A retrospective analysis of the GDC's performance against its newly-approved fitness to practise guidance

C. T. Gallagher*[1] and A. I. De Souza[1]

IN BRIEF

- Highlights that all registered dentists and DCPs are subject to the GDC's fitness to practise proceedings.
- Provides a concise, easily-understood, and up-to-date synopsis of the GDC's fitness to practice machinery.

RESEARCH

Objectives To assess if the GDC considers relevant factors at all stages of its deliberations into misconduct, as required by the determinations in the cases of Cohen, Zygmunt, and Azzam; and to assess whether those circumstances described in the *Indicative Sanctions Guidance* as warranting erasure from GDC registers led to that outcome. **Design** Retrospective analysis of practise committee transcripts **Materials and Methods** The consideration of specific factors in determining impairment of fitness to practise was compared with their subsequent consideration when determining the severity of sanction. Additionally, cases that highlighted aggravating circumstances deemed as serious enough to warrant erasure were monitored. Pearson's X^2 test was used to detect any variation from the expected distribution of data. **Results** Sixty-six cases met with the inclusion criteria. Of the five factors considered, all but one was more likely to be heard when determining sanction having first been factored in to the consideration of impairment. Additionally, there was a statistically significant correlation between the aggravating factors and erasure from the registers. **Conclusions** The GDC do, in general, consider relevant factors at all stages of their deliberations into practitioner misconduct, and act in a manner that is consistent with their own guidance when determining sanction.

INTRODUCTION

General Dental Council

The regulation of dental profession in the UK falls under the remit of the General Dental Council (GDC), which has a statutory responsibility to ensure the continued fitness to practise (FtP) of its registrants under section 27 of the Dentists Act 1984.[1] Since 2007, the GDC has also been responsible for the registration of clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists, and orthodontic therapists, collectively known as dental care professionals (DCPs).[2] A person's FtP may be impaired by reason of, for example: illness; deficient professional performance; or misconduct, including a criminal conviction, or a police caution.[1]

If there are concerns that potentially raise questions about the registrant's fitness to practise, the GDC must start an investigation. The Registrar must refer the matter to the Investigating Committee,[1] which much investigate all cases so referred.[1] The Investigating Committee may dispose of the case by issuing a warning the registrant concerned, or may refer it to the appropriate practice committee,[1] provided certain threshold criteria are met.[3]

There are three practice committees: the Health Committee (HC), which considers cases where it appears that a registrant's fitness to practise is impaired by physical or mental illness; the Professional Conduct Committee (PCC), which considers whether an allegation referred to it amounts to misconduct and if this misconduct constitutes an impairment of fitness to practise; and the Professional Performance Committee (PPC), which considers allegations where it appears that a dental professional's performance is deficient and – again – if this amounts to impairment of FtP.[1] At any stage of the investigation, the registrant may be referred to the Interim Orders Committee (IOC). The IOC can suspend or restrict a registrant's practise while the investigation continues if it is necessary for the protection of the public, or otherwise be in the public interest or in the interests of the registrant.[4]

Membership of a practice committee is drawn from a panel made up of 144 members: 51 dentists, 53 lay people and 40 DCPs. Panels considering individual cases normally comprise three panellists: one from each of the three categories of membership. Additionally, a legal assessor sits with each panel and advises on points of law and of mixed law and fact, including the procedure and powers of the panel.[4] One or more specialist advisers may also be present. Their role is to provide advice to the panel in relation to medical issues regarding an indicted individual's health or performance.[4] This mirrors the composition of the General Medical Council's (GMC) analogous committees,[5] but differs from the General Pharmaceutical Council's (GPhC), upon which the chairman must be legally-qualified.[6]

The practice committees meet in public, except where they are considering confidential information concerning the registrant.[4] Both the GDC and the registrant are invited to attend the hearing. The GDC is normally represented by counsel, and the registrant is usually present and legally represented.[4] The parties call witnesses, who may be cross-examined by the other party, and have questions put to them by the relevant practice committee.[4] There are three stages to any hearing, namely:

- Findings of fact;
- Decision of impairment;
- Sanction.

At stage 1, the panel will decide if specific facts or accusations are proven based on the

[1]School of Life and Medical Sciences, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB
*Correspondence to: Dr Cathal Gallagher
Email: c.t.gallagher@herts.ac.uk
Tel: +44 (0)1707 285 075; Fax: +44 (0)1707 284 506

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civil burden of proof (that is, 'on the balance of probabilities').[7]

At stage 2, the Committee decide whether the registrant's fitness to practise is impaired as a result of the fact(s) proven at stage 1. All charges must be assessed in terms of whether the registrant's fitness to practise is impaired. The introduction of the concept of impairment was first applied to the medical profession to remove the cumbersome procedural complications that maintaining four conceptually distinct channels of discipline (serious professional misconduct; seriously deficient performance; deficient performance; and health concerns) had produced.[10]

Both the GDC and the registrant may address the committee with respect to impairment of FtP and, in relevant cases, both parties can present additional evidence relating specifically to impairment. It is important to emphasise at this point that the practice committees are required to decide on whether or not a registrant's fitness to practise *is* (currently) impaired; not whether it *was* impaired at the time at which the proven facts occurred.

If the Committee concludes that the registrant's fitness to practise is impaired, the hearing moves to stage 3, at which the following sanctions are available: to take no action; to reprimand the dentist or DCP; to place conditions on their registration; to suspend their registration; or to erase their name from the appropriate register. In deciding on the appropriate sanction, the GMC, GPhC and other regulators overseen by the Professional Standards Authority for Health and Social Care (PSA) make reference to their respective *Indicative sanctions guidance* (ISG).[5,11] These ISGs outline the decision-making process and factors to be considered by each regulator's committees in cases that have been referred to them. Until recently, the GDC had no equivalent overarching guidance: rather, each practice committee used its own short guidance document.[7–9] However, at its meeting on 1 April 2014, the Council approved a draft of its own ISG, which underwent an eight week public consultation exercise from 1 May to 30 June 2014.[12] The results were approved by the Council on 30 October 2014.[13]

Any decision that restricts a registrant's registration or removes them from the register can be appealed in the High Court (or in the Court of Session in Scotland).[1] The GDC, in common with all statutory bodies overseen by the PSA, is bound by rulings of the Administrative Court of the Queen's Bench Division of the High Court (and its equivalent in Scotland), and may have to change its guidance for deciding whether fitness to practise is impaired based out the outcome of such appeals.[14,15]

Cases

Among the relevant appeals to the High Court was Cohen *vs*. GMC,[16] which clarified that practice committees must focus on registrants' current and future fitness to practise, and not on disciplining them for past misconduct.

At stage 2 of Cohen's hearing, his fitness to practise was deemed to be impaired by virtue of an act of misconduct. This was dealt with at stage 3 by the imposition of a relatively mild sanction, namely: to place conditions on his registration. He appealed the decision to the High Court, reasoning that due consideration of certain mitigating factors was not taken at stage 2 and, had these factors been taken into account, his fitness to practise would not have been found impaired, and his hearing would not have progressed to stage 3.

In the opinion of Silber J, the GMC's (Fitness to) Practise Committee considered that it followed automatically that Dr Cohen's fitness to practise was impaired from the factual findings of misconduct. He stressed that 'it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practise is impaired [at stage 2]'. He disagreed with the decision that it was not relevant to take mitigating circumstances into account at stage 2. A major point of mitigation, namely that the misconduct was 'easily remediable', was only considered as significant by the committee at a stage 3, when it was dealing with sanctions. He specifically concluded that 'they did not consider it relevant at [this] stage because they did not mention it in their findings at stage 2, but they did mention it at stage 3'. Sibler J reasoned that, if misconduct is incapable of being remedied, this is of great importance at stage 2; similarly if the misconduct is easily remediable, this must be very relevant and merit very serious consideration by the committee. Accordingly, he ruled that Dr Cohen's fitness to practise should not have been regarded as impaired and the sanctions imposed by the panel should be substituted for a warning.

In the ruling in the case of Zygmunt *vs*. GMC,[17] Mitting J further asserted that a practitioner's current fitness to practise must be gauged not only on past conduct, but also by reference to how he or she is likely to behave or perform in the future.

Mitting J agreed with the assertion of Silber J in Cohen that when fitness to practise was being considered (at stage 2), the task of the practice committee is to consider the misconduct in the light of all relevant factors in determining whether fitness to practise is (rather than was) impaired. He quashed the decision of the panel on the question of fitness to practise being impaired and remitted it to the panel to re-determine in the light of the guidance given in the judgement.

In Azzam *vs*. GMC,[18] it was established that the Committee must give appropriate weighting to mitigating circumstances at stage 2, especially where they may affect the current FtP.

McCombe J ruled that the practice committee erred in deciding to give little weight to evidence attesting to Azzam's training and performance in the period following the incident because such evidence was relevant to the issue of whether his fitness to practise was impaired *at the date of the hearing*. He stated that it must behove a practice committee to consider facts material to the practitioner's fitness to practise looking forward. For that purpose, they should take into account evidence as to his present skill set, and to any steps taken since the misconduct occurred, to remedy any deficiencies.

AIMS

The aim of this research is to examine determinations of impairment of fitness to practise and sanctions imposed by the GDC during the period between 27 August 2013 and 10 October 2014. Among the objectives are: to assess whether the practice committee are adhering to the judgements in Cohen, Zygmunt, and Azzam when determining fitness to practise; and to assess whether those circumstances described by the GDC in their new ISG as warranting erasure from the professional registers lead to that outcome in the year leading up to their publication.

These objectives will be tested using the following hypotheses:

- Specific aggravating/mitigating circumstances considered when determining the appropriate sanction at stage 3 will first have been considered when determining fitness to practise at stage 2;
- The amount of time that has passed since the misconduct occurs has a direct effect on whether fitness to practise is found to be impaired; and
- Cases citing specific aggravating circumstances are more likely to lead to removal from the Dental Register.

MATERIALS AND METHODS

The GDC are responsible for ensuring the determinations of their public hearings are published in a timely manner.[4] A list of practice committee decisions, together with the

reason for each decision, is published on the GDC website in accordance with rule 29(3) of the General Dental Council (Fitness to Practise) Rules Order of Council 2006.

100 hearings, held between 27 August 2013 and 10 October 2014, were selected as the initial data set. Of those 100, hearings were parsed for analysis on the basis of specific inclusion criteria. Only cases in which a registrant was appearing before the PPC or PCC at first instance were included. Review hearings and cases appealing for restoration after a previous determination were excluded, as were interim order hearings, and cases where none of the allegations were found proven at stage 1. All allegations that required progression to stage 2, including those involving criminal convictions and/or cautions, misconduct, and deficient professional performance, were included. Cases by the Health Committee were excluded, as such cases are often heard in private, and subsequently not reported, or reported in a truncated form.[4]

Each case that met the inclusion criteria was analysed. Descriptive data, including the commencement and completion dates of each hearing, the range of dates over which the alleged misconduct occurred, the registrant's particulars, and any sanction imposed were recorded. Additionally, each case report was subjected to a thematic analysis: at each of stages 2 and 3, it was determined whether the practice committees made reference to certain aggravating circumstances or points of mitigation in reaching their determinations of impairment and sanction, respectively. Specifically, each report was parsed for the deliberation of certain circumstances highlighted in the ISG as being of significance,[19] namely:

evidence of the registrant's insight into the nature of their misconduct, and his/her attempts to address it;[19]

- whether there was a risk of harm to patients or the public;
- whether dishonesty was involved;
- the registrant's behaviour during the period between the date on which the alleged misconduct occurred and the date of the hearing.

To assess whether aggravating and mitigating circumstances considered when imposing sanctions are first considered when determining impairment, we applied the same standard as Silber J in *Cohen*: we did not consider a mitigating or aggravating factor was considered at stage 2 if it was not reported in the transcript of stage 2, but was subsequently mentioned at stage 3. In each instance, the circumstances were labelled as either present or absent. In cases where a mitigating or aggravating factor was not mentioned at ether stage 2 or 3, it was considered not to be relevant in that case. The analysis was conducted by one of the two authors: the other author then checked the coding for reliability and validity. These data were tabulated in a form amenable to quantitative analysis using IBM SPSS Statistics, version 20.0.[20]

Pearson's chi-squared test was used to detect a variation from the distribution of data that should be expected: so, for example, if consideration of risk of harm at stage 2 is not consistent with consideration at stage 3, the distribution is unequal and would form part of a correlation that the test would detect.

Aggravating circumstances deemed by the GDC as serious enough to warrant the sanction of erasure, specifically dishonesty and risk of harm to patients or the public, were sought out in the stage 3 deliberations. For each case in which either of the aggravating circumstances of risk of harm or dishonesty was considered, the X^2 test was carried out to determine if their inclusion in the deliberations was more likely to lead to the sanction of erasure.

RESULTS

In total, 66 of the 100 cases met with the inclusion criteria. Insight was considered at stage 2 in 56 of 66 hearings (85%). For the 56 cases in which it was considered at stage 2, it was subsequently examined again at stage 3 in 36 cases (64%). Insight was first considered at stage 3 in 5 cases (8%). In a further 5 cases (8%), it was not included in the panel's deliberation at either stage which is seen in Table 1.

Pearson's chi-squared test was conducted to determine any correlation between insight as a factor at each of stages 2 and 3 of the FtP hearing. There was a statistically significant correlation between the stages at which this specific circumstance was first given consideration ($X^2(4)= 15.864$, $p = 0.003$). There was a moderately strong positive association between the stage of first consideration and insight determined using Cramér's phi ($\varphi_c = 0.347$, $p = 0.003$). The registrant's insight into their misconduct was more likely to be heard at stage 3 if it was first considered at stage 2, indicating that the practice committees were considering this factor at stage 2 in the first instance.

Similar results were observed for two of the other factors, namely: risk of harm to patients or the public ($X^2(4) = 13.648$, $\varphi_c = 0.322$, $p = 0.009$); and dishonesty ($X^2(4) = 67.870$, $\varphi_c = 0.717$, $p <0.001$). The fourth factor, behaviour of the dentist or DCP since the misconduct occurred showed no correlation ($X^2(4) = 6.815$, $p = 0.146$), indicating that this is equally likely to be considered at stage 3 in the first instance.

Risk of harm to patients was examined at stage 2 in 49 of 66 hearings. It was considered as a mitigating factor (that is, there was no risk of harm) in just 3 of those cases (6%), and as an aggravating feature in 46 cases (94%). In 47% (23/49) of cases this factor was considered at stage 2 before stage 3, compared to only 8% (2/25) in which it was considered first at stage 3 which is seen in Table 2.

Dishonesty was considered at stage 2 in 32 of 66 (48%) of cases examined. It was deemed to be an aggravating factor in 26 cases (81%) and, by virtue of its absence, a mitigating factor in 6 others (19%). It was first factored at stage 3 in just one case, and was not considered relevant at either stage in 33 (50%) cases. In 96% (26/27) of cases where dishonesty was considered at stage 3, it had first been considered at stage 2 as shown in Table 3.

The behaviour of the registrant since the misconduct occurred was considered at stage 2 of 45 hearings (68%). Of the 45 cases in which it was considered at stage 2, it was subsequently examined again at stage 3 in 23 cases (51%): however, it was first considered at stage 3 in 12 of 35 (34%) of all cases in which it factored at that stage. In a further 9 cases (14%), it was not included in the panel's deliberation at either stage shown in Table 4.

Furthermore, there was no correlation between the amount of time that had passed since the last occurrence of misconduct and a finding of impairment of fitness to practise ($X^2(4) = 3.173$, $p = 0.529$), although this ranged from less than six months to more than three years. Neither is there any correlation between time passed and severity of sanction ($X^2(4) = 21.785$, $p = 0.150$), despite it being among the mitigating circumstances listed in the ISG.[19(s.5.16)]

Where harm or risk or harm to the patient was involved 50% (11/22) of cases resulted in removal from the relevant professional register. Where no such risk was found, 36% (16/44) of practitioners were sanctioned by erasure. There is a statistically greater chance of erasure being the ultimate sanction where risk of harm is an aggravating factor ($X^2(8) = 39.884$, $\varphi_c = 0.322$, $p <0.001$) as shown in Table 5.

Similarly, where dishonesty was involved (22/66), the sanction was removal in 77% of cases, compared to the 22% of registrants who were removed where dishonesty was not an aggravating factor (in 44 of 66 cases). There is a statistically significant, moderate correlation between dishonesty and erasure ($X^2(8) = 27.160$, $\varphi_c = 0.454$, $p <0.001$) shown in Table 6.

DISCUSSION

Fitness to Practise

Four factors were chosen to assess whether aggravating and mitigating circumstance were given due consideration when determining fitness to practise. Insight into the misconduct and behaviour since it occurred was selected, as its presence reflects that the practice committees are complying with the ruling in the Zygmunt case, in which it was emphasised that a registrant's current fitness to practise must include consideration of how they are likely to act in the future, in addition to their past conduct. The registrant's behaviour in the interim period, during which they are free to continue unimpeded in their practice (unless an interim order is in place), must be considered if the practice committees can claim to be looking forward when deciding the current status of fitness to practise, especially in cases where the dentist or DCP has made an effort to remedy any shortcomings that contributed to the misconduct. Additionally, before seeking to overhaul their performance or behaviour, a registrant must first comprehend the nature of their misconduct: insight must be in evidence before reparations can be made.

Risk of harm and dishonesty are considered to be among the most severe aggravating circumstances described in the ISG. These were included here as they are deemed to potentially warrant a more severe sanction,[19] and, as such, failure to consider them at stage 2 can lead to harsher consequences, as was the case for Dr Zygmunt.

Risk of harm was factored into 51 of 66 of hearings. It was initially a factor at stage 2 in 49 (96%) of these. Dishonesty was considered relevant to 33 cases, and was first considered in determining fitness to practise in 22 (97%). The registrant's behaviour since the misconduct occurred was a factor in 57 cases. It first entered the panel's deliberations at stage 2 in 45 (79%) of these cases. Insight was a factor in the greatest number of hearings (61), and was heard at stage 2 in the first instance in 92% of cases. Each of these factors was more likely to be considered at stage 3 following initial consideration at stage 2. When considered together, these figures indicate that the GDC are guided by the rulings in Cohen, Zygmunt, and Azzam.

This statement must, however, be tempered by the observation that there is no correlation between the amount of time that passed since the last occurrence of misconduct and a finding of impairment of fitness to practise. In the absence of an interim order, the registrants were free to continue working unimpeded for periods ranging from six months to more than three years.

Table 1 Correlation between consideration of insight as a mitigating factor at each of stages 2 and 3 of 66 GDC fitness to practise hearings

	Determination stage?		
FtP Stage?	Yes	No	Total
Yes	36	20	56
No	5	5	10
Total	41	25	66

Table 2 Correlation between consideration of risk of harm as an aggravating factor at each of stages 2 and 3 of 66 GDC fitness to practise hearings

	Determination Stage?		
FtP Stage?	Yes	No	Total
Yes	23	26	49
No	2	15	17
Total	25	41	66

Table 3 Correlation between consideration of dishonesty as an aggravating factor at each of stages 2 and 3 of 66 GDC fitness to practise hearings

	Determination stage?		
FtP Stage?	Yes	No	Total
Yes	26	6	32
No	1	33	34
Total	27	39	66

Table 4 Correlation between consideration of subsequent behaviour as a mitigating factor at each of stages 2 and 3 of 66 GDC fitness to practise hearings

	Determination stage?		
FtP stage?	Yes	No	Total
Yes	23	22	45
No	12	9	21
Total	35	31	66

In that time, these dental professionals, by definition, did not commit any further acts of misconduct that might cause their fitness to practise to be further impaired. That their fitness to practise *was* impaired at the time of the misconduct is not in question: rather that the amount of time during which they continued to practise safely is materially relevant to the issue of whether it *remains* impaired on the day of the hearing. This would form a significant part of the registrant's 'present skill set' as referred to by McCombe J in Azzam, but did not seem to affect the outcome of the fitness to practise determinations.

Sanction

The purpose of sanctions is not to be punitive, but rather to protect the public interest. This includes protection of patients, colleagues and the wider public for the risk of harm; maintaining public confidence in the profession of dentistry; protecting the reputation of dental professionals; and maintaining proper standards of behaviour.[19] Section 7.31 of the ISG states erasure may be appropriate when the dental professional's behaviour involves any of a list of aggravating factors, which include: serious departures from the professional standards set out by the GDC; doing or risking serious harm to others; lack of insight; and serious dishonesty.

That is not to say that removal from the Register is the only available sanction where such factors are identified. All sanctions must be proportionate to the impairment. In practice, PPC and PCC achieve this by adopting a 'bottom up' approach when deciding upon the appropriate outcome: the lowest sanction is considered in the first instance; if it fails to protect the public interest, the next most severe sanction is considered, and so on, until an appropriate result is achieved.

The ISG underscores cases 'where a continuing risk of serious harm ... is identified' as

Table 5 Correlation between risk of harm as an aggravating factor and the sanction of removal from the Dental Register

	Sanction		
Risk of harm found?	Removal	Other	Total
Yes	11	11	22
No	16	28	44
Total	27	39	66

Table 6 Correlation between dishonesty as an aggravating factor and the sanction of removal from the Dental Register

	Sanction		
Dishonesty found?	Removal	Other	Total
Yes	17	5	22
No	10	34	44
Total	27	39	66

being candidates for the sanction of erasure.[19] The fundamental duty of dental professionals to 'put patients' interest first' is of paramount importance.[21] As well as working within the limits of their own competence, practitioners are required to promote and encourage a culture that allows all staff to raise concerns openly and safely,[21] and are required to raise safety concerns.[21] Reference to insight in the ISG emphasises the requirement for evidence of the registrant's understanding of the problem: where insight is not evident, it is likely that the misconduct may recur, since the registrant does not recognise it as inappropriate. In such cases, it is likely that conditions on registration or suspension may not be appropriate or sufficient, and – by applying the 'bottom up' procedure outlined above – the committee may have to consider the ultimate sanction of erasure from the Register.

Requirements for honesty implicit in *Standards for the dental team* (which is published by the GDC) are highlighted by the ISG.[21] *Standards for the dental team* states that registrants must be honest and trustworthy, and must act to maintain the public's trust in the profession.[21] Dishonesty in financial and commercial dealings is also emphasised.[21] Even where it relates to matters outside the practitioner's clinical responsibility, dishonesty is deemed as particularly serious, must be treated as a serious aggravating circumstance by the practice committees, as it can undermine the trust the public place in the profession.

Where risk of harm was identified as an aspect of a registrant's misconduct, it was almost one-and-a-half times as likely that removal from the professional register would result compared to cases where no such risk was present. Where dishonesty was involved, removal was three-and-a-half times as likely to result.

Limitations

This does not claim to constitute a complete qualitative analysis of how specific factors influence the decision of the GDC's practice committees: rather it seeks to make way for such an analysis by first demonstrating that the committees have been working in a way that is consistent with the spirit of the new *Indicative Sanctions Guidance* in advance of its official implementation. This research does not consider the extent to which aggravating or extenuating factors are considered when determining sanction, nor does it seek to address how they are affected by the facts of each individual case.

There has been a call for formal evidence on the factors to be considered in judging fitness to practise, which is currently limited.[22] Some evidence can be found in research commissioned by the GMC,[23] but this is dated and specific to the medical profession. It has been recognised that this should be supplemented by independent research.

CONCLUSIONS

The mitigating circumstances of insight and subsequent good behaviour, and the aggravating factors of dishonesty and risk of harm were more likely to be considered in determining the appropriate sanction having first been taken in account when determining impairment of fitness to practise. Additionally the presence of these aggravating factors was more likely to lead to the sanction of erasure than their absence. However, we were unable to show that the passage of time was accepted as a mitigating factor in determining either impairment or sanction. Therefore, we conclude that the GDC do factor the rulings of High Court appeal cases into their deliberations on the impairment of fitness to practise; and that they have been acting in a manner that is consistent with the new *Indicative Sanctions Guidance* in determining which sanction to apply.

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