# Is the support that dental registrants in difficulty receive from postgraduate dental teams and other sources adequate?

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## In brief

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| Describes the views of dental registrants in difficulty on the support they receive form postgraduate dental teams. | Compares their views on what constitutes the ideal supporter with the professional experience of supporters and their views on the strengths they bring to the role. | Describes the views of registrants and supporters on the funding of the service. | Reports the registrants' experience of support they receive from other organisations. |

**Objective** The aim of this research was to investigate the views of dental registrants in difficulty (DRiDS) on the support they received from postgraduate dental teams (PgDT) in Health Education England (HEE) and other sources. These data were complemented by the views of those appointed from the PgDT to support them on the service they provide. **Method** Qualitative data were collected by recording one-to-one semi structured telephone interviews, lasting approximately 30 minutes, with registrants in difficulty and supporters purposefully sampled from across England and Wales. Recordings were transcribed and the interview data analysed for recurring discourses and themes using thematic framework analysis. **Setting and subjects** All regional leads for DRiDs services in PgDT across the UK were asked to invite the DRiDs they were in contact with and the supporters they had appointed to contact the research team. Attempts were made to contact all who returned consent forms and six DRiDs and 11 supporters were eventually interviewed. **Results** Overall the DRiDs thought that the PgDT were very helpful. They were in many cases the only source of expert support and advice, particularly with regard to developing a personal development plan and collecting evidence about their practice to present to the regulator. There was a good match between the qualities that DRiDs wanted their supporters to have and the strengths supporters felt they brought to the role. The DRiDs had mixed views about the support provided by their indemnifiers and could not identify any other organisations that provided support once conditions had been imposed. Some had the support of peers; but both DRiDs and supporters felt there was a need for further support in addition to the educational support provided by PgDT and legal support provided by the indemnifier. **Conclusion** The DRiDS regarded the PgDT as their primary source of support and, in general, were very satisfied with the character and competence of the service.

## Introduction

The receipt of an official notification of an investigation into a registrant's practice from the authorities, either the General Dental Council (GDC) or NHS local Area Team (AT), is arguably a life changing event for the majority. While the regulator will investigate any complaint or circumstances that it considers may represent a risk to safe practice or bring the profession into disrepute, the majority relate to clinical care and/or governance.[1] The decisions of the regulator at hearings to adjudicate on the matter will be influenced by evidence provided by the registrant that their practice is safe or that they are taking steps to address any shortcomings. Conditions imposed by the regulator on continued practice will often include undertakings that registrants undergo further training and subsequently provide appropriate evidence that their practice no longer poses a risk to patients. In England, Wales and Scotland the primary source for educational support for dental registrants in difficulty (DRiDs), either in preparation for hearings or as a result of conditions placed on their registration, are the postgraduate dental teams (PgDT) based in regional offices of Health Education England (HEE) and equivalent postgraduate deaneries in Wales and Scotland. In Northern Ireland registrants in difficulty are referred to National Clinical Assessment Service (NCAS) for assessment.[2]

Registrants in difficulty, either as a result of a complaint from a patient or an investigation into their practice by the authorities, are normally encouraged to contact their indemnifier for

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**Table 1 Relevant questions for DRiDs and supporters**

| Relevant interview questions for DRiDS | Relevant interview questions for supporters |
|---|---|
| Please describe the support provided by the PgDT: | What is your position? (dentist, dental care professional, other HEE employee) |
| Do you have any comments on the quality of the support? | Qualification date: |
| What was most helpful? | Further post graduate qualifications: |
| Any areas where support was lacking in some way? | Relevant experience, in your opinion, for supporting dentists in difficulty: |
| Who else provided/is providing support? | What do you consider to be your strengths? |
| Which source of help do you consider most important to you? | What do you consider to be your weaknesses? |
| Do you have any comments on how the support process could be improved? | How is your time in role funded? |
| Were there areas where support would have been useful but was not available? | Your views on funding: |
| What do you think are important qualities for a mentor/clinical supervisor to have? | Your views on how best to help dentists with conditions: |
| Any other comments on the suitability/quality of the mentor/clinical supervisor appointed to help you: | And if there were no financial restrictions? |

advice as soon as possible. The GDC insists all clinicians have indemnity cover in place as a condition of practice primarily so that patients can claim compensation when a problem occurs. The indemnifier will also support members with legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, regulator inquiries, legal and ethical dilemmas and disciplinary procedures.[3] Whilst the indemnifiers do provide some educational input for their members and the profession as a whole, their primary function is medico-legal support.

In the UK, all healthcare professions have their own frameworks and processes in place for dealing with underperformance. Nurses may have a Condition of Practice order imposed upon them by the Nursing and Midwifery Council as a result of an investigation and hearing. It imposed 265 such orders in 2015–2016.[4] Nurses may also have to attend a capability or performance review meeting called by their employer. Remediation via supervision, coaching and re-training is usually the responsibility of the employer and monitored by the individual nurse's manager. The Royal College of Nursing is also a source of advice and support for nurses who are under investigation or who are called for a capability or performance review.[5] If the remediation is actioned by the employer, a continued failure to improve would lead to more formal second and third reviews and ultimately dismissal. Failure to comply with conditions placed on a nurse's practice by the Council would lead to removal from the register.

Since 3 December 2012, all UK doctors must undergo revalidation every five years supported by annual appraisals. Every doctor is responsible for identifying and then informing the General Medical Council (GMC) of the designated body which administers their appraisals and revalidation. Organisations that employ or contract with doctors are required to appoint a senior doctor called the responsible officer (RO) who manages the governance systems, the appraisal of doctors, deals with practice concerns and advises the GMC about doctors' fitness to practise.[6] A doctor with restrictions on his/her practice needs to obtain the approval of his/her RO for workplace arrangements. The RO should also agree the doctor's personal development plan (PDP) and meet with the doctor, as required, to discuss their achievements against the aims of their PDP. Thus, remediation is primarily the responsibility of the RO within the employing organisation. Only if the doctor cannot identify a RO can he/she seek permission for an education director, dean or someone of similar standing to undertake this role.

A 2007 survey of the assessment and remediation of physicians in five English speaking countries reported that methods for measuring performance and competence were well developed and sophisticated.[7] However, the provision of remediation was more patchy and variable. The authors made the comment that many programs were narrowly focused on correcting the deficiencies of the clinician and did not consider the wider factors that might adversely influence performance. Only a few undertook a structured psychological assessment and only two, of which one was UK based, carried out an occupational health assessment as standard. In addition, the long-term effectiveness of the remediation process was not monitored and thus it was difficult to be certain of its effectiveness.

DRiDs, if they are dentists, are usually self-employed and do not have an employer to seek support from. They are supported by PgDTs and their indemnifiers. The number of dentists getting into difficulty has increased significantly in recent years.[1] PgDTs have responded by developing processes and creating teams that are able to provide that support. Our previous paper investigated the services provided by the PgDTs for DRiDs.[8] This study sought to investigate the views of DRiDs about the support they received primarily from the PgDT but also from their indemnifiers and other sources. These views were compared with the views of supporters appointed by PgDT about their role in the service.

## Method

### Data collection

Approval for the investigation was received from a HEE Research Governance Committee and the consent of the relevant dean/director of the dental section of HEE's regional offices and the Welsh Deanery obtained. A letter was sent to the person responsible for managing their DRiDs service asking them to cascade information on the study and an invitation to participate. Respondents were consented by the research team to participate in the study, when they were assured of the confidential and anonymous nature of the research. Using one-to-one telephone interviews, each lasting about 30 minutes, data were collected from registrants in difficulty and supporters purposefully sampled from across England and



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Wales. Semi-structured interview questions, informed by an in-depth literature review on the subject matter and good research practice for this type of study, covered a number of pertinent areas, including the views of registrants on the support they received from the PgDT or deanery, indemnifier and other sources and their views on what were the important qualities that a supporter should have. The supporters were asked about the relevant experience they had for supporting DRiDS, what they considered to be their strengths and weaknesses in the role and the best way to support DRiDS. They were geared towards obtaining rich data on the experiences of participants with regard to the support received by DRiDS. An indicative set of interview questions may be found in Table 1.

## Data analysis

Interview data were transcribed and analysed for recurring discourses and themes using a thematic framework analysis.[9] The research team acted as co-analysts and a coding framework was devised as a result of their deliberations. The team consisted of clinicians and non-clinicians with expertise in postgraduate medical education research. This construction of codes and thematic categories was done by the co-analysts working independently, but deliberating together on interpretations until agreement was reached. The quality of the findings was highly dependent on the rigour of the data collection and subsequent analysis and interpretation. We attempted to achieve rigour by using established techniques to ensure credibility, transferability, dependability and confirmability.[10] Inter-rater reliability ensured that multiple coders were involved in identifying areas of agreement to ensure consistency and to minimise any potential for bias in interpretation. There were very limited disagreements about coding definitions and all were successfully resolved. The research team engaged in constant comparison, involving checking the consistency and accuracy of interpretation and especially the application of codes, as well as careful consideration of negative cases.

## Results

Out of 11 DRiDs who returned consent forms it was possible to interview six, all of whom were or had been working as general dental practitioners (GDPs). Their circumstances showed significant variation from one seeking to be re-registered, others that had come to this country from overseas and some who had practiced in the UK for a long time. Those who were interviewed were, apart from two, being supported by different PgDTs. Of 12 supporters who consented, 11 were interviewed. Nine were dentists, one a dental care professional (DCP) and one an administrator. The main reasons for non-participation were either a failure to respond to an email requesting they contact the researcher for an interview or the email address given being incorrect. There was a wide geographical spread of interviewees with seven from the North West and North East, eight from the South West and two from Wales.

We identified five relevant thematic categories in the data which are summarised in Box 1. Verbatim extracts are included in order to provide illustrative primary source data for each thematic category. Each respondent is quoted using a unique identifier (number+DRiD/supporter status).

**Box 1 Major relevant thematic categories**

Initial contact with PgDT:
- Ease of access, first interview, type of support

Qualities looked for in supporters:
- Ideal qualities of supporters, age/experience of mentor

Mentors' views on competence in role:
- Career experience. Strengths and weaknesses

Finances and charging:
- Attitude to charges, financial advice and support

Other sources of support:
- Friends and colleagues, support network, indemnifiers, psychological support

## Initial contact with the PgDT

The registrants in difficulty were asked about their initial contact with the PgDT. Occasionally there were delays while matters were clarified. Some had not realised that they needed to contact their PgDT. Others were not sure who to contact and even occasionally the PgDT was not sure if they were able to help. However, once the channels of communication were open the first interview happened quickly, usually within two to three weeks. Most registrants found this first interview very useful and reassuring; though some felt they needed more structure.

*'Once there was a quantity of emails from me to get things established and then I felt I was leaning on the person to get things going, but once it had got going it was pretty swift. There wasn't much flexibility because obviously I'm a working dentist and it was pretty much, you know, this day, that time, you know, so yes, apart from that not too bad.*[…]*The meeting took place after a couple of weeks'* (97 DRiD).

*'Very, very reassuring, orientative, informative, an open friendly hand'* (95 DRiD).

They all received help in developing their personal development plan (PDP). Some had already made a start on this but they found the help of an experienced supporter invaluable in the further development of their PDP.

*'So basically, a lot of help with the portfolio, a lot of ideas for evidence and ideas on the type of evidence to include, with some examples as well of what has been done in the past. So there was a lot of guidance. And also they've been able to read the things that I have done and comment on them'* (84DRiD).

## Desirable qualities

When asked what they looked for in supporters, they wanted them to be non-judgemental and understand the problems from the DRiDs point of view. They also wanted supporters to have experience of the regulations and working environment within UK general practice.

*'So someone who has been through it from a personal point of view who empathises with where you are at but also has things at their fingertips'* (93 DRiD).

## Mentors' views on competence

There was a good match with what DRiDS were looking for in their supporters and what supporters considered to be their strengths and interestingly also their weaknesses. Supporters had a significant depth of experience working in UK general practice and also in education.



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*'Thirty years an NHS dental practitioner, and practice owner, so I'm very much used to dealing with all the administrative side of it, and running my own practice with my partner. I've also been a vocational dental practitioner for on and off for fifteen years, and I've been involved with lots of local committees, and groups. I'd say I have a broad experience of general dentistry'* (78 supporter).

They thought that their main strength was to be able to listen objectively without being judgemental.

*'I think I'm a pretty good listener. I think the main thing is the first meeting that I have with a dentist in difficulty really is to let them open up and be non-judgemental and just document how they perceive the problem and then we will discuss it and see how I can help them move on'* (94 supporter).

However, interestingly, when asked about their weaknesses there were very consistent comments among supporters that they felt they had a tendency to be too empathic.

*'My weaknesses certainly are that I tend to see, or look for the good in pretty well everybody and I suppose that could be interpreted as being a little soft but I think that's because I'm overly empathetic'* (99 supporter).

## Finances and charging

The imposition of conditions led to significant financial constraint for those who were working because of the need to set aside time to meet the conditions. Others were unable to obtain work as a dentist. Those who were working would have preferred to have meetings with the PgDT outside working hours so as to minimise the disruption to their clinical practice.

'*There's a huge economic weight to all of this. I've actually cut down my working days from five days to four days just to give me more time and the business is struggling because it's twenty percent down*' (93 DRiD).

'*I don't earn a fraction of what I used to as a dentist and I still have my practice loan from when I used to own the practice, so yeah I am financially struggling quite a bit*' (84 DRiD).

In general, the DRiDS did not have to pay for the support provided by the PgDT teams, but some had to pay for courses and the time of mentors or clinical supervisors appointed by the PgDT. There appeared to be no consistent application of fees between different PgDTs. Where they had to pay, the DRiDs thought the charges were reasonable and understood that their supporter had to expend a significant amount of time and effort helping them.

'*Everything about my audit reports and reflective writing and evaluation of the safety I learned it from her. And she has counselled me correcting my drafts and that, so it's a lot of time and it's a lot of work, so I am happy to pay for my workplace supervisor. So the deanery no, I've never been specifically left with a bill or anything, no*' (95 DRiD).

The supporters felt that overall there were advantages to charging DRiDs for their services, but some had concerns that DRiDs would be unable to access the services they needed because of the cost.

'*I think to begin with I thought oh it's a bit harsh but actually I think it does concentrate their minds a bit and probably makes them buy in a bit more to the process. It makes them realise how serious it is and helps them engage with things*' (94 supporter).

'*The problem is it's at a cost and I think that some registrants, particularly those that are suspended with no income, we're not quite sure what we can do for them* [...] *I just wonder if there could be finance terms arranged for people or they could be pointed at some source of funding we could maybe do a bit more for them in that area*' (101 supporter).

## Other sources of support

Some DRiDS were not happy with the support they received from their protection society and, particularly once conditions had been imposed, felt that they had been deserted in their hour of greatest need. Others had a good experience.

'*Well yes because of the effects of the GDC, one of the immediate effects of the GDC conditions is that my indemnity company just walked away*' (88 DRiD).

'*I think the [indemnifier] have been very supportive really; the person I've dealt with has been very good*' (97 DRiD).

They also thought that a support group would be helpful.

*'Yes definitely, definitely* [to have access to mentoring and coaching] *and probably a focus group, perhaps people to – because you are very much alone and you feel that, and even now, because I've put myself on many courses,* […] *you feel this inferiority complex where you go along and you feel you are not quite as good as your peers'* (97 DRiD).

*'Apart from one or two friends who we go out and we'll either go for a walk or go for a meal, there's no-one there to support you, certainly as an individual, a single-handed private practitioner doing his own thing'* (93DRiD).

The DRiDs felt there was a need for more psychological support. Some DRiDS were able to get help from friends and colleagues. However, there was also a perceived need for a support network and more informal support as well as the legal and educational support they were already receiving.

*'Yes, certainly some psychological support, almost like semi-counselling type you know, a little bit of support there that would have been fantastic as well. I think you are pretty much left to your own devices and "you take it or leave it" approach, "here you go" you know, "if you are really interested about your career then this and this"'* (97 DRiD).

Supporters also felt that there was a need to ensure access to psychological support for DRiDs and while some, but not all, were able to refer to this type of service the biggest real or anticipated barrier was the cost.

*'But I've had quite a few registrants who I have been actually quite worried about on a mental health level and I have actually referred them on but then they haven't actually pursued it much further because of the cost involved. So I think it would be quite nice if we had more availability of counselling services'* (94 supporter).

## Discussion

Given the sensitive nature of the research, the number of registrants in difficulty successfully recruited to the study was predictably limited. In addition, we were not able to interview any DCPs in difficulty and their experience and views may be different. Therefore, the results are not generalisable in any quantitative sense. However, the paucity of qualitative research in this field means that these data may add to our understanding of the DRiDs experience. We were able to interview more supporters who also held different posts such as administrator, educational supervisor, mentor and manager of services for DRiDS; though we acknowledge



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that these are small self-selecting groups who may not be representative of all regions.

Overall, the DRiDs thought that the PgDT were very helpful. In many cases they were the only source of expert support and advice, particularly with regard to developing a PDP and collecting evidence about their practice to present to the regulator. There was a good match between what the DRiDs thought were important qualities in their supporters and what supporters considered to be their strengths. Almost all supporters thought they were overly empathic. This is probably a consequence of the sort of person recruited for these posts rather than any deficiency in competence; being the product of a reflective, conscientious and caring personality.

From the comments of DRiDS and supporters it was apparent that there was little consistency with regard to charges levied for the support provided by different PgDT. It was also apparent that policy with regard to charging had changed recently in some organisations. In general, there was no objection in principal to charges, either from DRiDs or supporters. Though there were concerns that some would be unable to afford the charges and so be deprived of educational support. It might be fairer to DRiDs if there was a consistent policy with regard to fees and also what support should be given to those unable to afford these fees across all PgDT. The Winchester report into remediation, commissioned by the GDC, also found that there was no consistent policy for charging and commented that some registrants may struggle to pay the fees charged.[11]

Some of the DRiDS were unhappy with the service provided by their indemnity organisation, although this was a small sample and the view was not held by all those interviewed. This attitude was reinforced on being told that the indemnifier would no longer provide ongoing indemnity cover for them and they would have to use, as one DRiD stated, 'a back street insurance company'. Registrants are not always aware that the cover provided by an indemnifier is entirely discretionary and that it may refuse cover for those considered to be high risk so as to contain costs for the benefit of the membership as a whole.[3]

Several countries have organised psychological support for healthcare professionals. In Australia a doctor or any healthcare professional can seek psychological support from an organisation called Beyond Blue that operates under the umbrella of the Australian Mental Health Commission.[12] Indeed this umbrella organisation oversees psychological support services that are available for all Australians in work. In Colorado, USA, a statutory created service, funded by license fees, has been set up to provide support for professionals experiencing physical, emotional, psychological and substance abuse concerns that might lead to problems with their practice.[13] The aim of the service is to identify the weaknesses and intervene at an early stage before a problem develops. This is seen as an alternative to a disciplinary program model and includes evaluation, referral for treatment, monitoring of the professional's compliance with treatment and recovery recommendations.

For those working in London, the NHS Practitioner Health Programme is a free and confidential NHS service for doctors and dentists with issues relating to a mental or physical health concern or addiction problem particularly where these might affect their work.[14] In general, the service can be accessed but isn't funded directly for those outside the London area. There are plans to implement a similar England-wide service for general medical practitioners in 2017.[15]

The GDC has updated its advice for registrants in difficulty on its website and has worked in partnership with the Samaritans to train GDC staff involved in the fitness to practise process to ensure they have the skills to recognise where an individual may need additional support. They have also provided a list of organisations that may be able to provide that support.[16]

## Conclusion

The DRiDS regarded the PgDT as their primary source of support and, in general, were very satisfied with the character and competence of the service. Some felt able to seek the help of their peers but only one felt he had the support of an employer. Their views on the support provided by their indemnifier were very mixed. No other organisations were identified as a source of help once conditions had been imposed.

Going forward there is a need to make the charges for the services organised by PgDT more consistent across the country and consider what support should be given to dentists and DCPs who may find it difficult to afford those services. Some thought should also be given to how a network could be created to help DRiDS with the additional support they may need in addition to their legal and educational needs.

As Humphrey and Locke have noted, there has been little research into the effectiveness of the remediation process.[7] There is a need to answer the fundamental question: does the present process of the imposition of conditions by the regulator followed by the satisfactory compliance with and then removal of those conditions, lead to continued safe practice in the future?

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