Strengthening the General Dental Council
A Consultation Response

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The case of Dr Shipman has focused public attention on the importance of regulation to ensure that all healthcare professionals meet minimum standards in the provision of patient care. The General Dental Council (GDC) has a central role in ensuring that all registered dentists fulfill these standards.

Sir Ian Kennedy said, in his Report that the GDC "needs an independence from the professions and from government which allows it to act in the public interest". (Kennedy Report). These observations arise from that basic principle.

Introduction

The independence of the medical and dental professions is perhaps the most important ingredient in the traditional patient/practitioner relationship in the UK. The preservation of public confidence and trust in the dental profession is within the guardianship of the GDC.

A past President of the GDC Sir Robert Bradlaw drew particular attention to the role of the general dental practitioner (GDP) and the very significant part GDPs play in the delivery of primary care in the UK. It is vital to recognize the fact that the delivery of primary dental care is still largely within the remit of dental practitioners in private practice. Unlike primary medical care, the NHS subcontracts the General Dental Services from the private sector. Much confusion in the public eye is created by the perception of NHS dentistry as some sort of state-owned brand.

The regulation of the practice of dentistry and the professional standards that apply are functions rightly delegated to the GDC through government legislation. **The various methods of funding the delivery of dental services are entirely separate matters not within the jurisdiction of the GDC.** These two discrete elements - standards and funding - can easily be confused and lead to erroneous conclusions where the structure and functions of the new GDC are concerned (e.g. an additional complaints procedure for private patients).

The key areas of concern in the consultative document are:-

- Fitness to practise

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- Lack of competition
- Price transparency
- Expansion of registration including professions complementary to dentistry
- Complaints procedures
- Professional indemnity

☐ Fitness to Practise

A significant omission in the proposals is the failure to identify the importance of **clinical competence** and the ability to review this at regular intervals following registration. Dentistry depends on the delivery of clinical services, most of which are operative as opposed to consultative, in the form of dental or oral surgery. The GDC has introduced the concept of "Lifelong Learning" at the heart of CPD but at no point is there any review of the central practical component that is clinical competence. Neither is there any review of clinical competence in the NHS Clinical Governance requirement that must raise serious questions of patient safety. The very title is misleading in itself and the omission of regular clinical validation is illogical and unacceptable.

Every year large numbers of patient complaints involve questions about the competence of the practitioner. Evidence from the defence organisations tends to suggest that a greater proportion of complaints arise against those dentists in sole practice and those in the later stages of their careers. The issue may acquire greater significance if there is any risk of variation in standards of skill and competence in those dentists recruited from overseas. Regular revalidation of clinical competence would assist greatly in maintaining benchmark professional standards nationwide.

Dentists who are erased from the Dental Register by the GDC are likely to remain unregistered for five years, even where their misdemeanor is considered remediable and there is a likelihood of being readmitted to the Register. This lengthy period of erasure should be accompanied by a requirement to maintain agreed standards of continuing professional development as is required for osteopaths. Those wishing to re-register should attend for an annual appraisal of their clinical competence at a recognised centre before any GDC reinstatement is considered.

☐ Solution-Clinical Revalidation

Degrees or Licences awarded at the end of a period of dental study and training are recognized by the GDC as a prerequisite for registration and have to meet with standards embodied in the Council's education monitoring role. The award of a degree or licence to practise dentistry presently marks the end of a period of intensive study and training. These awards should be considered to be the beginning of a lifelong professional career that requires periodic revalidation for continuing work in clinical practice. In order to achieve this with existing resources, the national network of post-graduate training centres should be required to take part in a new clinical revalidation process. Private practitioners

would be responsible for their own funding arrangements and NHS allowances granted as part of contractual obligations.

The five-year reviews of continuing professional development (CPD) carried out by the GDC should include a mandatory clinical review certificate awarded by a UK Dental School or Post Graduate Centre. It would be reasonable to include a minimum of five days of clinical work one of which should be allocated to dentistry carried out under patient contract (NHS or Private). This would have the benefit of a dual function that included assessing practice premises, clinical facilities and practice administration. The remaining four days should be allocated to improving clinical skills or learning new techniques during the five-year period. For those dentists who no longer wish to practise clinical dentistry and may perhaps be involved in research, commerce or administration there should be a GDC non-clinical registration facility.

☐ The market place and competition

The Government must recognise the shortcomings of too much central control. The shortage of dentists in the UK is the result of a series of political decisions made by successive Governments of all complexions as opposed to a market failure. The NHS has depended in the past on the mass production of cheap dentistry and a dentist/population ratio of nearly half of most other European countries. The reduction in graduate numbers (closure of a dental school) equal opportunity legislation and the terms and conditions of the NHS general dental services (GDS) have combined to deliver a predictable shortage of primary dental care personnel. Although it is suggested that the market is not working well for consumers “partly due to inadequate regulation”, this is untrue. Many experts within the profession argue that there has been far too much regulation, political interference and control. Indeed the private dental market is a shining example of how freedom of choice is leading to the introduction of exciting new materials and technology- Titanium and Zirconium being two notable examples. The pioneering technology of Titanium implants has been funded by private enterprise and the lives of many patients have been transformed as a result. The NHS benefits from these advances.

☐ Expansion of Regulation

There is no doubt the proposals to include new categories of personnel (PCDs) into registration will be welcome and assist in addressing the chronic shortages of dental manpower. The new grade of clinical dental technician will, however, be most unlikely to “reduce the charges made to patients” for prosthetic appliances. They will undoubtedly increase the quality of dental prosthetics but paradoxically will be unable to compete with the fees currently paid under the general dental service for denture work. In many laboratories NHS dentures are manufactured from cheap materials by unqualified personnel and so better materials and properly trained “denturists” will come at a price. Present “denturist” fees are well

in excess of GDS fees for denture work.

☐ Price Transparency

The mixing of NHS and private treatment should undergo a detailed review with the intention of implementing much stricter control. A very clear demarcation must be made between the two methods of funding and the publication of private professional fees made available either on the Internet (practice website) or via a practice brochure (preferably both). There is currently considerable ambiguity and confusion caused by the lack of clarity in costs and regulation. It would be a step forward for those practices offering both NHS and private dental care to be obliged (GDC Standard) to provide a written contract signed by the patient clearly stating the private content and fees payable.

☐ Complaints procedures

To create and operate a separate complaints procedure for private patients would do little apart from adding an additional layer of bureaucracy and the potential to cause considerable confusion in circumstances where patients were receiving mixed treatment. There should be a single independent common mechanism to assess complaints relating to all clinical dental matters. There is a strong case for taking the opportunity to set up a single independent body to look after all clinical complaints. The General Dental Council should not undertake this role because it would clearly have conflicts of interest seeking to judge and also to administer any punishment or remedial measures. An independent body would also be able to adjudicate on private fees and would refer breaches of the NHS GDS Terms and Conditions through the new Primary Care Trust structure. The use of Adjudication procedures is well tested and accepted by other professions to resolve customer complaints and the principle should be introduced into dental practice
There has to be equity and independence concerning all clinical matters and respected benchmark standards that are applied universally.

☐ Professional Indemnity

The proposals on professional indemnity are long overdue and strongly supported. Chiropracters and Osteopaths are not alone in having to produce pre-registration evidence of indemnity insurance under their respective Acts of establishment. Solicitors are also required to have insurance indemnity since the collapse of the monopoly mutual provider-the Solicitors Indemnity Fund. Contractual insurance based on properly underwritten risk rated premiums would provide benefit for practitioners practising clinical excellence in a properly risk managed environment.
The “one price for all” mutual model is now obsolete. It cannot be right that dentists have no contractual indemnity, no certainty that a claim will be met once

it has been notified and no security of cover either during a professional career or in retirement. Of even more concern is the lack of financial monitoring by the Financial Services Authority and the clear lack of reserves available to mutual societies. By any modern measure they can be regarded as insolvent because their total assets are exceeded by debts, reserves and IBNR. Insurance would also act as an early warning for those GDC registrants who may be breaching fitness to practice regulations with frequent claims or complaints. Approved providers of indemnity insurance would no doubt be interested in a centralised clinical complaints referral procedure.

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