Cause for concern: BDA v GDC

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Key points

Questions the success of the policy of the BDA towards the GDC with regard to the annual retention fee.	Summarises the benefits of general, health and professional regulation.	Makes suggestions to improve regulation and thereby reduce the number of charges brought before the GDC, the GDC's expenses and so the ARF.

In this Opinion article I will discuss the relationship between the BDA and the GDC, the nature of the BDA's and dentists' language when communicating with the GDC and when discussing the GDC in public forums, such as this journal. I also suggest ways this relationship can be improved for the benefit of dentists and the GDC.

Introduction

As I approach retirement after 40 years, as a dental student, a 'wet-fingered dental grunt' and continuous BDA member, I am disturbed, disappointed and disquieted by the recent editorials[1,2] and opinion pieces[3–5] published in this journal. Disturbed that a professional journal should publish these articles. Disappointed that colleagues should treat fellow professionals with so little respect. Disquieted for the future regulation of the profession which so many of us hope will change positively in the near future.

Section 9 of the General Dental Council (GDC) Standards[6] states:

- '9.1.1 You must treat all team members, other colleagues and members of the public fairly, with dignity and in line with the law'
- '9.1.2 You must not make disparaging remarks about another member of the dental team in front of patients.'

The GDC as a body has been considered part of the dental profession,[7] but at the very least we should remember that the GDC includes registered dental professionals[8] and that they are colleagues. The *British Dental Journal* is most certainly a public media, representing the UK dental profession; it is not only read by professionals but by non-registrants as well. Previous editorial policy was to be inclined towards unbiased reporting rather than influence,[9] being concerned that indiscriminate publishing of opinion papers could be negligence on the part of the Editor.[10] Like many readers I enjoy the Editor's humorous editorials. But should it not also be part of the role of the Editor to moderate controversy by both editing articles submitted and providing reflective editorials: rather than invective?

It has probably always been the case that the 'angry young men' will be outspoken; irreverent; show uninhibited disdain; and their writings express raw anger and frustration as the changes fail to meet exalted aspirations for genuine reform. But it is the role for older colleagues, especially those with influence in the profession, to proffer constructive advice: not to make immoderate statements undermining the institutions which support the 'system'? It should not be for those who are about to exit the profession to hold up progress by decrying the GDC and Care Quality Commission (CQC) etc – who do a thankless job with their own human frailties.

All of us should be aware that the 'system' is there primarily for the benefit of all, both patients and dental professionals. One can only hope that these articles have not further divided the profession from its regulator and that those individual regulators will be understanding and forgiving. Understanding of the emotions expressed and forgiving of the language.

No one can doubt the sincerity of the authors or their belief in the truth of what they have written, most especially because of the passion and emotive language. However, the BDA's leaders have been expressing these attitudes for some years, without any apparent change in GDC policy.

But perhaps the worst thing for me is the plain bad manners of our leaders with regard to Dr William Moyes, Chair of the GDC, addressing[11] and referring[5] to him as 'Mr' and contracting William to 'Bill'.[11] He has a PhD (Theoretical Chemistry from the University of Edinburgh).[12] Surely, after the 'Call me Doctor' controversial battle of the 1990s, of all professions we should be able to accord him his title. I was taught that when writing to people to never use nick-names. How do you react when people get your name or title wrong?

Why did we have to refer to Dr Moyes' reappointment as a Chair of the GDC as a 'missed opportunity'?[13] He is in post now until 2021, so he is the only game in town. As registrants can we really allow this situation to continue? It has been going on for too long, can we really

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afford to wait a second decade before we start finding a solution?

We (the profession) have, however, concentrated, publicly at least, upon the cost of the Annual Retention Fee (ARF). Repeatedly mentioning that the money raised through the ARF rise for 2015 was based on an unlawful consultation in 2014.

My late father was an old-fashioned solicitor who when asked what his best legal advice had been, always responded with 'never litigate.' Legal action in which one side (the profession) gets to pay all the costs regardless of who wins is unlikely to reduce the individual registrants' expenses. It is of course appropriate that the BDA is reflecting upon the recent litigation and the legal maxim of Quis custodiet ipsos custodes?[5] But perhaps this is something best left unspoken?

Our leaders are persons of great experience but O'Donnell humorously described clinical experience as 'making the same mistakes with increasing confidence over an impressive number of years.'[14] Maybe if we want change we need to reconsider our approach?

In contrast Dr Moyes has been unfailingly polite in the published correspondence which I have read and has even written: 'we should, both separately and together, be moving on to tackle the substantial agenda of current and future issues.' and continued:

'I have set out above three important areas where I would welcome the GDC and the BDA working together to benefit patients and registrants. No doubt there are many more. I believe it is time for our organisations to look to the future rather than the past. We know that the GDC will be stronger if it takes these matters forward in partnership and it wants to do so with the BDA, amongst others.'[15]

As a child had I behaved in the way the profession has there would have only been plain bread and butter for tea and it would have been early to bed to allow me time to reconsider. It would seem likely to me that the GDC has decided to keep the ARF and allow the profession to reconsider its position. We have been metaphorically sent to bed.

The GDC's largest variable cost influencing the ARF is the level of complaints received and the number of charges brought before the GDC.[16] Surely what the profession and the GDC both want is increased professionalism which, if sorted, should reduce the number of charges brought before the GDC and so inevitably the ARF itself. Have we as a profession failed to engage in regulation to our own disadvantage?

General regulation

Regulation is for our benefit and that of our patients, but for some reason individual registrants do not believe this. In my lifetime regulation has changed from loose minimalism to rigid direction. Why? Perhaps because it saves lives?

The airline industry is usually taken as the example of the benefits of regulation. We all expect to be able to fly safely. We would not expect the pilot to just pop out to the plane, kick the tyres and then take off. We want those pre-flight checks which ensure our safety. Why wouldn't our patients want the same things as we do?

Since the 1980s there has been a cultural change – as a society we have an expectation of safety. When I bought my second practice I acquired two seriously leaky gas fires (waiting room and surgery) and an aspirator which if you touched it in the wrong place gave you an electric shock! Few would argue that there should not be safety regulations throughout society. Yes it represents a significant burden to comply with these regulations, both in time and money. However, it brings benefits to everyone. Younger colleagues will perhaps be unaware that the safety features of modern cars have delivered a fall in road traffic accident deaths which we would never have imagined possible. New cars used to be built and sold without either seat belts or air safety bags – perfectly legally!

The dental profession has to comply with this regulation and individually we should accept it willingly, it is the price we all, as citizens, pay for our communal safety. Sadly, it is necessary for individuals to have a degree of fear of the consequences of non-compliance. I imagine that this is greatly magnified for younger registrants by their use of social media which means that they will hear about colleagues' misfortunes in (possibly unreliably) lurid detail. My staff have to be reminded regularly that I do not need my happy work time upset hourly by yet another 'disaster' brought directly to them via their phones – ignorance is bliss!

Health regulation

Both medicine and dentistry involve multiple interventions many of which can go wrong. Each adverse event has the economic costs of reduced output and the costs of putting it right. There are also emotional costs to the patient of: pain, anger, sorrow, grief, revenge and the desire for compensation. In addition there is emotional cost to the responsible professional: guilt, feeling of inadequacy. The purpose of these regulatory bodies is to provide a framework of safety to prevent mistakes and cut the costs of adverse events and the additional costs of repair.

We are getting the benefit of our medical colleague's experience. Brennan *et al.*[17] identified in 1991 the cost of adverse effects in medicine. This has been taken forward in the UK by the Chief Medical Officer, Liam Donaldson, with the document in 2000 'An organisation with a memory' and in 2001 the establishment of the National Patient Safety Agency.

The concept is of safety through design, using the systems approach which we are all aware of from the airline industry. This requires risk assessment analysis, communication, standardised systems and check lists.[18] It recognises that many of the adverse events relate to psychology/human factors. Although this may not be as clear cut as we might wish.[19]

The financial imperatives mean that as a society we need to cut health costs by reducing adverse events. Mr Hunt the Minister for Health is committed to making savings of 1.5–2 billion pounds from safer care across the whole NHS by 2020.[20]

One might have supposed that the benefits of these regulatory changes would have been self-evident to dental professionals.

Carried out correctly there will be:

- A reduction in adverse outcomes
- Happier patients
- Less litigation
- A level economic playing field.

These benefit all dental professionals. When I first started in practice there were colleagues still using boiling water baths (cheap) rather than autoclaves (expensive). Most hand-pieces were not autoclavable – merely wiped with methylated spirit between patients. When I purchased, at great cost, autoclavable handpieces I was not unaware that there were colleagues who were quite legally continuing to undertake what I felt to be outdated but significantly cheaper practices – the 'good old days'!

Deep safety is the objective not a tick box culture. If as a profession we treat this only as a tick box exercise carried out to please others, then there can be little hope of success. Characters like Mr Tickawayo the CQC inspector, who appears as slippery as a new born baby weasel, depicted in Charlie and Rufus on YouTube is of course amusing, but should not be confused with reality.[21]

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Professional regulation

Only registered dental professionals can provide dentistry in the UK, that is, we have a monopoly on its supply. It is only appropriate that there should be a regulatory authority. In the UK this is provided for by the Dentists Act 1984.[22] Harold Shipman a general medical practitioner was found guilty in 2000 of murdering 15 patients and the subsequent Shipman Inquiry estimated the total number of victims at 250. The subsequent Government's White Paper, 'Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century', concluding that regulation that is independent of government and practitioners is the way forward.[23] This led to the dental members of the GDC being appointed rather than elected.

In the early 1990s I was appalled at the low fees paid under the NHS, certainly not a 'decent return', and angry that I felt forced to 'go private'. So I myself stood for election to the GDC, as I could not understand why the GDC did not stand up for patients and require a fair NHS. Wisely the electorate did not vote for a young man who did not understand the system. But a kindly elder practitioner did take me to one side and explained to me the role of the GDC. It is not to protect practitioners or patients from the pricing vagaries of the NHS. The Act requires that:

'1 Constitution and general duties of the Council.

(1)There shall continue to be a body corporate known as the General Dental Council (in this Act referred to as "the Council").

(2)It shall be the general concern of the Council to promote high standards of dental education at all its stages and high standards of professional conduct among dentists, and the Council shall in particular perform the functions assigned to them by this Act.'[22]

In very simple terms this requires the GDC to undertake two roles:

- Education/prevention: undergraduate education (dental schools) and postgraduate education (specialist training and postgraduate training)
- Regulation/removal.

So whilst individual GDC members are interested, the GDC (as a body) is statutorily disinterested in pricing. It is not turning a blind eye. The GDC only wishes to diminish patients' access to poor quality care and prevent dentists harming patients. As a professional I also want my regulator to deal with the mad, bad, and dangerous.

GDC and education

All dental professionals will I imagine have felt the anxiety moving from a protected undergraduate environment watched over by clinical supervisors and clinical academics to the less protected environment of vocational training/foundation training and then finally to independent practice. This is inevitable.

I myself was only too aware that the very limited introduction to general practice finance at dental school was inadequate as others have described.[24] It became quickly apparent that my undergraduate training was incomplete. So I went on postgraduate courses and did a clinical attachment at a local dental school. This would be I suppose normal. Whilst the GDC is responsible for supervising undergraduate education it is not acceptable to criticise the GDC because of individual personal failings. If, however, an individual registrant is aware that a dental school is providing a programme of education which is deficient then surely they would have a duty to draw this to the attention of the GDC?

Younger colleagues will be delighted to know that when I first qualified, the older practitioners, some of whom had served in WWII, were far more patronising to us, in ways that would now be considered workplace abuse or bullying. I recollect having instruments thrown at me and one consultant telling me that I would not have any opinion worth hearing until I had been qualified at least five years, but that he was doubtful if he would ever take any notice of anything I said.

The GDC and regulation

Contemporary Britain is a post-modern society, characterised by individualism, consumerism and constructivism.[25] This has led to an increased demand for aesthetic procedures as personal appearance is of increasing importance. Evidence shows that over 50% of patients who subsequently litigate against plastic surgeons were assessed by a psychiatrist (in the back of the court) to have mental and behavioural disorders such as narcissistic disorder – so I suspect it is the same for dentists undertaking aesthetic procedures.[26] We are all aware of the rise in litigation and FtP cases.

The GDC only attempts to provide 'just' regulation, not retribution. Justice requires: collection of evidence; thorough sifting of the evidence; and mature consideration. All justice systems have inherent delay. It has always been the plea of litigants that this delay is unacceptable. Students of Cicero will recollect his eloquence appearing as the prosecutor of the former Governor of Sicily, Caius Verres, against the criminal delay to influence the choice of judges.[27] The National Audit Office reported that in the UK courts delays are getting worse against a backdrop of continuing financial pressure. Backlogs in the Crown Court increased by 34% between 2013 and 2015, and waiting time for a crown court hearing has increased by 35% (from 99 days to 134) since 2013.[28]

We would all hope for fair, impartial, informed assessment by the GDC. Inevitably this must take time and costs money. The quality of this justice must be reflected in the price which we as registrants pay in our registration fees. We cannot hope for speed and thorough examination of the case at low cost. These are mutually incompatible. Would registrants actually wish to have the minimum cost regulator dispensing summary justice without proper investigation? Fortunately, unlike the courts, the GDC does not have cash limitations; it can raise the ARF as necessary to ensure justice.

The level of the ARF has been an issue – since 1998 when the GDC sought a 50% increase in fees.[29] The GDC's finances have come in for criticism. It must be difficult to estimate how many complaints the GDC will receive, how many will need to be investigated further, how long the investigations will take and cost. Conduct accounts for the largest proportion of the GDC's expenditure.[16] Whilst all registrants would wish the GDC to keep a tight control on finances I am sure that they would also wish for fast efficient process – justice delayed is justice denied.

Numerically, concerns have risen since the 1980s. Had they continued to rise at the same rate in the past three years the GDC might have needed all the money raised in the ARF. Speaking to colleagues, everyone feels we are on a upward gradient, I do not think anyone expected the present plateau, and nobody feels that we have reached the summit yet. Sadly we all expect further increases, where it will end nobody knows.

GDC improvements

The GDC has attempted to cut costs, for example it cut catering costs in 2001/2 by 42%.[16] As a young man it would never have occurred to me that individual members of the GDC would

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leave the august halls of Wimpole Street. But in 1998 they developed a web site. Shortly after they formed the GDC Road Show,[30] travelling the length and breadth of the country and have had stands at conferences. Whilst I suspect that not all colleagues take the opportunity to attend and hear first-hand the thoughts of our regulators, these were significant steps forward, in an effort to engage which was most welcome.

Whilst the old elected GDC was not in the past noted for its sensitivity as Dame Margaret Seward noted in her Valedictory message in 1999,[31] things are changing. In 2017 the GDC published 'Shifting the balance'.[32] Dr Moyes, the present Chair of the GDC, wrote in the introduction: 'Increasingly, however, the system of professional regulation in dentistry is losing the support of those regulated.'[32] He went on to write: 'We recognise that it is an antiquated system. We have come to the conclusion that our approach is outdated. We need to find a better way.'[32]

Surely every registrant should be happy to read that the Chair of the GDC has come to the same conclusion that most registrants made some years ago?

The paper clearly states the problems:

'the current system of regulation:

- Does not deliver clear enough benefits for patients nor give them the confidence that their concerns are being addressed within an appropriate timescale;
- Has encountered difficulty in maintaining the support of those regulated because it is often cumbersome and stressful for those subject to enforcement, and does not do enough to promote learning;
- Is insufficiently flexible to enable a proportionate and graduated approach, resulting in a reliance on expensive enforcement action.

Good regulation should involve a very broad spectrum of tools and mechanisms designed to positively influence behaviour. Proportionate and fair enforcement sits at one end of the spectrum. But good regulation starts 'upstream' with communications, engagement and learning; persuasion and influence; leadership, partnership and an expression of common goals.'[32]

I cannot put it better than the Chair:

'Changing the system will be challenging, but one thing is certain; we have an opportunity to work together to improve dental regulation in the interests of both patients and professionals. I hope you will join us in seizing it.'[32]

Sadly the principles underlying 'Shifting the balance' were first stated by the GDC 15 years ago.[16] Moreover the GDC's current proposals are surely too modest to make any significant impact. Perhaps they are limited by the hostility of the profession? As a profession we desperately need far better regulation to help us avoid the morass of litigation and Fitness to Practise (FtP) proceedings.

Perhaps we would be wise to recollect the words of the Duke of Wellington: 'Wise people learn when they can; fools learn when they must.'[33]

Surely, when this situation is costing each individual registrant so much money and angst, we have now moved to the point when even a fool must learn that we need improvements?

As a child I used to be fascinated by a lone black swan (the emblem of Dawlish) with its red beak gliding across the water. Sadly, our problems are not solitary black swans, they are more like magpies – ubiquitous birds of ill-omen. But at least there has been research,[34] so we know what ends up at the GDC and can put the problems right if we so choose.

Sadly, of the dozen most frequent charges brought before the GDC,[34] number 1 'Poor clinical treatment' and number 12 'Management of staff' would be probably be the most difficult. But the remaining ten in the top dozen could be amenable to fairly simple resolution.

How can we encourage people to embrace changes that will be beneficial for patients and ourselves? We should limit ourselves to solutions which have:

- An easy method of implementation
- Good-quality guidance
- Clear benefits – with numbers, feelings and experiences demonstrating that the change is better than status quo.

The status quo is not acceptable. So at a time when both sides want change and clearly see the benefits we need to look for easy to implement solutions. Like the GDC I believe that the answers lie 'upstream' but I would suggest fishing in some other rivers for fish which are easier to catch. With this in mind I am of the opinion we should lobby the GDC for changes some of which may require amendments (or Section 60 orders) to the Dentists Act 1984.

I first played with computers in 1970, so am a computer Neanderthal, but even I am aware that they can take on much of the routine work which is tedious but essential. I believe that computerisation could be our salvation, saving us from the various vexations and vicissitudes of modern dental practice.

Automated indemnity insurance

Indemnity insurance should be improved. This represented 22/510 of charges heard in a five year period.[34] The present requirement for registrants to make a declaration that they have indemnity insurance is suboptimal. It should be expected that insurers be required to register with the GDC as providers and that each insurance provider should then notify the GDC of each policy in a similar way that the police can check a driver's motor insurance. Should then a registrant fail to renew, the GDC could advise registrants that their registration was suspended until their insurance was renewed. No longer would registrants need to make an annual declaration of indemnity insurance – another burden lifted.

Continuing professional development

I am confident that the whole profession would aspire to continue to improve continuing professional development (CPD). We need to lobby the GDC to alter the Standards to improve this. Presently, verifiable CPD in the UK is largely (but not limited to) a mixture of lectures or journal reading. The present trust based system is suboptimal.

Sadly, in lectures one often sees participants managing their online status, texting or playing games. On one memorable occasion I recollect a colleague (now sadly dead) cheering the cricket score! In addition we will all have sat through lectures which were poorly presented and perhaps even irrelevant to our own sphere of practice. Are these lectures made more memorable by undertaking them whilst cruising down the Volga? Try telling it to your patients and listen carefully to their body language!

Dr Rufus Fideo's (the YouTube guru of the dental surgery) comments with regard to journal reading:

'Rufus: "What, you mean you actually read them!"

Charlie: "Yes, don't you?"

Rufus: "No of course not, I fail to see how reading an article on a school-based epidemiological study of dental neglect in adolescents in a deprived area of the UK is going to help me sort out Mrs Scoggins' UL6."

Charlie: "If you don't read the articles how do you answer the questions?"

Rufus: "Honestly Charlie, you guess."'[21]

The GDC seems to agree with Dr Fideo as it writes:

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'There was very little evidence to suggest that current models of CPD have an impact on the quality of care delivered, performance or competence. A further conclusion, however, was that the public expects professionals to keep their knowledge and skills up to date by carrying out CPD activities. We therefore need to close the gap between those two conclusions, and ensure that CPD meaningfully contributes to patient care, patient protection and professional development.'[32]

Those of us who have attended the Dental Protection Society's Complaints Management training understand how good it is. It is small group training, with professional tutors with an excellent knowledge of the subject, and specialist work books. Unlike other CPD providers one does not see attendees playing with mobile phones or tablets. We are engaged – I think largely because of the high quality and that you cannot sit at the back. It is of high quality because the provider has a financial interest in its success. If we get the message and act on it there will be fewer claims to pay out.

I am sure that our patients would hope for something better than guessing the answers to journal questions as training for activities as important as medical emergencies.

The GDC should alter the Standards to require that registrants should have indemnity insurance which includes mandatory training as part of the insurance package (medical emergencies; disinfection and decontamination; radiography and radiation protection; legal and ethical issues; complaints handling; early detection of oral cancer and safeguarding for children, young people and vulnerable adults) provided by the indemnity provider.

This would mean that all registrants would either have to complete mandatory training or lose their insurance and so their registration. This could be approximately ten hours CPD provided annually. The indemnity provider would be able to electronically confirm direct to the GDC that individual registrants had undertaken the CPD. There would be a shift of costs from the GDC to the indemnity providers so there could be an immediate reduction of the ARF. The cost to the indemnity providers could be lower than the present costs as they would be providing a product across the UK and so would benefit from the economies of scale. It would also be hoped that the costs would be further offset by the improved professionalism and skills of all registrants reducing litigation and FtP hearings.

It would be reasonable to expect all other providers of postgraduate education to be required to inform the GDC when individual registrants have undertaken education. So all CPD providers would register with the GDC and send details of attendees to the GDC electronically. No longer would registrants need to make an annual declaration of CPD – a burden lifted.

Software training

There is little point in having sophisticated software if the registrant cannot use it optimally. Drivers are required to pass a driving test. No insurance company would underwrite a motor policy for a driver who had not passed the driving test. Yet we do not ensure that registrants are trained to use software which they use every day? When you buy Software of Excellence (SOE) you can receive training which takes several days provided by qualified trainers. Again, excellent small group learning because the software providers want the software to work with minimum support. Yet when a newly qualified registrant arrives in my Health Board they receive local software training provided by a colleague. Many of them appear to struggle. We should lobby the GDC to require indemnity providers to require registrants to declare their software annually and show that they have had training provided by the software provider, not a 1/4 of an hour with a colleague! Again, this could be automated by the software provider declaring the education to the indemnity insurer.

Radiography

It is possible now for computer programmes to be used to read radiographs and provide diagnoses. Obviously this will only work for digital radiographs. We should lobby the GDC to amend the Standards to require all radiographs to be held digitally and be electronically audited.

Then the radiography programme could:

1. 'Read' the radiographs and grade each one (1,2,3) and record the score in a separate file. It could audit all radiographs taken and if the results fall below the necessary level could electronically inform the indemnity provider, who could require the registrant to undertake further education in practical radiography. No more scratched sensors now!
2. Alert individual practitioners of potentially cancerous boney lesions
3. Have a service indicator (just like in your car) within it set by the service engineer so that if it was not serviced in a timely manner after a short warning period it turns off the X-ray machine and the indemnity provider would receive an email. Radiation represented 59/510 of charges heard in a five year period.[34]

Practice records computerisation

We should lobby the GDC to require that all practices should be required to computerise and use NHS BSA/GDC approved dental practice management software. No longer should registrants be expected to remember so many details in a busy practice when the software programmes can do so much more of the work. The programmes in general use are over a decade old. They are no longer fit for purpose; they need improvement for today's busy dental practice. Are you using games from ten years ago?

Record keeping is the second highest category of charges – 61/510.[34] Our electronic record keeping systems should automatically include:

Medical history

1. If when completing the medical history the box for smoking has an entry 'yes', then the programme should automatically print out an 'Advice Sheet' for the patient and an item of treatment, 'Smoking cessation advice given', inserted into the treatment plan
2. The software I use has no mention of dementia. It was designed for fit healthy individuals, but with our aging population we need to expand the space for patients with many complex diseases
3. The software should recognise certain drugs/diseases and flag them to the practitioner. For example 'bisphosphonate' medications would produce a patient advice sheet if an extraction were planned and create a screen 'pop-up' of a link to the NICE guidelines. This must be kept minimal to avoid registrants ignoring it
4. No appointment should be completed without a current medical history in place. The lack of a current medical history represented 28/510 of charges heard in a five year period.[34]

Examination

There should be a requirement for empty prompts within the examination item, for example, mucous membranes, the examination could only be completed with these subsections completed first.

The software should prevent:

1. Completion of the exam item without recording either BPE or 6ppc
2. A course of treatment with a BPE of above 0 not including instruction in oral hygiene and if above 1 to include scaling, etc
3. Examination appointments could not be completed without a written treatment plan automatically being printed and emailed to the patient. Consent issues represented 53/510 of charges heard in a five year period
4. If there is mixing of NHS and private within the one course of treatment there should be automatic printing of an approved GDC statement also emailed to the patient. Mixing of NHS and private represented 24/510 charges over a five year period[34]
5. The software should be able to create the recall interval using an algorithm based on the charting, the BPE, number of new cavities, patient age etc.

Diagnostic radiographs and intervals

The programme should be able to examine the individual patient's past records and automatically insert routine bitewing radiographs if required

1. Radiographs should not be able to be completed without a report
2. Certain items would automatically generate radiographs in the treatment plan, for example, crowns, bridges, inlays and prolonged gum treatment. Then these items could not be completed without the radiographs being previously closed.

Sedation

Sedation items should not be completed without a second appropriate person logged in. This represented 21/510 charges over a five year period.[34]

Advice sheets

All items of treatment for which advice is necessary should be automatically printed, emailed and/or texted to patients.

Drug prescription

All prescriptions should be printed through the dental practice management software. This could automatically prevent (or make more difficult) self prescription and prescribing for staff. This represented 16/510 charges over a five year period.[34]

Accounting

All practices could be required to produce their accounts in a standardised way using the same approved software. This would greatly help when:

- Fraud investigations are necessary
- Associates are negotiating with practice owners
- Buying and selling practices.

This would ensure that all sides would be able to understand the accounting.

Provision of records to the NHS Business Services Authority [NHS BSA]

We should lobby the BSA to change the SGDSC. All NHS practices should be required to automatically allow the NHS BSA to interrogate the practice system – so that never again would there be a failure to provide records to the BSA. This represented 25/510 of charges heard in a five year period.[34]

Root out our 'rotten apples'

NHS dental fraud has been with us all my practising career – it should have been dealt with years ago. The sad case studies presented by Professor Trevor Burke[36] recently of practitioners providing repeated over-treatment of 12 units of dental activity (UDA) courses of treatment should never be allowed. This is in clear breach of SGDSC Clause 177 which states:

'A prescriber shall not prescribe drugs, medicines or appliances whose cost or quantity, in relation to any patient, is, by reason of the character of that drug, medicine or appliance, in excess of that which was reasonably necessary for the proper treatment of that patient.'[37]

The dental practice management software should include within it coding which would inform the practitioner that this item of treatment has been recently provided for the patient. If the practitioner then attempts to bill the NHS BSA the software could also inform the NHS BSA. One of these case studies indicated that patients were having repeat treatment by different dentists but at the same practice. Clearly the NHS BSA could tackle this by altering the practitioner numbers for corporate associates to reflect the reality. Then the tacit collusion at over-prescribing would be at an end.

Moreover, the NHS BSA needs to update its computer system. The recent nationwide collapse of NHS computers is indicative that they are old and ill-maintained. There is no reason to suppose that the NHS BSA is any different. One suspects that like UK banks they expect and accept that there will be fraud (8.3p per £100 in 2015 for credit cards).[38] My Grandmother would have asked, 'Who causes the theft: the man who leaves temptation in the way or the thief who takes it away?' With better algorithms this could be a thing of the past. NHS fraud represented 57/510 charges over a five year period.[34]

Supporting professionals from overseas

The GDC is on record as stating: 'New registrants who have undertaken their training outside the UK may face specific challenges in their transition to working here. These may include understanding the workings of the NHS and contracts, adapting to different patient expectations or different ways of working within a dental team. We are considering the role we should play in assisting these registrants in overcoming such challenges and helping to ensure that avoidable problems for patients or registrants do not arise.'[32]

All new registrants face problems. We should lobby the GDC to amend the Standards so that all new registrants have training in legal and ethical issues, and complaints handling provided by their indemnity provider prior to commencing practice. In addition, all registrants undertaking NHS general dental practice for the first time, or after any significant break from practice, should have training outlining their responsibilities provided by the NHS BSA before they (re)commence practice.

First tier complaints/Independent concerns management

We need several nationwide universal dental concerns services which are independent and work. By the way it is 'concerns' rather than 'complaints' if you are politically correct. These should be in competition with each other to ensure minimum costs. Managing many of the concerns before they get near the GDC. The GDC on its website states that it is unusual for the Dental Complaints Service (DCS) to be financed by the regulator, implying that it was not a role for the GDC.[35] This is something which perhaps the BDA, the FGDP, the NHS or the Royal Colleges could organise for their members/staff. Clearly, it would be inappropriate for the indemnity providers to have this role as there would be a clear conflict of interest. The GDC should be lobbied to make it a requirement of the Standards to be part of an independent concerns service. This could significantly reduce litigation and certainly GDC costs as they will no longer be referring minor concerns on to the appropriate person or funding the DCS. It will also make individual

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registrants more comfortable knowing that minor troubles are not going to the GDC.

But it will only work if patients are aware of its existence! In my own hospital there are notices explaining how to raise concerns in virtually every waiting room. It was truly facile to complain when the GDC placed public advertisements in newspapers informing the public of the DCS. Rather we should lobby the GDC to mandate the placement of 'How to raise concerns' notices including the details of the service not just in every dental waiting room but on all appointment cards. Do we really believe complainants go back and read notices? Wouldn't this be better than patients popping something into their search engine and getting the Dental Law Partnership?

Emergency drugs/electrical safety/ pressure vessels/workplace insurance etc

We should lobby the CQC as it should be ensuring that no practice ever falls out of date. Providers of these products could be required to register with the CQC and advise them two months before the product will expire/require inspection etc. Then the suppliers can warn the registrant in good time, but if an order is not placed then CQC can contact the practice prior to expiration warning of practice closure if the products are not replaced. Health and safety accounted for 18/510 charges brought over a five year period.[34]

Payment of the retention fee

Two registrants known to me have failed to renew their registration. One was due to the worry and anxiety of family sickness. This could happen to any of us. We all make mistakes. We should lobby the GDC to improve the payment of the retention fee. Payments should be made due two months before the end of the year. Then if the registrant did not pay the GDC could send letters and emails advising that the registrant would cease to be registered well in advance to minimise the chances of accidental failure to pay. The BDA and or the FGDP could also locally contact members as well as part of the membership benefits.

GDC communications with the profession

We need to lobby the GDC to improve communications with the individual registrants. In the past each registrant received a copy of the GDC Gazette, which itemised changes and gave details of the charges against registrants who were erased. It was difficult reading. But unlike the website which requires a positive action to visit, (which we [registrants] would not wish to access) the Gazette sat hauntingly upon the desk. The GDC needs at least to email all registrants the electronic equivalent of the Gazette. This would help DCPs to understand what happens when things go wrong, perhaps allowing them insight into their own practice circumstances. Additionally it would be better to send an A5 (cheaper postage) paper copy of the Gazette to all registrants' home addresses so that the significance is not lost in the hurly burly of daily practice. Have you actually read 'Shifting the balance'?

Some will feel these measures are a 'spy in the cab', but in reality they are just allowing technology to support our busy lives and thereby prevent us walking on the GDC's carpets. Surely, a timely reminder is better than falling foul of Wimpole Street? The HM Revenue & Customs (HMRC) now advertise the closing date for tax returns on the radio – to 'help us', why cannot the GDC also 'help us'? These simple measures could reduce, by 50%, the charges brought before the GDC.

The measures would go a long way towards improving the external view of the profession. Moreover the reduction in the number of charges brought would reduce the GDC's expenses making a reduction in the annual retention fee inevitable. Were the GDC then to amass treasure and sit Smaug-like astride it, judicial review would inevitably be successful.

In the longer term we will need a new Dentists Act, which hopefully will incorporate many of the aspirations of our younger colleagues, hopefully guided by older colleagues' wisdom and experience. This will be the time to consider Quis custodiet ipsos custodes and ensure that the regulator is also regulated. This can only be achieved with extensive lobbying of Parliament which will require a Herculean effort of will across the four nations in each and every Parliamentary constituency by the regulator and profession working together. A daunting prospect which will only be possible if the profession stands together, supporting our leaders within the BDA, and that leadership carries the membership with it.

Conclusions

We should accept that we individually are all fallible and that our institutions are also fallible. As Don Berwick wrote: 'Improvement is a continual journey and new challenges will arise.'[39]

We can all conclude that the relationship between the BDA and the GDC is not working as we would all have wished. Perhaps we should change tactics? Perhaps we should change our negotiators? Clearly this is a matter for the BDA in private.

Very truly I tell you that we cannot break the chains, neither can we loosen the shackles of regulations, nor should we want to – as they are for our benefit. If we reject our regulators there can only be a confrontation which cannot be won. In fact we can lose much more. Self-regulation was largely removed because it was not working. If the present regulation fails we could have something more draconian.

Very truly I tell you that to win as a profession we must engage with regulation. The solutions to our problems lie in our own hands. We need to be pro-active: advise our regulators and support them. We must reach out to them. The BDA should enter into meaningful private dialogue avoiding public confrontation. Jaw, jaw not war, war. We should aim for amicable discussion, moderation, forbearance and courtesy amongst the disputants. The thoughts of younger colleagues should be received with the same attention as those from the maturer wisdom of older colleagues. All sides should avoid impatience and take time to meditate and deliberate before speaking.

It is appropriate that the BDA should communicate with its members, but should keep that reporting factual.

Very truly I tell you that if we reduce the number of charges brought before the GDC by improved professionalism through better regulation we will reduce the work of the GDC, its costs and our retention fees.

However, the GDC have been considering these changes since 2002: all my practising career we have waited for a perfect NHS contract. So perhaps we should take Milton's angel Raphael's advice: 'Think onely what concernes thee and thy being; Dream not of other Worlds.'[40]

Good luck to you all. This will be my last year Cassandra-like telling patients and managers truths which they do not heed. But I fervently hope and pray that our profession, which has provided me with a good living and many happy memories, can reach a better place.

Deo volente I hope to travel south soon. Perhaps sometime in the future you will drive through the mountains behind the Portuguese Algarve. If you should hear the tune *Sarie Marais* and spy an old man, a Rhodesian Ridgeback and a flock of goats – come over

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and introduce yourselves. You will be very welcome, your children can have a glass of freshly squeezed orange and for yourself perhaps something stronger? You can tell me how the ARF has risen to £2,000 or £3,000 or whatever the fantastic figure is by then. Old men do not sleep well and it would be nice to have a chuckle at your expense as the swallowtail butterflies frolic on the evening breeze, the sun sinks slowly into the Atlantic Ocean, and I gaze up at the star-bejewelled sky before bed. For very truly was it said: 'A prophet is not without honour, but in his own country and among his own kin and in his own house.'[41]

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