



Consultation Response

The General Dental Council's proposals to increase the Annual Retention Fee

Introduction

Dental Protection Limited (DPL) is a wholly-owned subsidiary company of the Medical Protection Society (MPS) which is the world's largest professional indemnity organisation for doctors, dentists and other healthcare workers, having over 300,000 members internationally.

DPL serves and supports over 65,000 dental members of MPS in 70 countries worldwide. This total includes approximately 70% of UK dentists and a higher proportion of UK dental therapists and hygienists. DPL Members have access to indemnity in respect of claims in negligence, as well as legal advice and assistance with complaints of all kinds, including GDC Fitness to Practise (FtP) enquiries for UK members.

We have experience of managing claims in negligence worldwide, and we assist dentists with inquiries by Dental Councils and other Regulators in all of the jurisdictions where we operate. We are well placed to comment meaningfully on the current consultation.

DPL has given careful consideration to this consultation document and the supporting documentation. We would not normally comment on what is essentially a business decision by the GDC, being mindful of the GDC's obligation to balance its budget, raising the necessary funds primarily by means of the Annual Retention Fee.

On this occasion, however, the GDC has justified the unprecedented scale of the increase in the ARF primarily on the basis of the increase in the number of 'complaints' that it has to deal with. In calculating its likely operating costs, the GDC has also predicted that this volume of incoming 'complaints' will continue to rise for the foreseeable future, and appears to have assumed that the number of Fitness to Practise (FtP) investigations will need to rise at least in proportion to this. The only conclusion that one can draw from this is that the GDC sees no need for any reassessment of its approach, and no potential for improving what has become an increasingly dysfunctional and unnecessarily costly system. We fundamentally disagree with the GDC's view as reflected in this starting position, and it is for this reason that we feel it necessary to contribute to this consultation.

These flawed premises touch upon areas that we have regularly discussed with the GDC and having expressed our concerns in this regard on so many occasions, it is disappointing that the GDC still seems to see no alternative but to continue on the path on which it has embarked (despite criticisms not only across the width of the dental profession but also from the GDC's own regulator, the PSA), rather than to question why no other healthcare regulator in the UK shares the GDC's approach where Fitness to Practise matters are concerned.

Dental Protection has the advantage of a further insight which will hopefully inform and support this consultation, given that we deal with many other dental regulators around the world on almost a daily basis. We have previously commented on the fact that the regulatory activity by the GDC in the area of FtP is in our view wholly disproportionate, and does not meet the aim of 'right touch' regulation. In our experience, no other dental regulator in the world is so far removed from the principles of 'right touch' regulation where Fitness to Practise is concerned, and the GDC regularly investigates matters that would not concern any other dental regulator that we work with. Given recent events, it is simply unsustainable for the GDC to believe that it alone has the balance right.

For as long as the FtP process continues to operate so unsatisfactorily, dentists are effectively having to fund the GDC's unnecessarily high costs not only through their ARF, but also through the subscriptions that they are needing to pay to their defence organisations. The true cost of the GDC's refusal to acknowledge that a radical change of approach is required, is much greater than the massive extra sum that the GDC now feels the need to collect.

Assumptions and background

The GDC has not been transparent in its public statements, to some extent reflected in the consultation document, as regards the growth in 'complaints'. It would be more accurate to refer to the number of matters reported to the GDC. It is inappropriate to imply that these matters are mostly, or wholly complaints initiated by patients about the quality of the care and treatment they have received. Individual pieces of information which reach the GDC are very often matters which can and should have been acted upon by other parties or organisations. Referrals to the GDC are an abdication of the responsibility of many such organisations, the motive often being to shift the associated costs and risk of challenge, and we do not believe that the GDC has taken a sufficiently firm line in its dealings with many of these organisations. A referral of a registrant to the GDC has become the cheapest and most convenient option, and we are not aware of any effort made by the GDC to discourage this increasingly common abuse of the GDC's powers and functions.

Indeed, the recent advertising campaign by the GDC may even have compounded the problem. The failure of the GDC, when designing these advertisements, to encourage patients to use the in-house complaints procedures that the GDC requires every registrant to make available for their patients to use, has raised genuine concern that the GDC may have lost touch with what it is tasked to achieve. In just the same way, organisations should have internal procedures to deal with any concerns they have about the performance of any registrants that they employ or otherwise commission services from. It is not the GDC's role to replace that.

In both instances, it is within the existing powers of the GDC to ask complainants/informants whether these preliminary procedures have been tried and exhausted, before rushing to process these referrals without the slightest question, as potential Fitness to Practise cases. It is perverse for the GDC to require registrants to make available, and to operate, effective in-house procedures for managing patient complaints, and then to waste registrants' ARF payments on a proactive advertising campaign which deters patients from using these in-house procedures, instead directing them to complain to the Dental Complaints Service or GDC. This wastes ARF income both in the cost of the advertisements and in the cost of processing complaints that could and should have been resolved in-house by registrants at no cost to the GDC. It is little wonder that the profession has become exasperated by the lack of judgement, financial responsibility and competence displayed by the GDC.

Options

There are a number of ways to address a shortfall in any budget. For example,

- the income can be increased to meet the anticipated demand
- the anticipated costs and the areas in which they are expected to arise can be reviewed and steps taken to contain or reduce them, or
- a mixture of both methods can be applied, seeking an appropriate balance that does not undermine what the organisation exists to achieve.

In the GDC's case, it appears that the FtP Directorate has simply asked the GDC to increase the income to match the anticipated (greater) expenditure. There is no real evidence that the FtP Directorate has taken any functional steps to reduce its expenditure within the constraints it faces through the delay in making procedural changes through a Section 60 Order. The GDC's decision to increase its in-house legal team has not had the desired effect because the team lacks experience and competence, wasting huge amounts of time for all parties and incurring additional costs unnecessarily, as a result of arguing with defence solicitors on simple points.

The use of inexperienced (less expensive) Counsel by the in-house team in FtP and IOC hearings is also counterproductive, slowing down the hearings and on occasions over-prosecuting some points,

while inadequately prosecuting others and then wasting time trying to remedy that. The lack of focus and apparent lack of awareness of the GDC's statutory remit where IOC powers are concerned is a continuing cause for concern and a growing source of wasted expenditure.

The fundamental problem is that although complaints (in their broadest sense) are increasing in number, both directly to the GDC and via referrals from the DCS, those handling the complaints at the earliest stages are not applying the correct statutory tests, which means that far too many dentists are being investigated, when there is no real prospect of their Fitness to Practise being found to be impaired if the case was to be considered at the PCC.

Additionally, there are far too many Interim Orders Committee (IOC) hearings involving matters with little or no evidence of the slightest risk to public safety, and consequently where no order is made. This suggests that the incorrect test is being applied to referrals to IOC. In some cases the GDC reaches for the blunt tool of an IOC referral where cases have not been processed by the GDC in timely fashion. If the case is not serious enough for the GDC to process it quickly and efficiently, it is not likely to be serious enough to merit an IOC referral many weeks or months later. It appears increasingly that IOC referrals are being made in these numbers simply to create the illusion of appropriate regulatory activity to secure public safety. The reality is that the GDC's judgement is being called increasingly into question, at the same time as wasting ARF income.

In the 2005 amendment to the Dentists Act 1984, the GDC was given the option to refer dentists to a Professional Performance Committee (PPC) as an alternative to the PCC or Health Committee. The number of PPC referrals in the past eight years has been lamentably small, and embarrassingly so. If the GDC has chosen not to take full advantage of the powers bestowed by a Section 60 Order of nine years ago, it is difficult for the GDC now to argue that it is hampered by having to wait a further nine months for a Section 60 Order to give it additional powers to improve the current FtP procedures. One significant opportunity has been ignored for almost a decade, and registrants are being asked to meet the much greater costs of running the same cases as matters of professional conduct rather than performance.

In a typical performance case, the facts can usually be agreed in advance, as can an action plan involving a personal development plan developed with the Deanery, resulting in a short hearing, typically less than a day, at which conditions can be imposed with a review hearing planned. This avoids the need for endless pages of allegations to be proved line by line as occurs in a contested misconduct hearing. The impact on the costs of the overall case would be significant, and from a budgeting perspective, unarguable.

One has to ask why so few Performance referrals are made. We can only think this is because the cost of a formal assessment of performance carried out by NCAS is significant (£30-40,000) however, it is worth noting that it is still less than the cost of a three day hearing. If an NCAS assessment shortens a hearing by more than three days and given that the GDC says that the average misconduct hearing is four days, it is a false economy to ignore this possible course of action. A less charitable view of the GDC's reluctance to make use of the powers bestowed by the 2005 Amendment Order in respect of Performance, might be that culturally the GDC is more comfortable with being viewed as a 'big stick' regulator than as a regulator which protects the public proportionately, adopting a 'big stick' approach only when no other option is sufficient to maintain public safety.

Early stages of FtP

This leads to DPL's main concern which is that the early stages of FtP up to and including the IC stage are not fit for purpose and it is fundamentally wrong to reinforce the poor performance of those employed by the GDC at the early stage by rewarding their underperformance rather than addressing the mistakes, misunderstandings and wrongs for which they are responsible.

The correct test to be applied to any information received should be firstly to determine

- a) whether or not the information might amount to an allegation of current impairment in fitness to practice of the registrant, and
- b) that there is a reasonable prospect of that allegation being proved. For an allegation to reach that threshold, the facts have to be capable of being proved (a fact which is frequently overlooked) and those facts will collectively have to amount to misconduct, or poor performance. The courts have set out what the term 'misconduct' means, as have the Law Commissioners. It is in all material respects no lower a test than the previous test of 'serious professional misconduct', and should amount to disgraceful misconduct. Critically, it is not the same as negligence although there is clearly great confusion and lack of understanding amongst the FtP team in this regard. In order to represent 'misconduct' any conduct would have to fall far below or seriously below the standard of a reasonable group of registrants.

It appears that the present difficulty arises because 'misconduct' is being interpreted as simply below an acceptable standard rather than seriously or far below that standard. The lay case workers are not being assisted in this because the clinical reviewers at the early stages also do not appear to grasp the fundamental difference between 'below' and 'far below' an acceptable standard. In addition, the NCAS clinical reviewers do not appear to understand the 'reasonable practitioner' test. Typically, they are measuring the standard of the ordinary practitioner against published FGDP guidance without recognising the fact that this guidance was always designed to be aspirational, ie the 'gold standard' rather than the minimum standard expected of an ordinary practitioner. As far as we are aware, no formal enquiry has ever been made of the publishers of this guidance as to what it purports to represent, and as a result, heads of charge in FtP cases regularly include allegations of a breach of a third party standard for which there is little or no evidence base, and in some instances, which has since been withdrawn or amended. A similar misinterpretation occurs with guidance published by various other sources.

This reveals yet another failing within the FtP procedures, in relation to the quality of the advice the GDC seeks and receives from its clinical reviewers and some of its expert witnesses, and the fact that IC and PCC members do not appear to understand the provenance of the standards that they are using as the basis for their considerations.

These fundamental but constantly repeated errors create the proverbial 'perfect storm', in that virtually any clinical complaint is identified as a misconduct case and referred to the IC with numerous repetitive allegations. Far too often, the IC similarly fails to understand its role, which is to close any case where the allegations do not meet the 'reasonable prospect' test or will not amount to current impairment. The IC has the option to close the case with advice or a warning, but in many cases where this can and should have happened, instead the IC seems to either seek additional records, where they already have sufficient information on which to base allegations, or simply to rubber stamp decisions already made by the GDC staff before the committee convenes. In other words, we remain concerned that IC fails to operate as a body with independent thought and one which is separate from the GDC.

The consequence of this lack of independent thought, coupled with the prevalent misunderstanding of what misconduct and current impairment means is that numerous cases are referred for full inquiry which will, after investigation, be referred back for closure prior to a hearing, or in the worst scenario, result in a full hearing at which no impairment is found. This irresponsible use of money paid by registrants does not serve the public interest in any way.

If the GDC was to audit the decisions of case workers, NCAS clinical reviewers and the IC itself against the 'realistic prospect' test and the court's stated view of misconduct, we are confident that many fewer cases would be referred to IC and beyond. We are also confident that if cases were properly progressed as performance cases rather than misconduct, substantial sums would be saved. Arguably, the public interest would be far better served by this more proportionate approach than by the present somewhat heavy-handed and disproportionate focus on maximising the number of hearings.

Good regulation is not necessarily more regulation, nor is the perception of greater levels of regulatory activity an inherently desirable goal. The quality and appropriateness of the regulation, rather than the

quantity is undoubtedly preferable. Our concern is that this message has not reached the GDC, who apparently still believe that increased regulatory (especially FtP) activity equates to success.

The prosecution of cases and hearings

Having made the point that too many cases without merit are being referred for PCC hearings, the length of the hearings is determined to a large extent by the complexity of the heads of charge and the number of allegations raised. Here again, the issue of proportionality is not being given sufficient consideration and expensive legal resources are having to be used to correct fundamental errors that are being made 'upstream', ie at the earlier stages of the FtP process..

The GDC's legal representatives and its instructed prosecuting Counsel are drafting pages of detailed and often repetitive allegations, for numerous patients. This will necessarily result in a contested hearing unless many of the allegations can be admitted. Even then, considerable time and cost is added to the preparation stage, and significant time is subsequently taken processing such admissions during the hearing itself.

DPL recognises that the GDC is running a pilot scheme addressing some of the issues surrounding post-referral case management and we welcome this initiative. If successful, it could have a modest impact but it will still not address the main issue, which is the volume of cases referred to IC by case workers - that are subsequently referred by IC to practise committees and IOC. These are the areas where major savings can and should be made, with little or no downside risk in terms of the protection of the public.

Summary

DPL believes that the GDC has failed to exhaust all of the alternative options, especially in relation to the costs associated with Fitness to Practise procedures, before rushing to the assumption that a substantial increase in the ARF is required in order that new and existing complaints can be processed in the same dysfunctional way that has led to the current crisis.

We fully understand that the ARF has not increased for four years, and we acknowledge also that the GDC's FtP workload has increased. What we cannot and do not accept is that the GDC is helpless within its existing powers to address the multiple failings of the present FtP system without the need for such a radical adjustment to the ARF. The GDC, like any other business, should be prepared to cut its coat according to its cloth and if this means fewer 'nonsense' cases, fewer overworked cases, and fewer cases proceeding much further through the system than is justified by their merit, then so much the better. We have seen no evidence that the public interest would be undermined in any way by a rationalisation of the GDC's approach to FtP cases, and this should be the GDC's prime concern, not the present preoccupation with a perception of being the UK's most proactive and 'muscular' healthcare regulator.

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