How the General Dental Council and NHS UDAs crushed the compassion out of dentists

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Key points

The combination of the perceived fear of the GDC's lengthy draconian processes, coupled with the government-imposed UDA contract, have crushed the compassion out of many dentists.

This article traces why many dental clinicians are now disillusioned and demotivated, with many having significantly less desire to help some patients because of the many perceived risks involved.

The resulting omnishambles has not benefited many patients because 'defensive dentistry' is now practised widely, partly due to a lack of trust in the GDC or the government, or indeed, in the fairness of many of their patients to be reasonable or tolerant of even minor or unpredictable problems.

Abstract

Various actions and policies of governmental agencies and the General Dental Council (GDC) have crushed the compassion out of many dental professionals. Compassion is not the same as sympathy or empathy; compassion involves doing something practical to overcome a patient's problems. However, many compassionate dental professionals now think of the GDC as a bit like being trapped in a lift with a wasp. The statistical probability is that nothing really terrible is going to happen to you for trying to solve a patient's problems pragmatically, but the tension and the worry that it might is always present. One effective way to reduce the chances of a painful experience is not to undertake slightly risky procedures. It is far, far safer to make copious notes but then to refer on anything potentially problematic, especially under the flawed NHS Units of Dental Activity system, 'just to be on the safe side', while bowing low to the GDC and claiming it is 'outside of one's competence'. The net result is a lack of clinical engagement in solving patients' problems practically, coupled with an ongoing lack of experience and confidence in solving similar patients' problems, as well as shifting some problems unnecessarily on to overloaded hospital departments. Who benefits from those perverse outcomes?

Introduction

The General Dental Council (GDC), overly influenced by some intolerant individuals, along with various UK government departments, have produced what many dental professionals now perceive to be an unfair and bullying regulatory system.

One consequence of this regulatory mess has been the gradual crushing of compassion out of many well-meaning clinicians. Insensitive over-regulation, coupled with the iniquities of state-sponsored dental terrorism,[1] sometimes called the Units of Dental Activity (UDA) system, have resulted in a serious reduction in the practical availability of NHS dentistry for lots of people. That is partly because many caring dental professionals are nervous that if any complaint is made to the GDC about anything, by anyone, at any time, then they are likely to be assumed to be guilty until they can prove, eventually, that they are innocent of that accusation. Others who share responsibility for this unhelpful climate of fear include various civil serpents (sic) in the Treasury and the Department of Health, who imposed a politically motivated, variously flawed UDA system, as well as avaricious 'no win no fee' lawyers and aggressive consumer groups.

Crushing much of the compassion out of many general dentists might have been an unintended consequence of those actions.[2] That outcome might not have been the primary aim of the GDC, or of other statist organisations, such as the Care Quality Commission. However, the perverse outcome has been the widespread demoralisation of many caring dental clinicians and a consequent reduction in their compassion for some patients. Compassion is not the same as sympathy or empathy.[3]

Compassion involves doing something practical to overcome a patient's distress or helping to solve their real problems effectively. One definition of compassion is 'the sensitivity of healthcare providers to understand patients' suffering and their needs and to consciously help them to achieve general wellbeing'.[3]

Compassion is central to good patient-focused healthcare. However altruistic their aspirations might have been initially, which obviously varies, there is now a widespread feeling among dental professionals – young and old – that there are increasingly serious risks involved in endeavouring to do something pragmatic and well-meaning to help patients with their problems. Their fear now is that if something turns out not to be 'perfect' later, as judged by someone, sometime later, then any criticism could lead to serious personal and professional consequences.

Many dental professionals now worry that some at the GDC will believe the patient's version of the truth automatically and then look to find some fault, somewhere. The

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notion of 'innocent until proven guilty' is a commonly held point of view in the majority of legal systems across the world. The widely perceived worry now is that this is not the stance of the GDC. That default situation arises because, as cases pass through fitness to practise procedures, each escalation requires there to only be a 'realistic prospect' of any of the catch-all charges being proved. That low index of doubt then becomes the focus of some GDC case officers, who then 'push it on up the line'.

Part of the problem relates to the proliferation of 'hired gun experts', renting themselves out to avaricious 'no win no fee' lawyers and to the GDC. Some of their flawed reports are based on aspirational standards, heavily promoted by specialist societies, many of whose members or officers have narrow or vested interests, rather than ones based on the average standards (the Bolam Test standard). Those subjective reports can be seized upon by lawyers who are conducting the prosecution of a dental registrant on the GDC's behalf, in order to formulate wide-ranging and worrying charges. Unfortunately, once unsubstantiated allegations have been made, it can be very stressful (and expensive) to refute those, while those making them can walk away scot-free.

However, some of those cavalier 'experts' now need to be much more careful. 'Experts' need to be more aware of the potential for them to be imprisoned for up to two years if they stray beyond their remit – or if they make false, rash, or inappropriate allegations in their report to a court when this is accompanied by a statement of truth.[4,5]

Some compassionate dental professionals now think of the GDC as a bit like being trapped in a lift with a wasp. The probability is that nothing really terrible is going to happen to you, but the tension and the worry that it might is always present. One effective way to reduce the chances of a painful experience is not to undertake even slightly risky procedures. It is far, far safer to make copious notes but then to refer on anything vaguely problematic, especially under the NHS UDA system, 'just to be on the safe side', while bowing low to the GDC and claiming it is 'outside of their competence'. The net result is a lack of clinical engagement and ongoing lack of experience and confidence in solving similar patients' problems, as well as shifting some problems unnecessarily on to overloaded hospital departments.

For instance, if a compassionate but pressurised dentist, who, when seeing a patient who got squeezed in to an already full day because the patient was in agony with a swollen face, did not record a basic periodontal examination and write a full justification for them taking a radiograph and immediately reporting it in great detail before treating the patient, then they could well be criticised later on. Many 'experts' who are used to aid the prosecution of cases on behalf of the GDC would struggle to remember the last time they were in such a pressurised situation themselves, if ever. If, in their desire to actually treat the patient's urgent problem, that busy dentist did not write a mini–thesis describing all the theoretic discussions that some might allege would have been ideal in Utopia, they can get criticised, years later, by a hired 'expert', who works mainly for an avaricious 'no win no fee' plaintiff lawyer, or the GDC. The real insanity is that this can happen despite the fact that the outcome was that the dentist focused on the patient's needs and that reasonable, if not 'perfect', treatment was delivered quickly and thereby got rid of their agony, even if it was not a 'perfect' experience for either side. That reasonable outcome often seems to get forgotten by some GDC nit-pickers and instead it is only the record of the processes that appear to be what counts. Humanity and compassion count for nothing – allegedly, only records do.

The fallacy that 'if it was not written down it did not happen' and other fallacies in dentistry

The often quoted warning that 'if it wasn't written down it did not happen' has become something of a mantra among certain dental 'educationalistas' and has been recited so often by some plaintiffs' tame 'experts' and by some lawyers, that many people have come to believe that it is true. That is an evidential fallacy. As a matter of law, it is not true.[5] It is not a law of evidence and neither is it a law of logic.[5,6] Lots of things that happen in real life do not get written down. Conversely, many things that did not happen get written down as though they did (see UK tabloid press articles).

However, third party payment agencies – not least the NHS itself – appear wedded to this mantra because it can be used to avoid making payments that are properly due.[5] In the case of the NHS, this is often justified on the grounds of public interest and the responsible management of public funds. Perversely, the flawed NHS system itself is what actually creates the very conditions (pressure of time) that make incomplete records much more likely.[5]

The vast majority of human communication is non-verbal.[7] Most of the really important diagnostic information can be gleaned from watching and listening carefully to a patient, noting exactly what they are saying and how they are saying it, with an interested clinician's eyes and ears being fully open and being 'fully present', rather than furiously making notes. In fact, overtly scribbling or typing notes, rather than sympathetically engaging face-to-face with a patient, can often detract from the chances of that patient being open and honest enough to reveal the bits of information and relevant context that are so vital in getting the full diagnostic picture. That is what is really important in providing compassionate dentistry and not defensive notes or behaviours. Indeed, there is plenty of evidence from medical consultations that a clinician's non-verbal communication/body language strongly influences patient perceptions and satisfaction.[7,8] Patients sense very quickly whether a clinician is looking after their interests primarily, or is looking after themselves or some 'NHS system'.

Trust, dentistry and society

Dentistry, in common with society generally, needs mutual trust in order to function.

One formula for trust is:

$$\frac{Credibility \times reliability \times intimacy}{Selfishness}$$

That means that the patient needs to perceive that their current dental professional is credible or believable. That clinician needs to prove that they are reliable, which means seeing them more than once to assess that reliability. Both credibility and reliability become really important whenever intimacy is involved. Intimacy and the mouth are fascinating topics. Obviously, the mouth is a hyper-charged, intimate area with sophisticated nerve endings everywhere, with enormous emotional and psychologic issues involved. It requires massive amounts of trust to let anyone in there.

The thing that destroys trust most quickly is selfishness or self–orientation. In other words, having real concerns about the other person's interests and how those might well

predominate in any exchanges. Concerns might include being damaged, diminished, hurt, or ripped off for their sound tooth tissue or for their money. Credibility and reliability are impossible to prove if a patient has to risk seeing a new dentist very often as 'just another number in an NHS practice'.

A complex mix of other factors has resulted in there now being minimal mutual trust or loyalty, with many 'dental consumers' now shopping around, both online and physically. Loss of trust in dentists was aided and abetted by the GDC's infamous 2014 advertising campaign inviting 'consumers' to complain. Possibly encouraged by that GDC campaign, opportunistic lawyers now advertise aggressively in various media to encourage complaints, usually to line their own pockets, rather than because of any altruistic concerns for patients or any obvious desire for fixing the systemic flaws in a NHS UDA system that contributes to causing problems.

Lest people forget, it was the former chairman of the GDC, the not-so-greatly-lamented Bill Moyes, who, in his Pendlebury address, urged dentists to treat patients more as 'consumers'. The 'consumer is king or queen' mantra has several, perhaps unintended, consequences.[2] Some consumers complain to regulators about things that they caused themselves via their consumer habits, such as smoking, frequent snacking on sugar and/or ineffective interdental home cleaning. It is a fallacy that any dentist can force 'consumers' to control those crucial risk factors – no more than any dentist can control any 'client's' genes. How come the Mensa-level incumbents of Wimpole Street and Whitehall remain wilfully or blissfully unaware of those basic facts?[9]

McNamara's Fallacy and other fallacies

A fallacy is an error in thinking. One definition of a McNamara's Fallacy is 'to make important something one can measure rather than measuring important things'. It is a 'McNamara's Fallacy'[10] that recorded notes are the most important determinant in achieving a satisfactory patient outcome. It can be incredibly difficult to measure some things in dentistry, such as compassion, gentleness, care, consideration, diagnostic skills or clinical judgement, all of which sensible patients value. However, instead of measuring those difficult but really important things, politicians, bureaucrats, or their dodgy management consultants choose something unimportant but easy to measure. That unimportant 'something' is then claimed to be a valid surrogate for measuring something that is really important but which is difficult to measure: it isn't. For instance, one common NHS fallacy is that waiting for less than four hours in a hospital emergency department means that you get the best treatment for your problem(s) That's a fallacy because it does no such thing. Waiting time is easy to measure and relatively unimportant. The long-term outcomes from that visit are difficult to measure but are very important.

Unfortunately, the 'sainted' NHS has a recurring history of encountering some kind of crisis of delivery, such as exists now, usually followed by calls for extra funding from the Treasury and an accompanying re-dis-organisation (sic).

Some years ago, when using external management consultants became ever more fashionable in the NHS, supposedly to add authority and fresh thinking to each successive review, the NHS adopted the same management and productivity tools from industry and manufacturing, with new measures ('metrics') becoming increasingly commonplace throughout the NHS. Intense focus on key performance indicators or performance measures led to measurement for the sake of measurement – not just in the NHS but reaching into every corner of healthcare where it was often just expensive and wholly inappropriate. The UK government's obsession for collecting data, any data, even using highly dubious measurements, while remaining clueless about how to interpret the dodgy data sensibly, often distorted clinical behaviours and priorities and produced many perverse outcomes in healthcare, including those caused by the UDA system. Unintended consequences produced by regulatory or management consultant idiocy included disaffection, disillusionment and reduction in patient-focused compassionate clinical care, burnout, career changes and retirement of many compassionate clinicians. Various surveys by the British Dental Association and other concerned dental organisations have revealed major problems with morale, motivation and career satisfaction, making it very difficult to recruit full-time NHS dentists in many parts of the country. While it is usual for government departments and/or the GDC to dismiss those surveys nonchalantly as being biased in some way, their own 2020 NHS dentistry survey is truly damming. Extracts from the NHS summary on working hours and morale revealed a stressed and demoralised workforce. The relevant extract[11] reads:

- 'This report provides headline information on dental working patterns, motivation and morale for self-employed primary care dentists in England, Northern Ireland, Scotland and Wales for 2018/19 and 2019/20. Information on average weekly hours, weeks of annual leave, the division of time between NHS/health service and private dentistry and clinical and non-clinical work, is presented, as well as measures of motivation and morale
  - Dentists who spend more of their time on NHS/health service work (as opposed to private work) tend to work longer weekly hours and take less annual leave
  - The more time dentists spend on NHS/health service work, the lower their levels of motivation
- The most common contributory factors to low morale are increasing expenses and/or declining income and the risk of litigation and the cost of indemnity fees…while regulations are also cited as a major cause of low morale among principal dentists
  - Nearly two-thirds of principal dentists and over half of all associate dentists across the UK often think of leaving dentistry'.

Just how much more evidence is required? A parliamentary inquiry was established in 2019 to look into NHS dentistry and took lots of evidence from various individuals and organisations before it was disbanded, apparently because of the general election. Unsurprisingly, it has not been re-established. The latest news about the abandonment of the pilot schemes for a new NHS dental contract was met with utter dismay by many dental professionals – especially by those who tried hard to make it work. Many experienced (and understandably, more cynical) dentists were convinced that the Treasury and Department of Health were just stringing things along until they could get an excuse to bury any new contract six feet under. Just why would the government want to change their beloved UDA system? It gives them the control they seek at minimal cost.

The dangers of 'defensive dentistry'

Most compassionate dentists strive to do the right thing for that patient, at the right time, for the right reasons. Compassion probably varies greatly in individual dental professionals and it is doubtful if it can be taught formally. However, it can be fostered and encouraged with the right culture or it can be destroyed by a callous and brutalising system. Dentists ought to be able to do the right, practical thing quickly and effectively for their patients, without fear or resorting to 'defensive dentistry'. In healthcare generally, 'a defensive approach' hollows out the relationship from the inside from the start because there is no mutual trust. That malignancy of mistrust metastasises into extensive, defensive note-keeping and increased ordering of questionable tests, often just to avoid later potential criticisms.

It is a fallacy that writing copious notes or ticking boxes on a screen, protocol or *pro forma*, are valid surrogate measures for a satisfactory clinical outcome. Notes are of importance in that they can record some processes that might (or might not?) have been undertaken but relying on them still requires trust. Drop-down menus in computer software can now populate clinical records in seconds with things that might (or might not) have actually happened but which tick the boxes for what should have happened. Copious notes and records of conversations about various theoretic, but not practical, options, might appease some GDC 'experts', or deflect criticisms by some 'no win no fee' lawyers, or satisfy some other NHS bureaucrat,[5] but focusing meticulously on doing those first drastically reduces the amount of clinically available time left to do the actual dentistry. The consequence is that fewer patients get their problems solved effectively from the very limited NHS resources available. Is that perverse outcome genuinely protecting many patients' long-term interests? Really? Last year, about 1,000 NHS dentists found a very effective way of avoiding NHS bureaucracy: they walked. One suspects that some from the NHS pilot schemes might abandon hope now and join them, along with some other waverers.

NHS dentistry and the GDC

NHS dentistry is certainly not the envy of the dental world, regardless of how often that mantra is chanted by some semi-house-trained populist politician. For most people, it has not been 'free at the point of delivery' for decades. Factually, it is miles behind other countries in many patient healthcare outcomes, as a myriad of international surveys show, with Denmark, Norway, Sweden and Switzerland trouncing it in Europe alone.

The new chairperson and GDC members need to reflect on their unquestioning support for the problems, anomalies and vagaries of the UDA system, which have caused a myriad of practical problems for many NHS patients and dentists alike. They need to stop proposing the NHS UDA system as the best or the default system for all patients' dental care: it isn't. If the holier-than-thou regulators really don't know how the UDA system has adversely affected many patient outcomes in relationship to managing serious decay problems in children, or dealing effectively with periodontal, wear, prosthodontic or endodontic problems, then they are incompetent. If they do, but haven't done anything concrete to change things to protect patients, then they are complicit. The GDC appears to have accepted, unquestioningly, the baying of a consumer lobby which wants the best available quality at the lowest possible cost and believes firmly that cheapest must always be best. Someone needs to remind anyone sensible at the GDC, or in Whitehall, of one of the fundamental laws of life, which is that one can get two out of three 'good, quick and cheap' but you cannot get all three of them in a deal. In other words, you can get something quick and cheap, but it won't be good long-term. You can get something that is good and quick, but it won't be cheap. You can get something good and cheap, but it won't be quick. That option is called a very long hospital waiting list.

Rather than genuinely looking after patients' interests, the GDC has been a supine slave to government policies and has not criticised the NHS UDA system openly. Consequently, it ought to show much more tolerance for the very difficult problems in general dental practices that have ensued as a result of their long-term complicity. If they really want patients to get access to dentists for reasonable, if not 'perfect', dentistry, they need to cut some slack to those dentists still doing a decent enough practical job slaving within it. The GDC scribes need to stop writing pious cant in civil service 'doublespeak' about aspirational 'standards' unless the systems actively encourage those to be achievable routinely by the average dentist. In many areas in dentistry, the obsessive pursuit of fundamentalist 'perfection' is the enemy of the 'good' for teeth, as witnessed by the gross biologic and structural damage done to many teeth to achieve the supposed 'perfect occlusion' in full mouth rehabilitations or those dodgy and unstable procedures undertaken to produce the mythical 'perfect smile'.

How the GDC and the UDA system combined to de-skill some NHS dentists in endodontics

An idealised root filling and restoration would be great for everyone in Nirvana. It might well be the aspirational standard in some imaginary Utopian society but, as sure as eggs is eggs, that isn't the norm in the current NHS UDA system.

The UDA system offers a paltry three UDAs (about £60–£90) for any or all of the required root fillings, which incidentally involves doing all the fillings and periodontal therapy required. That munificence has to cover the costs of getting to the often difficult endodontic diagnosis, then must compensate adequately for the time required for all the discussions of all of the theoretic options, as well as supplying single-use expensive endodontic instruments and materials, not to mention the considerable clinical time required and the sophisticated skills involved. That's insane, ridiculous and grossly unfair. Worryingly, many 'hired-gun GDC experts' seem blissfully unencumbered by any recent practical knowledge of the fee structure or of the very real problems encountered in current NHS general dental practice. Please remind me again about how many angelic GDC-registered endodontic specialists, or GDC experts, whining about endodontic aspirational 'standards', actually work routinely under the usual NHS UDA system?

The GDC should emphasise that a dentist only has to show the average skill, not some aspirational endodontic specialist level of skill. The multiple flaws in the NHS system have resulted in that average being what it is. In fact, there is a massive disconnect between supposedly idealised endodontic standards and clinical reality. In truth, even if the eventual radiographic outcome of an urgent, pain-relieving endodontic intervention might not be entered in the local endodontic show for first prize, there is copious evidence worldwide that even a half-decent cleaning of the root canal system and a well-sealing coronal restoration results in lots of teeth being kept for many years.[12.] However, because of the serious regulatory, technical, or legal risks potentially involved in not filling all the canals 'perfectly' for those UDA peanuts, there is, sometimes, a quiet request for the 'healing tongs' because the tooth is deemed 'unsaveable'.

Diseased, but pragmatically treatable teeth, now get binned quickly. Doing so saves clinical time and instrument costs, while removing the dangers of later radiographic evidence showing a 'suboptimal' (but effective) root filling but with the tooth still present many years later. However, that pragmatic and quite reasonable outcome might expose one later to the circling 'no win no fee' sharks or to get one 'in front of the beak' sometime later. Are those understandable decisions to extract teeth, rather than take any risks, being driven by perceived fears of Doberman lawyers, the GDC draconian processes, or the UDA system? Take your pick.

Fear stalks the land of undergraduate training

It appears now that the academic undergraduate default teaching is often to recommend that every chrysalis dental student first protect themselves in all transactions, with all patients, in case there is a later complaint. Goodness only knows when the 'safe learner' became the acceptable end point for graduation in the UK. It used to be the second Bachelor of Dental Surgery year. Whatever happened to clinical training being equally important to dental education?[13]

The existence of a very close relationship between government and healthcare regulators (like the GDC) is probably dangerous. The government, for its own short-term political goals, wants to create the illusion of more access to dental care of some sort, by measuring the number of the contacts with someone/anyone. In their cunning plan, their assertion is that 'all patient contacts with a dental professional are equal'. That measurable outcome of 'a contact' can be delivered by non-dentists, who can be trained more cheaply and more quickly and who can be paid much less. By deliberately not measuring the outcomes of those contacts, the government can assert that they have no data to prove there is any difference in long-term clinical outcomes based purely on counting those 'contacts'. Clever, sneaky or Machiavellian manipulative? Consequently, the GDC's role in inspecting the training delivered in dental and dental care professional schools is critical in protecting patients.[13] It is easy to see how genuinely important, hard clinical skills might become dumbed down over time, with undue emphasis being placed on soft skills which might underpin a different agenda, while the expensive-to-teach clinical skills have to be miraculously found later on, somewhere, sometime.

Appropriate postgraduate training courses can show interested dentists how to solve many difficult clinical problems, for example, how to manage wear by additive composite techniques. However, because it would be financial suicide to undertake such time-consuming procedures under the NHS UDA system, that often becomes a pointless and frustrating exercise for everyone involved and those with those sophisticated skills migrate from the NHS system.

The ménage à trois in UDA dentistry

A sort of *ménage* à *trois* is going on in UK dentistry with each party 'having a bit on the side' in the relationships. The patients are looking at the dentist and saying 'I really like you...honestly' but they are also looking simultaneously at the government and the GDC and mouthing 'control those greedy so and so's and get me as much of what I want for as little as possible'.

In turn, many NHS dentists are looking at the patient but at the same time, glancing at the UDA contract, while deciding on 'how much, or how little, or of what, am I willing to give you in return for what the government-imposed UDA system is paying me'.

The government, after compulsorily nicking their taxes and national insurance, wants to schmooze floating voters but it also wants total control of the dental profession for as little as possible.

It demands the maximum amount of something measurable for minimum costs, while simultaneously refusing to take any responsibility for their actions resulting in individual patients' poor outcomes.

Summary

Dentists are not saints and have never claimed to be. However, the combination of the government-imposed UDA contract, together with perceived fear of the GDC's draconian processes, have been highly effective at crushing compassion out of many NHS dentists. The GDC has helped to destroy patients' trust in dental professionals but has failed miserably to replace it with anything either measurable or worthwhile.[1,9]

The perverse outcomes have been that many NHS dental clinicians are disillusioned and demotivated and many have run out of compassion.[11] Sadly, they now don't trust the GDC, the government, or indeed, many of their patients, to be fair or reasonable or tolerant of even minor or unpredictable problems.

Having had the enforced downtime to reflect on things during the lockdown caused by COVD-19, is it any wonder that many dental professionals are reluctant to return to a hugely pressurised environment, involving many clinical difficulties, often unrealistic patient expectations, claustrophobic personal protective equipment and multiple personal risks, while having to watch their every step as they try to navigate a safe way through the dangerous GDC and NHS minefields?

Cui bono? Do NHS patients really benefit from this omnishambles?

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