb local resolution → Dental Complaints Service (private) → Ombudsman (NHS).

- **Complaint defined**: any expression of dissatisfaction about any aspect of a dental service or treatment that requires a response
- **Local resolution**: direct in the workplace, or to the Health Board / NHS → most complaints end here
- **After the response**: the complaint must be **fully investigated** and a full **written** response provided

Diagram 2 — The three stages of a complaint about a dental service, with the statutory clock.

Table 5 — Complaint time limits

Requirement	Limit
Acknowledge the complaint	3 working days
Primary response	10 working days (20 for hospitals)
Complaint made after the event	< 12 months
Complaint made after the patient realises the problem	< 6 months

4.1 Dental Complaints Service

- **What it is**: independent complaints service **funded by the GDC** → for patients of private dental practice, including a private service delivered within an NHS practice
- **Step 1**: encourage local resolution → give advice
- **Step 2**: work with both parties to reach agreement without taking sides → a professional second opinion may be requested
- **Step 3 — panel meeting**: ★**2 lay members + 1 dental professional** → hears the case, facilitates resolution, makes a recommendation
- ✗ **Powers over registration**: those belong to the GDC's FTP committees alone

> ★ EXAM PEARL
> The DCS is **funded by the GDC but independent of it**, and handles **private** complaints only. NHS complaints run local resolution → Ombudsman. Sending an NHS complaint to the DCS is the classic wrong option.

4.2 NHS Ombudsman

- **Position**: independent of both the NHS and the DCS → investigates only if the patient remains dissatisfied after all previous procedures
- **Outcomes**: apology · explanation of what went wrong · change in the decision made · repayment of costs · change in procedure · improved facilities
- **Compensation**: for patients disadvantaged by administrative failings

4.3 Public protection issues and illegal practice

- **GDC remit**: serious concerns about the clinical practice, behaviour or health of dental professionals — **at work or in their own time**
- **Threshold**: conduct that could be causing significant harm to patients or the public · significant harm to colleagues · undermining public confidence in the profession
- **Examples investigated**: serious or repeated mistakes in patient care or treatment, including breaking patient confidentiality · not responding to a patient's needs, including failing to refer for further investigation · violence, sexual assault, misconduct and discrimination, **including online** · criminal offences including potential fraud or theft
- **Illegal practice**: someone **not registered** with the GDC offering or providing dental services → explicitly includes **tooth whitening** and **fitting dentures**; also illegal to use a dental professional title when not registered
  - covers unregistered, ★**erased or suspended** individuals who offer treatment or advice, offer whitening, make or fit dentures direct to the public, call themselves dentists or other dental titles, or receive payment for dental treatment or advice
  - an erased or suspended registrant who treats a patient commits illegal practice — the same offence as a beautician offering whitening

§5 Reporting matters to the GDC — sections 1, 2 and 5

GDC *Guidance on reporting matters to the General Dental Council*, effective **1 February 2025**; legal basis in the Dentists Act 1984, sections 26B, 36M, 27 and 36N.

> KEY POINTS
> **§1** concerns about fitness to practise — yours and colleagues'. **§2** regulatory or public body proceedings. **§5** co-operating with an investigation. Shape throughout: act locally first, GDC immediately if the concern survives that.

5.1 Section 1 — concerns about fitness to practise

- **Your own**: you **must** inform the GDC if you have concerns about your own conduct, performance or health that impact on your fitness to practise
- **Health triggers to consider**: diagnosis of a **new** physical or mental health condition that might affect safe practice · a **relapse** in an existing condition · changes to the work environment that have **reduced local support**
- **Local first**: speak to your manager, employer or practice principal about the risk your health poses → act on it
  - advice from peers, occupational health or a medical doctor · changing, adapting or limiting practice · reasonable adjustments
- **Then escalate**: still concerned your fitness to practise might be impaired → inform the GDC **immediately** and **cease practising if necessary**

- **Conduct and performance**: address locally in the first instance → GDC immediately if you remain concerned, the issue cannot be resolved locally, and patients may be at risk or confidence reduced
- **Colleagues**: you **must** raise concerns about a colleague's health, conduct or performance → graduated: speak to them · encourage them to get help · notify their manager, employer or principal → GDC immediately if still concerned
- **Limit on referral**: raising a concern with the GDC is a serious matter → use professional judgement, raise only where there is a ★**reasonable concern not related to personal or employment matters**

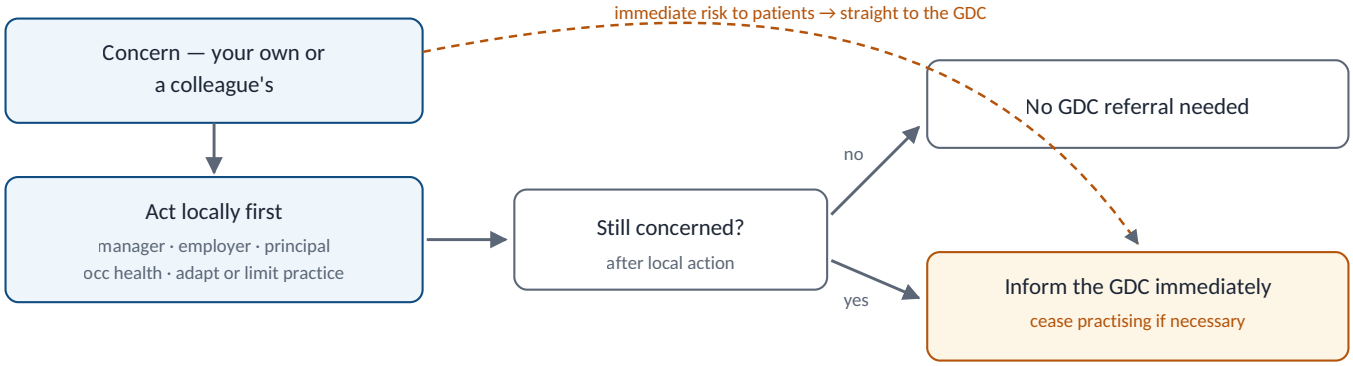

Diagram 3 — Section 1 in shape: local action first, GDC immediately if the concern survives it — or at once where risk is immediate.

5.2 Section 2 — regulatory or public body proceedings

- **Must**: inform the GDC **immediately** if you are subject to the fitness to practise procedures of **another healthcare regulator** — in the UK or anywhere else in the world
- **Should**: contact the GDC if findings made by **any public body** raise concerns about your conduct, performance or behaviour such that patient safety and/or public confidence could be affected
- **If someone else reports it**: the GDC may open a fitness to practise case where it considers the finding raises such concerns

5.3 Section 5 — co-operating with an investigation

- **Respond**: contacted by the GDC or a public body → you **must respond in full within the time specified**
- **Indemnity first**: if the communication concerns your fitness to practise → notify your indemnity/insurance provider as soon as possible; you may seek advice from your indemnifier or professional association
- **Two continuing duties**: a concern raised **by** you or **about** you → professional obligation to **co-operate with any investigation** and to **comply with any sanction** that may follow (e.g. conditions on your practice)

Table 6 — Must or should: the reporting triggers

Trigger	Duty	Timing
Own FTP concern surviving local action (§1)	must inform	immediately; cease practising if necessary
Colleague's FTP concern surviving local action (§1)	must raise	immediately
Another healthcare regulator's FTP procedures (§2)	must inform	immediately, worldwide
Findings by any other public body (§2)	should contact	where safety or confidence could be affected
Letter from the GDC or a public body (§5)	must respond in full	within the time specified

★ EXAM PEARL

Watch the modal verbs: **must** for another healthcare regulator's FTP process, **should** for other public-body findings — "must" is compulsory, "should" applies unless exceptional circumstances outside your control. And failing to reply to a GDC letter is not a neutral act: non-co-operation is itself a fitness to practise matter, mirroring Standards 9.4. First move on receiving one is always **contact your indemnifier, then respond in full and on time**.

§6 Records, retention and defensible practice

KEY POINTS

Good records = good defence. Adults ≥ 11 years · children to 25 or 11 years, **whichever is longer** · extensive work indefinitely. Patients do not own their records but have a right of access.

- **Wise precautions**: radiographs whenever justified · study casts for the stages of treatment · pre- and post-operative photographs
- **Always**: protect the patient's **eyes and airway**
- **Stay current**: familiar with current evidence · hold a **Personal Development Plan (PDP)** for structured learning · refer to a specialist when needed · best infection control measures · act in accordance with up-to-date GDC guidance
- **Record content (4.1)**: contemporaneous, complete and accurate · up-to-date medical history at **every** visit · amendments clearly marked and dated · treating clinician's name or initials
- **Ownership and access (4.4.1)**: patients do **not** own their records → right of access under data protection law, arranged promptly
- **Security (4.5.2)**: send or store confidential information securely → **encrypted** if electronic · back up computerised records and images

Table 7 — Record retention

Patient	Retention
Adults	at least 11 years
Children	until age 25, or 11 years — whichever is **longer**
Extensive dental work	indefinitely

- **What counts as the record**: radiographs · consent forms · photographs · models · audio/visual recordings of consultations · laboratory prescriptions · statements of conformity · referral letters
  - ✗ the practice's written record of that patient's **complaint** — deliberately kept separate (5.1.7)

★ EXAM PEARL

The trap is the word **LONGER**. A 9-year-old treated today → records to age 25 (16 years beats 11). A ★**16-year-old → 11 years, i.e. to age 27**, not to 25.

§7 Consent and capacity

KEY POINTS

Valid consent = **informed + voluntary + capacity**. Consent is a process, not an event. Self-consent from 16; under 16 by Gillick competence. No one consents for an adult who lacks capacity — treatment proceeds in their **best interests**.

- **Ground rules**: every patient has the right to choose whether or not to accept your advice or treatment → no treatment except after patient consent

Table 8 — Types of consent and where each is enough

Type	Scope
Implied	Primary examination only
Verbal	The minimum that should be obtained for treatment
Written	Most preferable — long or complicated plans; **compulsory** for conscious sedation and GA (3.1.6)

- **Valid consent needs three**: **informed** — enough information, nothing hidden, no leading or misleading · **voluntary** — the patient feels free to decide · **ability** — capacity to make an informed decision
- **Signature ≠ validity (3.1.2)**: the signature verifies that consent was given → the **documented discussion** determines whether it is valid — the practical face of *Montgomery*
- **A process, not an event (3.3)**: must remain valid at each stage → specific consent for what you do at each appointment
- **Withdrawal (3.1.5)**: patients may withdraw consent, refuse treatment or ask for it to be stopped after it has started → follow their wishes · explain the consequences and risks of not continuing · make clear they carry responsibility for future problems · record it all
- **Age**: mentally capable patients ★**16 and over** consent for themselves

- **Gillick competence**: a child under 16 with **sufficient understanding and intelligence to fully understand what is proposed** may consent → turns on understanding, not on urgency or on the parents being unreachable
- **The lecture's emergency conditions** for treating a child under 16 without parental consent: every attempt made to reach the parents · an emergency with a critical time factor · treatment in the patient's best interests
  - worked example → avulsed upper central incisor, parents uncontactable: replant, splint, document every attempt to reach them. A teacher cannot give proxy consent

★ EXAM PEARL

Correction to the slide. What the lecture describes as Gillick is the **emergency doctrine**. Gillick competence applies in non-emergencies too and does not require the parents to be unreachable. The slide also reads "Mental Capacity Act 20057" and gives **18** as the age of self-consent — the Act is **2005** and applies from age **16**; 18 is the minimum age to *create* an LPA.

7.1 The patient who lacks capacity

- **Common law**: **no person** can consent on behalf of an adult who lacks mental capacity
- **MCA 2005**: allows a person to grant another individual a **Lasting Power of Attorney (LPA)** to make medical decisions should their capacity become impaired
- **No LPA**: treatment necessary to preserve **life, health or well-being** may proceed, provided it is in the patient's best interests
- **Capacity test (MCA 2005)**: understand · retain · use or weigh · communicate

1. **Encourage participation** — help the person take part in the decision
2. **Identify all relevant circumstances** — what they would take into account if they had capacity: past and present views, beliefs and values, religious and cultural
3. **Avoid discrimination**
4. **May capacity return?** — relevant if treatment can be deferred
5. **Consult others** — carers, close relatives, the LPA, a deputy appointed by the Court of Protection
6. **IMCA** — an Independent Mental Capacity Advocate may be appointed where **major medical treatment** is contemplated

- **Final decision-maker**: the clinician carrying out the particular treatment
- ✗ **Never a factor**: cost to the practice

CAUTION

Relatives are **consulted, not consenting**. "Obtain consent from the next of kin" is the single most common wrong answer in a capacity vignette — next of kin has no such power unless they hold a registered health-and-welfare LPA.

§8 Standards for the Dental Team — the nine principles

KEY POINTS

Nine principles, binding on all registrant groups at all times, **equally important and not in order of priority**. **Must** = compulsory · **should** = the duty would not apply in all situations, or exceptional circumstances outside your control affect compliance. Serious or persistent failure → removal from the register.

Table 9 — The nine principles

#	Principle
1	Put patients' interests first
2	Communicate effectively with patients
3	Obtain valid consent (→ §7)
4	Maintain and protect patients' information
5	Have a clear and effective complaints procedure
6	Work with colleagues in a way that is in patients' best interests
7	Maintain, develop and work within your professional knowledge and skills
8	Raise concerns if patients are at risk
9	Make sure your personal behaviour maintains patients' confidence in you and the dental profession

8.1 Principles 1 & 2 — interests first, communicate effectively

- **1.7**: patients' interests before your own or those of any colleague, business or organisation
  - 1.7.5 refuse gifts, payment or hospitality that could affect, or appear to affect, your professional judgement
  - 1.7.8 do not end a professional relationship **solely** because a patient complained → any decision must be fair and justifiable, put in writing, with arrangements for continuing care
- **1.5**: 1.5.3 follow Resuscitation Council (UK) guidance on medical emergencies · 1.5.4 record **all** patient safety incidents and report them promptly to the appropriate national body
- **1.8.1**: hold appropriate **insurance or indemnity** so patients can claim compensation
- **2.2.1**: before treatment starts explain the options — **including delaying treatment or doing nothing** — with risks and benefits of each, plus full information on the proposed treatment and possible costs
- **2.3.6 / 2.3.7**: written treatment plan before treatment starts, retain a copy, ask the patient to sign → must state the proposed treatment · a realistic indication of cost · whether NHS or private (and which elements are which if mixed)
- **2.4.1**: display a simple price list in reception → consultation · single-surface filling · extraction · radiographs (bitewing or pan-oral) · hygienist treatment; a "from–to" range is acceptable for variable items
- **2.1.2**: be sufficiently fluent in written and spoken English

8.2 Principle 4 — confidentiality

- **Breach = major misconduct** — and appears on the GDC's public protection list of matters investigated
- **4.2.3**: ✗ posting information or comments about patients on social networking or blogging sites → anonymised professional discussion must leave patients unidentifiable
- **4.2.8**: confidentiality **persists after the patient dies**
- **4.2.9 / 4.2.7**: covers photographs, video and audio, originals and copies, **including on a mobile phone** → no recording may be made without permission, and wider use needs separate consent
- **4.3.3**: patient at risk of significant harm, or abuse suspected → **must** inform the appropriate social care agencies or the police
- **4.3.4 / 4.3.5**: under court order or statutory duty release only the **minimum information necessary** → document your reasons for any release

Table 10 — Breach of confidentiality: consented vs unconsented

Consented	Unconsented but justified
Other healthcare professionals participating in the patient's care and treatment	Certain notifiable infectious diseases
Insurance companies seeking information about injury claims	Serious injury or dangerous occurrences
Solicitors acting for the patient or for others	When ordered by a court
—	In the public interest — justified even to protect a single member of the public

★ EXAM PEARL

Before an unconsented public-interest disclosure, **4.3.1–4.3.2** expects you to first try to obtain the patient's permission, **document the efforts you made**, and take advice from your defence organisation. Disclosing straight away without that trail is the wrong option even when the disclosure itself is justified.

8.3 Principle 5 — complaints procedure

- **5.1.1**: an effective **written** complaints procedure where you work → follow it at all times, respond within its time limits, give a constructive response
- **5.1.2**: employ or manage a team → all staff trained in handling complaints and know how the procedure works
- **5.1.4**: private practice, including a dental body corporate → similar standards and time limits to the NHS procedure
- **5.1.5**: displayed where patients can see it → patients should not have to ask for a copy
- **5.1.7**: written record of all complaints and responses kept **separate from the patient records** → so patients are not discouraged from complaining; use it to monitor performance
- **5.3.6**: usual timescale cannot be met → regular updates at least every **10 days**, and tell the patient when you will respond
- **5.3.9**: justified complaint → a fair solution, which may mean putting things right **at your own expense** if you made the mistake

- **5.3.11**: patient still unsatisfied → tell them about other avenues: the health service Ombudsman, or the DCS for private treatment

8.4 Principle 6 — colleagues, delegation and emergencies

- **6.1.6**: you can be held responsible for the actions of team members who do **not** register with the GDC — receptionists, practice managers, laboratory assistants
- **6.2.2**: work with another appropriately trained team member at all times when treating patients
  - exceptions → out-of-hours emergency · a public health programme · exceptional circumstances = unavoidable, non-routine, unforeseeable. **Leave and training are not exceptional**
- **6.2.6**: ★**at least one** other person available to deal with medical emergencies while treating → in exceptional circumstances a receptionist or the patient's escort
- **6.6.6**: as employer or manager → arrangements for ★**at least two** people available for medical emergencies when treatment is planned · everyone knows their role · regular simulated emergency practice
- **6.3.1**: delegate the **responsibility** for a task, never the **accountability** · **6.3.2** never take advantage of your position to pressurise a colleague who does not feel trained or competent
- **6.6.11**: display that you are regulated by the GDC, and the nine principles, where patients can see them

> ★ EXAM PEARL
> Two numbers, two roles: as a **treating clinician** you need **one** other person available for emergencies (6.2.6); as an **employer or manager** you must arrange for **two** (6.6.6).

8.5 Principle 7 — knowledge, skills and CPD

- **7.1.1 / 7.1.2**: find out about and follow current evidence and best practice → deviation permitted only if you **record the reasons** and can justify the decision
- **7.2.1**: carry out a task or treatment only if **appropriately trained, competent, confident and indemnified** — all four
- **7.2.3**: work only within your mental and physical capabilities
- **7.3.1**: know how much CPD is required to maintain registration and complete it within the required time

8.6 Principle 8 — raising concerns

- **8.1.1**: raise a concern where patients might be at risk from a colleague's health, behaviour or performance · any aspect of the treatment environment · or being asked to do something that conflicts with your duty to patients
  - the duty **overrides personal and professional loyalties**, and applies even if you cannot control the working environment
- **8.1.2 / 8.3.4**: never enter into — or, as an employer, offer — a contract containing a **"gagging clause"** about patient safety
- **8.2.2**: you do **not** have to prove a concern for it to be investigated → if you were justified in raising it, it should not be held against you; failing to raise one can put your own registration at risk
- **8.2.3**: raise concerns first with your employer or manager — **unless they are the source** of the concern
- **8.2.4**: inappropriate or no action taken → escalate to your local commissioner of health or the relevant body
  - Care Quality Commission (England) · Healthcare Inspectorate Wales · Regulation and Quality Improvement Authority (Northern Ireland) · Healthcare Improvement Scotland
- **8.2.5 — straight to the GDC**: local action impractical or failed · severity such that the GDC clearly needs involvement (indecency, violence, dishonesty, serious crime, illegal practice) · genuine fear of victimisation or deliberate concealment · you believe a registrant may not be fit to practise

> ★ EXAM PEARL
> Concerns about **other** healthcare professionals go to **their own regulator** (8.2.6) — a doctor to the GMC, a pharmacist to the GPhC. The GDC regulates the dental team only.

8.7 Principle 9 — personal behaviour

- **9.1.1–9.1.4**: conduct at work **and in personal life** must justify patients' trust → no disparaging remarks about a colleague in front of patients · nothing published in public media that could damage confidence · maintain appropriate boundaries with patients
- **9.2.1 / 9.2.2**: patients may be at risk from your health, behaviour or performance → consult a suitably qualified colleague **immediately**; do **not** rely on your own assessment of the risk you pose — seek occupational health advice as soon as possible

- **9.3**: inform the GDC immediately if → subject to criminal proceedings **anywhere in the world** (9.3.1) · subject to another healthcare regulator's FTP procedures · a finding is made against your registration · you are placed on a DBS or Disclosure Scotland **barred list** (9.3.4)
- **9.4 / 9.4.2**: respond fully within the time specified to a GDC letter, and co-operate with commissioners of health · other healthcare regulators · hospital trusts investigating · the Coroner or Procurator Fiscal · any other regulatory body · the Health and Safety Executive · lawyers representing patients or colleagues

§9 Safeguarding — non-accidental injury

KEY POINTS

The discriminator is the **mismatch between history and injury**, not the injury itself. Sequence: document → discuss → GMP → child protection advisor → hospital. Never confront the parent, never discharge unrecorded.

- **Suspicious features**: the history given by the parent is not consistent with the clinical findings · unclear history of trauma and unclear answers to history-taking questions · suspicious body marks, injuries or bruises — especially at the **front of the wrists, hands, arms, neck region and back**
- **Worked example**: 4-year-old, torn labial frenum + neck bruising, the mother's account of a fall changes twice → the shifting story is the finding that matters

1. **Documentation**
2. **Discuss** your suspicions with a colleague
3. **GMP** — if justified, call the patient's general medical practitioner
4. **Child protection advisor** — call the local advisor
5. **Hospital** — if afraid, refer

- **8.5.2 — before the case walks in**: know your local procedures for the protection of children and vulnerable adults, and who to contact for advice
- **4.3.3**: patient is or could be at risk of significant harm → inform the appropriate social care agencies or the police

★ EXAM PEARL

Nowhere in the sequence do you **confront the parent** with an accusation or discharge the child unrecorded. A delayed presentation and a shifting story carry more weight than any particular bruise pattern — the exam rewards "document and refer to the safeguarding lead", never "keep watching".