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Regulators and regulations: who will guard the guards? (or 'Quis custodiet ipsos custodes' as old Juvenal used to say)

Abstract: Overbearing regulators with their various labyrinthine regulations have had adverse impacts on dentists and their team's behaviours. This has produced the perverse outcomes of demoralizing dental teams as well as reducing their capacity and/or desire to deliver compassionate oral healthcare. These adverse outcomes do not seem to have benefited patients, or dentists, or their teams, in any sensible or measurable way.

Clinical Relevance: The vastly increased burdens on the UK dental profession of intrusive, bullying regulations, emanating from the various UK agencies, such as the supposedly fair and independent GDC, but including the increasingly politically controlled NHS and the CQC, have had unfortunate, perverse, effects on many dentist's clinical practices and affected the dental team's desires, or willingness, to be as compassionate as they used to be about helping to solve some patients' dental or oral problems.

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In the UK, we have reached a seriously worrying point in healthcare generally, but in dentistry in particular. Amongst many other problems, various supposed 'authorities' have grabbed, or been given, so much power that they are now regarded with awe and fear by many dentists or members of their teams. A possibly unintended but understandable consequence of that perception is that many dental professionals now think that their first duty of care in dealing with difficult, sometimes urgent, clinical problems is to stay within these often mutually conflicting guidelines or 'regulations'.

There is now a sort of tacitly accepted 'ménage à trois' going on in UK dentistry involving the patient, the dental team and one of the regulators, such as the

GDC or the CQC.

The net effect of these quietly dubious arrangements is that many dentists are now trying to serve at least three 'governors'. These are in the 'patient's best interests' while simultaneously trying to appease the often conflicting expressed, or implied, interests of different UK 'regulators'. To this complex mix one ought to add various financial pressures, organizational and ownership changes, as well as complicating social shifts and different demand factors.

On one side of this unfortunate mess, most dentists and their teams start off trying to 'do the right thing' for that individual patient, but now they are being forced increasingly to think (consciously or subconsciously) about *how to stay out of potential trouble with the 'regulations'* or with one of the regulators, eg the terrifying but allegedly fair and proportionate GDC, the much revered CQC, the box-ticking HSE and/or possibly some new commissioner of their services, depending on the latest whim

of some half-baked civil serpent (sic), or some questionably balanced or adequately informed committee who have decided to re-organize UK dental healthcare once again.

However, adopting that 'just doing my job' or taking a 'semi-institutionalized' position, while it is understandable for many dentists' teams, can create serious ethical conflicts with their more important and over-riding duty of care which is to do 'the best thing' for *that* patient at *that* time and to try to look after *that* patient's long-term best interests for the *right* reasons.¹

The consequences of running foul of those menacing and legally enforceable 'powers' or 'controllers', combined with various insinuations or veiled threats from them, can result in a default position which is *not to get into trouble with one of the regulators, or get caught in the maze of questionably legal 'guidelines' or the web of diktats that increasingly and intrusively now*

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rule, if not actually ruin, the lives of UK dental professionals.

Kafka and regulatory authorities

This current complicated regulatory situation is Kafkaesque. Readers will probably remember that Franz Kafka was a Czech writer who wrote about a nightmarish world in which distressed and isolated people were continually intimidated by impersonal and illogical authorities. They were forced to endure surreal and menacing administrations that were incomprehensible, impersonal and labyrinthine.

Many ethical dentists feel that they have somehow stumbled unwittingly into such a world and spend much of their time shaking their heads in disbelief at the lack of common sense, or proportionality, as demonstrated in various reported cases. It is important for all parties, including wider society and the profession itself, that bad, mad (or both) dentists or other dental professionals are identified early, sanctioned and/or removed from the register, when the problems involved are serious, but that this is done only after fair and due processes have been followed.

However, partly as a consequence of various reports and grim warnings of sanctions, some dental procedures that many older dentists would regard as routine, such as moderately difficult extractions or molar endodontics, are sometimes avoided or referred to hospitals by some younger or risk averse dentists. This is sometimes for fear that 'something might go wrong' and that they might fall foul of the GDC's draconian processes based on its apparent omniscience.

Some disciplinary committee's 'holier than thou' views are sometimes supported by supposed 'experts' from a very narrow 'subspecialist' field of dentistry or by some occasionally wet-fingered academic drafted in from some ivory tower. These 'experts' rarely, if ever, operate in the real world of current general practice and are usually seeing the dental problems of others with 20:20 hindsight and through their well polished 'retrospectroscope'.

Given the finger-wagging of the regulator, it is not particularly surprising that some nervous or inexperienced dentists can legitimately claim that, in refusing to get involved and referring the problem, that they are merely obeying GDC stipulations about acting within one's competence.

One quick question, please? How do you get competent and maintain competence? Answer: you practise over and

over again.

It is no coincidence that dentists and doctors are generally described as 'practising'. Maybe that word should worry patients more than it seems to. However, surgery of any kind is an imperfect art or science as most experienced surgeons and dentists know.² The majority of sensible, experienced people accept that there are learning curves and that lots of repetition is normally involved in getting better at various clinical procedures.

Needless to say, lessons have to be learnt quickly from encountering various clinical problems and the relevant skills improved as a consequence. One needs to be alert in constantly recognizing deficiencies and strive not to repeat errors or to continue to make clinical mistakes that might damage patients.

On the other hand, one should not be unnecessarily intimidated into not trying to do one's best to help with patients' problems for fear of a hugely disproportionate reaction if there are occasionally suboptimal results which do **not** do serious damage.

If well meaning but inexperienced dentists are sufficiently scared about possible criticism or regulatory sanctions, as well as being paid peanuts to take the clinical risks involved, one gets perverse but predictable outcomes. These include hospital departments being flooded by inappropriate referrals and society getting a worse service from a less skilled and/or a de-motivated workforce. For example, an extraction of a problematic painful tooth would probably **not** be criticized or get one into trouble with a regulator. On the other hand, a suboptimal molar root filling with a decent sealing restoration, which is often functional for very many years,³ might well be criticized years later by some avaricious ambulance-chasing lawyer. In cases of 'decent doubt', guess which treatment might now get done, with that decision being made, partly at least, in order to avoid a draconian regulator's questionably proportionate disciplinary procedures? Does that realistic scenario and outcome really help and/or protect unfortunate patients in a sensible way?

Fear of regulators stalks the land

It appears that few dentists now appear willing to ask out loud 'Who will guard the guards' (as queried by Juvenal), possibly out of fear of potential retribution by one of the regulatory authorities. Nonetheless, some legitimate questions need to be asked, such as 'Can the GDC prove, beyond

reasonable doubt, that it is a fit for purpose organization that acts proportionately at all times? Can it prove that it is composed largely of experienced, objective, fair, trained professionals who, as a direct result of their work actually do deliver measurably better outcomes for most dental patients? If so (which some dentists now doubt), can it be shown clearly that they are doing so in direct proportion to their escalating legal and other costs, which were used as the justification for the recent increase in the Annual Retention Fee (ARF)? Can they really justify terrifying so many well meaning dentists with the reports of their questionably fair or proportionate behaviours, or prove the absolute requirement to subject them to 'fitness to practice' hearings as a result of some minor clinical problem or a mainly commercial dispute?

How did we get into this mess?

Good question and it probably happened because of the 'law of unintended consequences' (Merton 1936).⁴

Various populist promises to potential voters about getting access to cheap, *allegedly* high quality, NHS dentistry have been and are repeatedly made by some politicians in their pursuit of their own short term 'how do I get elected' agenda. For instance, the oft-quoted politically sensitive 'sacred cow' mantra that 'The NHS is the envy of the world because it is free at the point of delivery and accessible to all based on need' has **not been true** in dentistry for over 40 years.

Patient charges and different payment systems have been introduced for most dental patients during those 40 odd years. Yet, for some reason, nobody openly challenges that blatant lie 'that NHS dentistry is free at the point of delivery' for the majority of people. Why has no one exposed this persistent untruth effectively or drawn the attention of the UK public to government's constant meddling and financial tinkering to try to control dentistry? They set the NHS fees and regulations, sometimes as a minority stakeholder, but take no responsibility for the consequences of doing this, even when it can and does have serious consequences for many patients' long-term dental health, eg in the practical modern management of toothwear.⁵

Yet the GDC could be considered to be tacitly complicit in some of this, in so far that it makes no comment on this market manipulation by what is the dominant dental stakeholder in many parts of the country. It

insists that the standard of care should be the same regardless of whether it is done under the NHS UDA system or some sort of private practice remuneration system. If the GDC ever bothered to look at the statistics on the changes in treatments, or endodontic prescription patterns, or considered the many surveys of the standards of impressions in dental laboratories, it would know that that is scarcely a tenable view. The GDC should instead be a robust defender of patients' long-term interests by not being a mere hand-maiden of Department of Health (DH) policies. It should be stating openly that it is impossible to provide high quality technical dentistry consistently for minimal fees and, if that is what patients want, it should know that the DH has little interest in looking after an individual patient's best interests. Both the DH and GDC are far too busy issuing various bits of 'guidance', often couched in impenetrable 'doublespeak' or legalese.

State-influenced fees dominating dentist's prosthodontic prescriptions

Witness, if you will, the sad but common plight of partially or completely edentulous patients, many of whom cannot get well designed or well-fitting cobalt chromium partial dentures or satisfactory complete dentures made in many areas of this country.

This a particular problem under the terms and conditions of the NHS, where the fees paid to dentists are so derisory that any decent intellectual analysis or prosthodontic clinical design input is forgotten in the interests of expediency.

The better-skilled laboratory technician's costs already greatly exceed the amount payable to the NHS GDP, who is paid a pittance for his/her experience or expertise and therefore is forced to compromise and supply a 'BSID' ('British Standard Issue Denture'). In relation to complete dentures, this can mean poor retention or stability due to inadequate extension or occlusal problems of the dentures. In the case of partial dentures, there is often little evidence of surveying being done first of all, or of guiding planes being prepared, or of other sensible mouth preparations being done, and the dentures supplied often do not include appropriate rest/clasp assemblies. However, that said, that is the *de facto* average standard (as judged by a Bolam Test).

Dentists in general leave various universities having been taught cobalt chromium design principles and yet sadly many succumb early on to the overbearing harsh economic realities of life as 'an NHS

dentist', or perhaps their practice principal's, or practice manager's, view of NHS dentures with consequential results that could be termed '*state sponsored denture terrorism*'. Sadly, this change in approach to denture design and provision can happen as early as their VT year.

The GDC publishes 'Standards' yet turns a blind eye to the very real financial difficulties and practical realities of dentists trying to achieve those as though that is not part of its remit.

'Protecting patients' is the mission statement or mantra of the GDC.

Really? I might be Irish, but please explain to me again just how does the GDC being tacitly complicit with a government department abusing its monopoly bargaining position to drive down denture fees, to the point where the denture product itself is now of dubious quality, actually protecting these deserving patients?

National scandal of the edentulous mandible

It is a national scandal that the internationally agreed consensus standard for treating patients with edentulous mandibles, to be normally supplied with two implants to retain a lower denture, is not being implemented normally for these dentally disabled patients in the UK.^{6,7}

This is particularly shameful because many of these unfortunate patients have paid compulsory income taxes and national insurance for much of their working lives because they believed that the NHS system would look after them in their hour of greatest dental need.

Some units in some parts of the country do their best with the limited resources and time available to do what the McGill and York Consensus state as being the standard of care which should be supplied for patients with an edentulous mandible. However, overall the provision of such treatment in the UK – the supposed envy of the world in healthcare – is very patchy, in spite of copious evidence of a marked improvement in many of these patients' quality of life.

Sadly, edentulism remains a serious but unglamorous disability in the UK. What has the GDC done about this as a regulator to protect the interests of these unfortunate patients? The silence is deafening.

Endodontics, NHS fees and the GDC

The dramatic fall in the number

of dentists doing root fillings on molar teeth under the NHS UDA system bears witness to government interference in altering systems and fees and, as a possibly unintended consequence, dentists' treatment prescription or referral patterns.

How exactly does the extraction of many teeth which could be have been pragmatically root-filled and at least 'semi-preserved' with a decent sealing restoration, if there were fair NHS fees for doing so, actually benefit patients in the long term?

Which dentist in their right mind would want to undertake technically difficult, time consuming, delicate molar endodontic procedures involving expensive equipment for financial peanuts and, in addition, possibly be blamed some years later for an academically 'sub-optimal' (but functional) result, by some lawyer's tame specialist or academic endodontist who actually now never treats NHS patients in general dental practice?

The *average standard* of endodontic treatment in the UK (and indeed elsewhere in the world) is actually very different to the supposed 'academic ideal' but that is the *average standard* against which general dentists should be judged (ie a 'Bolam test'). That said, please have a wild guess at which standard the GDC often *chooses* to apply?

No wonder that the number of molar extractions has risen and the number of NHS molar root fillings done in many general dental practices has fallen. Is anyone sensible really trying to suggest that the GDC remains unaware of these issues or has it, perhaps, just developed a convenient amnesia about them? Why has there been little effective whistleblowing about those sorts of problems?

On the other hand, if the GDC is aware of the practical effects of what these UDA fee changes in the NHS have caused (whether accidentally or deliberately) and have done nothing in practical terms to protect patients' best interests, then surely that might suggest some tacit collusion with government to control dentists' prescription patterns and more than a hint of subtle discouragement of such sophisticated dentistry.

If that level of dental sophistication is not what government departments want, or actually do want but cannot realistically afford it, then they should tell the UK population that openly and stop this obfuscation and implying that this is all the average dentist's fault.

Standards?

If the GDC was being really honest it should know that it is impossible to provide the highest quality outcomes in dentistry consistently for derisory state-controlled fees. Yet it persists with its assertions that the highest 'standards' of patient treatment can be miraculously achieved in this multiply flawed system.

If the GDC was being realistic it could recognize that here is reasonable evidence that teeth survive with pragmatic, if academically suboptimal, treatment, such as with a non ideal root filling and a well-sealing restoration on top.³

Pious platitudes and dentistry

To most experienced people the words 'cheap, quick, and high quality' when used all together constitute a blatant oxymoron, which means a mutually paradoxical statement. Yet it gets trotted out with monotonous frequency by politicians or others and gets challenged infrequently. In truth, rapid access to high quality and durability in dentistry comes at a commensurate cost.

Many business people will tell you that you can have 'two out of three things' from a choice of 'quick' or 'cheap' or 'good in the long term' but you cannot have all three in any deal.

Some politicians, gullible patients and regulators who should know better apparently think you can. 'Two out of the three' is the rule and therefore you have to choose which two out of three one wants in modern UK dental healthcare. This has been termed the 'Iron Triangle of Health Care' and involves juggling issues of access, cost and quality.

One version of this 'Iron Triangle' argues that, out of the same finite financial resources for healthcare, it is possible to get access and reasonable, but not necessarily great, outcomes for many people, or one can have great, quickly treated, results for many fewer people. Sadly, you cannot expect to have all three in any deal. It appears that this bit of fundamental business knowledge has escaped the 'Mensa level incumbents' of the GDC when it comes to dentists, but not it seems when it comes to themselves.

Efficiency and costs

The recent furore about the GDC was based on its chosen management consultant advice that, if the dentists, as

their main funding source, just handed them a mere 60% plus percentage increase in the Annual Retention Fee (ARF), they could then improve on their well known inefficiencies and their Kafkaesque fitness to practice processes. What really hacked off a lot of dentists was not having to pay more, as such, but having to pay more for what many perceived to be an unfair, inefficient, unrealistic, and occasionally vindictive organization. Many dentists might well be quite happy to pay even more if it meant getting some efficient, fair, proportionate and realistically informed treatment from an organization that used a bit of common sense and discretion occasionally.

Moral authority undermined

The GDC moral position to continue to regulate dental professionals has been weakened recently in other ways. For instance its position on dental bleaching was farcical for many years¹ and it never seriously tried to stop illegal dental bleaching effectively, eg in shopping malls by untrained 'beauticians'. If, however, dentists had allegations made against them of that sort of level of non-compliance about patient history-taking or note keeping, or such appalling cross-infection control, they would be off the register very quickly. Sorry, they would be off after an agonizing wait for their case to be heard when the GDC was good and ready to deal with it, having ruined the dentist's reputation by publishing details on the GDC website, sometimes based on unproven allegations.

Innocent until proven guilty

Whatever happened to the legal maxim that 'you are innocent until PROVEN guilty' (which is often attributed, wrongly, to the Magna Carta – a mere 800 years old this year). In fact, the principle does go back to Roman law and at least to the second century AD. Perhaps of more relevance to any dentist accused of doing something that he/she might, or might not, have done, or perhaps failed to do, the principle is incorporated in the Declaration of Human Rights 1948 article 11 section one. Dentists have the same human rights to be treated as fairly as anyone else, mainly because the last time I looked most of them were humans before they were dentists.

Anyone can now complain to the GDC that they are not **wholly** satisfied with some aspect of their treatment or a lack of what they consider they are entitled to have. The GDC has advertised in the past

for people to do just that which, while it might, allegedly, have been mainly to draw attention to a GDC private patient dispute resolution service, struck many dentists as being rather too close to incitement.

Unfortunately, dentists often cannot fight back fairly about a patient's complaints about them because one hand is, metaphorically speaking, tied behind their back due to 'patient confidentiality'. Furthermore, the perception of fair play or of being treated as 'innocent until proven guilty' or of proportionality is not helped by the GDC sometimes refusing to disclose all the supposed 'facts' early on.

Patients or consumers?

Dentists should be allowed and encouraged to look after the best long-term interests of patients and those altruistic and compassionate aims should be helped and not hindered by the GDC. They should not feel pressurized by an appointed GDC chairman who readily admitted in his Pendlebury address that he knew little about dentistry, but yet seemed to imply that in a market context that dentists should be doing 'whatever the consumer/customer wants'.

Reducing the status of patients to being mere consumers of dental healthcare is facile, simplistic and demeaning for them as well as to dental professionals. There was not a single mention of compassion in that address as though that is a rather tediously old fashioned or unimportant concept. I would challenge that simplistic model of treating any patient as merely a 'consumer'. However, if that consumer model is to be used by Mr Moyes, then perhaps, before the GDC blames dentists for many problems about which these supposed 'consumers' complain, a few moments of reflection by the good citizens of the GDC on some salient facts might be of help.

Dentists do not **cause** tooth decay or periodontal disease. Most dental diseases are self-inflicted by 'consumers' due to their own *sugar consumption* frequency, *ineffective cleaning* and/or *smoking*. These are **consumer** habits. They are their own risk factors that are very largely outside of the control of dentists or other dental professionals. Dentists can **advise but not force** patients to control such dentally risky behaviour.

Sadly, the evidence is that many patients do not pay much attention to, or comply with, advice given by dentists

about their consumption habits, eg about smoking.⁸ In one smoking study, less than one-third of patients would try to quit smoking if their dentist suggested it and fewer than 20% could even recall being given smoking cessation advice. Smokers still ignore the causal links between smoking and periodontal diseases,⁹ as well as the widespread medical warnings about different cancers and heart disease. They also ignore the graphic warnings on the cigarette packets that smoking **will kill them** and yet some still blame dentists if their teeth eventually get loose and fall out. Is that not bizarre, illogical 'consumer' behaviour? Some of them and their lawyers, especially if the fees involved are considerable, do not seem to think so and the GDC sometimes tends towards believing that sort of nonsense.

One other obvious problem with that 'consumer is king or queen' approach is that, if the dentist undertakes clinical procedures that are *inappropriate* but have been requested by the 'consumer', and if there are adverse outcomes as a consequence of doing just that, the 'consumer' (perhaps egged on by the GDC's own full page expensive advertisements last July) can now easily complain to the GDC and the dentist then can 'get done' by the GDC.

That realistic but perverse outcome would be funny, in an Irish joke sort of way, if many of the GDC's actions and inactions were not so tragic for many dentists and their families.

So what does the GDC need to do now to repair the trust of the dental profession in order to regulate it more effectively?:

- It needs to listen carefully to the criticisms that have been made;
- It needs to show some sort of insight into its failings and act fairly and proportionately in the future;
- It needs to ask for help where it is needed urgently. That might well include the chairman;
- It needs to be measured and proportionate in its assessment of what might be genuinely important issues of fitness to practice as opposed to what could be malicious intent by a patient who complains to the GDC for mainly commercial dispute reasons;
- The GDC needs to reflect on the old adage that 'there are three versions of the truth' (the patient's version, the dentist's version and the actual truth) rather than assuming that the patient is always right or reasonable;
- It should not assume that the dentist is wrong, or unreasonable, until it knows all

the relevant facts and circumstances and can prove some *serious* wrongdoing.

- Dentistry, like most surgery is an imperfect art or science. Life is seldom perfect. Dentists, patients and the GDC are not perfect either. Some commonsense, mutual tolerance and sensible discretion should be allowed for that;
- It should avoid ruining dentists' reputations by any one-sided publicity of some unsubstantiated allegations until fair and balanced due process has been carried out;
- It should be a robust defender of patients' long-term interests by not being a mere hand-maiden of the Department of Health.

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