The GDC – lifting the lid. Part 1: professionalism and standards

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IN BRIEF

- Gives an overview of the GDC's work maintaining professionalism and standards in dentistry.
- Details some of the complex dilemmas involved in maintaining dental standards.
- Outlines the way the GDC are addressing some of the issues that will affect the dental profession in future.

GENERAL

The General Dental Council (GDC) began life as a committee of the General Medical Council before becoming the sole regulatory body for the dental profession over 50 years ago. In that time, although the nature of its role in providing protection to the public has remained essentially the same, the environment in which it has had to operate has changed remarkably. In an attempt to help the GDC explain and clarify their work for the benefit of readers, the *BDJ* invited them to write a series in their own words describing their work, philosophy and plans for the future. This first part outlines some of the dilemmas faced over maintaining standards.

'What on earth are they up to? What planet are they on? Where do they dream these things up?'

Do they mean us? Maybe. We sometimes get the impression you think we have two heads – or none. Or a head but no heart. You may know some of what we do. You may know a lot about a bit of what we do. But do you know what we're like? In this series we aim to lift the lid on the GDC, showing you what it's like to be part of the GDC. We promise to try to avoid corporate speak, jargon and the 'party line'. Can we keep this promise? You'll need to read the whole series to find out...

We thought: 'Where shall we start?' We do bang on about the register, and we will later in the series. But the register is a means to an end. Instead, could we come up with one word to summarise what we're about, and start there? We decided to start with professional standards – OK, two words, but you get the point. What's it like to work on professional standards at the GDC?

Standards for dental professionals

Meet Janet Collins (Fig. 1). Janet has a view on lots of professional standards issues: for example, should dental hygienists be allowed to see patients who haven't seen a dentist first?

Janet isn't just anyone with a point of view, of course, so she keeps her private opinions to herself – that's part of *her* professionalism. Janet is Head of Standards at the GDC. Standards are at the heart of the profession, and therefore at the heart of our work – we register those who meet our standards; we turn down those who don't. All dental patients are entitled to high standards of professional and personal behaviour from those who provide their care.

You may think this is obvious, because you are registered – literally signed up to the high standards expected of dental professionals. But what does it mean, this word 'standards'? 'When I use a word,' Humpty Dumpty said, in a rather scornful tone, 'it means just what I choose it to mean, neither more nor less.' One person's 'standard' is another's rule, and another's guidance, and another's loophole. At the GDC, we walk a daily tightrope when we work on standards: make broad statements of principle and we risk being vague and unclear; give a yes or no answer and we risk depriving you of that most valuable and fragile quality – your professionalism, which involves making a million tiny decisions daily, and taking personal responsibility for them. This is the big balancing act when we work on standards.

'Some say you need to be "comfortable working with ambiguity" in this

Fig. 1 Janet Collins, Head of Standards at the GDC

THE GDC – LIFTING THE LID

1. **Professionalism and standards**
2. Registration
3. Education, CPD and revalidation
4. Fitness to practise
5. Illegal practice

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job. And that's true – but registrants like certainty,' says Janet. She's been at the GDC for 14 years in a variety of roles and still relishes the challenge. 'As far as I know, no other healthcare profession sets standards across a whole team, because other health teams tend not to have a single regulatory body. For example, doctors are regulated by one body, midwives and nurses by another, and healthcare assistants, not at all.'

Registering the whole clinical dental team is a huge opportunity, but we do need urgently to clarify for all team members what the ground rules are – the rules of engagement, if that doesn't sound too confrontational.

The GDC's guidance *Standards for dental professionals* lists the six key principles which should underpin all the judgement calls made minute by minute in every dental surgery and dental lab in the land. You know them, even if you couldn't reel them off pat, because they permeate your working life. You put patients' interest first and act to protect them. You respect patients' dignity and choices. You protect patients' confidential information. You co-operate with other members of the dental team and other healthcare colleagues in the interests of the patients. You maintain your professional knowledge and competence. And you are trustworthy.

That said, as Janet explains, 'trying to define standards that are clear to understand for professionals and make sense to patients but don't "lock in" principles that are going to date or be overtaken by events is a continuing challenge.

'I also ask myself: Will these standards make sense to a patient? What do they expect? Are they going to understand them in terms of their experience?' Questions pour in continually, from dental professionals, indemnity companies, the British Dental Association and the GDC's own staff. 'If the GDC receives a series of questions on a particular issue, does that signal a gap in our guidance that needs plugging?'

Part of Janet's role is to support the work of the GDC's Standards Committee, made up mostly of Council members, 'so anything considered by them hits my desk: indemnity, scope of practice, but also the need constantly to review and monitor and update guidance on standards.' She learns a lot from her colleagues in our Fitness to Practise team about the 'hot' issues of the day. And, of course, where there are standards, there are ethics.

Ethics

So what is it ethical for a dental professional to do, and what is not? And if it is not, why isn't it? Thorny questions.

'Scope of practice – who can do what within the clinical dental team – is obviously a key area for me,' says Janet. 'The 1984 Dentists Act says that dentistry is what dentists do, which to my mind is rather circular.

'Previously, only doctors and dentists could practise dentistry. Then, when dental hygienists and dental therapists were registered, that meant that certain registered people other than dentists could carry out particular tasks. When we extended the DCP register in 2006 – for four further classes of DCP – things changed again.'

You will know that lists of permitted duties were scrapped. Now a dental care professional can work 'within the limits of their competence'. 'That was a sound idea, in theory allowing dental professionals to develop and extend their roles easily, but in practice it is coming across as too vague. There is no clarity, and a lot of people are confused about what they can and can't do.'

Janet is right. To be fair, the Council recognises this problem, and is addressing it. 'We have to find a middle way,' says Janet. 'It can't be as open as "work within the limits of your competence", but at the same time we don't want to go back to the bureaucracy of permitted duties, which can curb innovation because they are so hard to change.'

Drawn from across the profession, the members of a working group focusing on scope of practice attempted to map a route through this middle ground. It was a challenge. Their working practices reflected this.

'The working group met every three to four weeks, which is quick-fire by traditional GDC standards! There were no agendas as such, no papers, and no pat answers. Sessions were like a structured brainstorming. Members were told in advance what the topic was to be, but not what the options were, to keep things dynamic and free-thinking.'

Fig. 2 Lay GDC member Peter Catchpole

One meeting, for instance, looked at the role of the orthodontic therapist. How do you differentiate them to a patient, compared with a dental hygienist or a dental nurse? Where might their roles overlap? What activities should be reserved to them?

A lay member of the GDC, Peter Catchpole (Fig. 2) has more than a little interest in the issue. 'We're certainly not planning any professional engineering but, for instance, if a nurse learns to scale and polish, that doesn't make them a hygienist. It's not just the tasks themselves that are relevant. It's not just a question of teaching you those, and letting you loose on the patient.'

The patient's health background matters. Peter is concerned that you might learn the skills to scale and polish Mrs Widget's teeth, but you also need to take into account her general health and obtain her consent. 'We're keen on the skills escalator, but there comes a point where you can't move from one title to another without undertaking the full programme or course.

'The patient's needs underpin everything. If you go to a GP, a practice nurse may give you an injection, and you'll probably feel secure receiving it. We need to ensure that patients in the dental chair feel equally safe, no matter who is treating them.'

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Formulating standards

Formulating standards is not always easy. Here's an example: recently an informal GDC policy workshop looked at issues around the character of students and would-be students. Could a dental graduate who's been convicted of a minor offence – and come clean about it – register? What if they go on a student drinking binge? Or are unruly and ill-disciplined enough to worry the school? Will a prospective student with a criminal history be able to register after receiving a BDS?

A more rigorous and transparent way of dealing with such questions was the aim. But once you start digging, particularly on standards, all kinds of possible repercussions spring up. It turned out that disability and ill-health raise similar issues. Should a dental school accept a prospective student with severe dyslexia, or one who is profoundly deaf, or is HIV positive – will they be able to register after graduating? Every policy issue links into every other at some point, and part of our job is to try to join up the dots and help the whole thing move forward in a manageable way.

Clearly, a disabled dentist is no less capable of being professional than a non-disabled one. A dentist with insight into the limits of their abilities, as dictated by disability or ill-health, limits their scope of practice, and we should trust them to do this.

Some conditions, though, impair judgement. So some registrants can't self-regulate, perhaps because of alcohol abuse or their mental health; or won't, due to a personality disorder. At this point, fitness to practise procedures – the subject of a later article – kick in. But otherwise, why not scrap health requirements? This is a real issue, not a theoretical or a rhetorical question. If we are going to have (or maintain) a rule, we need to ask a few questions about it. What is it trying to achieve? Will it work? Has it worked? How do we know? Could we do things better by changing the way we do them? Should we pronounce at all?

Setting standards for students and disabled or ill registrants or potential registrants is tricky enough. The target is moving, albeit slowly. Add technology – or worse, fashion – and it's like trying to pin the tail on a stampeding donkey.

'What am I allowed to do?' is a question that Janet Collins hears often. New technologies frequently lie behind the question, and are continually putting pressure on standards. 'New services don't drive standards, but they do influence them. Take tooth whitening. We're clear here: tooth whitening is a process designed to permanently or semi-permanently alter the appearance of teeth, so it is clearly dentistry, and should be done by dental professionals – not "smile therapists" or beauticians.'

When alerted to illegal tooth whitening in, say, a beauty salon, the GDC will always, in every case, issue a warning, and is moving to proactively prosecute (more of how the GDC is challenging illegal practice will be covered in a future article). But while beauticians have their tanks parked on dentistry's lawn, some dentists are keen to step into the beauty clinics' territory, often with justification. If the boundaries are being blurred, do dentists need to take some responsibility for that?

'Dentistry is so ill-defined in the Dentists Act that there is effectively no legal restriction on what dentists can do: if dentists usually do it, it's dentistry,' observes Janet. 'Of course, they can't take your kidneys out. That's obvious, isn't it? But trying to define exactly why it's obvious, in a way that helps answer a question about collagen, or bone harvesting, is a little less obvious.'

For a professional trained in the physiology of the face, experienced in pharmacology, and working every day on the aesthetics of patients' appearances, injecting fat to plump up the skin might seem all in a day's work.

'You could say it's clearly not dentistry, as no teeth are involved, so the GDC can't regulate it. But if dentists are doing it, we have to deal with it. We are concerned about training and competence in these areas and the difficulty of regulating them – but no one else has regulatory oversight.

'The bottom line is that patients are having these things done, and we are there to protect patients – *the GDC: protecting patients, regulating the dental team*. If something goes wrong, we have to deal with it. But in practice it's difficult to draw a line. If others are going to step in and do it, there's an argument for regulating dentists to do it. Dentists would be trained, professional, and most of all have indemnity, although it is fair to say that indemnity providers are split on the issue.

'Botox worries me because it is a form of the botulin toxin that effectively paralyses muscles to smooth away the appearance of wrinkles. But if it's a concern, is that an argument for or against allowing dentists to administer it?' And if it is an argument *for,* why stick to the mouth and face? 'We already know that some people advocate the use of Botox to control sweating. If a dentist can inject it into someone's face, why not their armpits? Why not their feet? Are we going to ring fence activities?'

Public pressure plays a role. General anaesthesia – bar sleep, the closest we come to death in an all but routine way – was banned in dental surgeries virtually overnight, following public shock at a series of deaths in the chair. 'That's obviously unusual and most issues take longer to resolve – the political will was there to get dental nurses and technicians registered, but it still took five or six years to bring about.'

Feeling a way towards a solution

The requirement for dentists and hygienists to have indemnity cover has always been there in ethical and professional terms, but when the Government decided to enforce it legally, the GDC and the General Medical Council were given powers to require 'adequate and appropriate' cover.

Given the choice, Janet would devolve the decision about adequacy to professionals and their practices, in consultation with the indemnity providers. 'You know your practice best; you know what cover you need – you decide in consultation with your provider and its risk management matrices.' But the Act doesn't allow that.

The GDC is feeling its way towards a solution. We have to find something more helpful than to research the market and say: now you decide.'

Back to standards in general, and a pensive Janet Collins. 'The movement

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in standards has been away from prescription, towards principles,' she summarises. 'More and more, we've stopped trying to define all the circumstances in which standards might apply. Instead, we say "you're the professionals; here are the principles; take them into account, and if you do, and can justify what you do as a result, that's OK."'

But Janet is beginning to wonder if this approach is right, relying as it does on a shared culture of professionalism. As our work on student character issues reveals, it depends on our supposing that across the range of educational, cultural and age-related factors, the fundamental tenets of professionalism – the ethical framework on which we can hang standards – is in place, and is the same for everyone. We may have to look at whether the standards are applicable across the whole profession. Are we making sense to everyone? Watch this space.

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