



**Response from Action against Medical Accidents (AvMA)
to the Department of Health Consultation Paper
'Strengthening the General Dental Council'**

Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

Introduction

AvMA welcomes the move towards modernising the General Dental Council to bring its regulatory function in line with the standards of professional performance now expected within our health services. As an organisation representing the interests of medical accident victims, AvMA believes that patient safety should be a core principle of all systems of healthcare provision and regulation. In this respect, the consultation document was disappointing in that there was insufficient evidence that patient safety was the guiding principle in the proposed reforms. Whilst certain aspects of the proposals would potentially give greater protection to patients, the move towards relaxing the rules with respect to dental bodies corporate and the business of dentistry could pose a risk to patients. To safeguard the interests of patients, any relaxation of the rules would have to be within the context of introducing a robust system of regulation including provisions to ensure that patients are informed and supported in their choices. There needs to be increased transparency with patients having access to information about available NHS treatments and their costs. It is also a fundamental requirement that the patient's voice, both individually and collectively, is recognised in principle and in practice as an essential part of these regulatory systems.

Dentistry has perhaps suffered from the view that patients are only exposed to limited harm - the wrong tooth being extracted or an unnecessary filling being carried out - whereas the potential for harm is far more significant. There are many examples past and present: the avoidable deaths of children and adults in

the dentists chair before restrictions on the use of anaesthetics were brought in; patients who have died or suffered permanent damage as a result of conditions such as endocarditis or oral cancer; the risks of cross infection through poor sterilisation; and the many who have been left with a lifetime of pain, disfigurement and psychological damage as a result of unnecessary interventions often driven by profit or simply the victims of incompetent practice.

One of AvMA's major concerns relates to the lack of effective regulation of non-NHS dentistry, particularly in the light of the rapid erosion of access to NHS dental treatment. The proposals set out in this document have the potential to vastly expand the scope of non-NHS dental practice whilst doing very little to improve the regulatory framework. With an increasing proportion of dental treatment now falling outside NHS regulation, there is an urgent need for non-NHS dental treatment to be brought in line with other areas of independent healthcare and be subject to inspection by the Healthcare Commission (Commission for Health Audit and Inspection).

Response to Consultation Questions

Q1. Are proposals for the modernisation of the GDC's fitness to practise powers and registration requirements correct? If not, have you any suggestions as to how these may be improved?

- 1.1. The proposals for the modernisation of the General Dental Council are long overdue. Having now reached this crossroads, it would be iniquitous and a disservice to patients and the profession, if the reforms do not fully reflect the changes that are taking place in healthcare provision, and in particular, making patient safety the core and guiding principle of any regulatory system.
- 1.2. AvMA is concerned that whilst these proposals may help the GDC to 'catch up' with some of the reforms which have taken place to other professional regulatory bodies over recent years, they fall short in terms of creating a regulatory body that has patient safety as its guiding principle and is equipped to deal with the challenges of healthcare provision in the future. In reforming the GDC, lessons need to be learnt from the sort of issues and criticisms faced by other professional regulatory bodies and in particular, the GMC, over recent years. AvMA welcomes the inclusion of performance within the fitness to practise procedures but is concerned as to whether these reforms will go far enough.
- 1.3. There are some very positive changes within the proposed Fitness to Practise procedures but these need to be complemented by the introduction of revalidation for practitioners because in order to protect the

public, the emphasis should be on addressing poor practice before it becomes a Fitness to Practise issue.

- 1.4. Patients reporting concerns to professional bodies have in the past felt, perhaps justifiably, that their first hurdle was to get the regulator to accept their complaint, the impression often being given that the regulator was there to protect the practitioner. The role of patients as partners in the workings of the GDC needs to be recognised and for systems to be put in place to ensure that they are adequately supported in the process.
- 1.5. AvMA would recommend that the Fitness to Practise procedures should be subject to further consultation.

Q2. Should the minimum period of erasure be 5 years?

- 2.1. This is a difficult issue not least because there is a lack of clarity in practice if not in principle as to how the sanction of erasure is used.
- 2.2. If the assumption behind erasure is a life-time ban, five years may appear a somewhat arbitrary minimum period. However, erasure appears to have been used where the nature of the offence dictates that nothing short of erasure would be acceptable either to the profession or the public but on the basis that ten months later the practitioner has the ability to apply for re-instatement. Clearly, the ability to apply for re-instatement after such a short period does in itself suggest that erasure can be viewed more as a punitive sanction than a means of protecting the public.
- 2.3. If a minimum five year ban is introduced, would this in effect mean that a practitioner having been excluded from practice for this period, would then be deemed unfit to return to practice and therefore, it would in effect be a life-time ban? Alternatively, if some practitioners are in fact going to be re-instated after five years, would they not pose an even greater threat than if they had been banned for a shorter period.
- 2.4. Before a decision is made on the minimum term, it needs to be made clear how erasure is to be used and in what circumstances. The guiding principle should be patient safety and maintaining the highest professional standards. We also need to be clear what influence if any, a five-year minimum erasure would have on the decisions of the conduct committee and whether there is a risk that they would err on the side of the practitioner.
- 2.5. In tandem with reviewing the function of erasure, it is essential that there is a fundamental review of sanctions/remedies available to the Fitness to

Practise Panels short of erasure. This is to ensure that a practitioner found guilty of misconduct where erasure is not deemed appropriate, is only returned to practice in accordance with the interests of patient safety be this through a combination of suspension, retraining, restricted or conditional practice, and supervision.

- 2.6. Ultimately, patients and the public need to be assured that practitioners will be held properly accountable and appropriate action taken to prevent other patients being harmed whilst at the same time being fair to the individual healthcare professional.

Q3. Are proposals for new requirements for practising under registered names adequate? If not, have you any suggestions as to how these may be improved?

- 3.1. The safeguards that are introduced should ensure that the practitioner is easily traceable and identifiable and that all details are current. Practising under a name other than the registered name should be a professional conduct issue. These rules will need to take into account the cultural differences in the use and format of names.

Q4. Do you agree with the suggested creation of rights for an applicant to appeal against the GDC's refusal to grant registration?

- 4.1. Yes providing the appeals process applies the same test for eligibility for entrance on the register rather than entry by default as a result of procedures having not been adhered to.

Q5. Do you think the new governance proposals are sufficient? If not, have you any suggestions as to how these may be improved?

- 5.1. The most significant failing with respect to current regulation and patient safety is the lack of regulation of non-NHS dental practice. Therefore whilst we would agree that it is essential that the GDC works cooperatively with other regulator bodies, at the present time, there is limited scope for this with respect to non-NHS dentistry.

Q6. Do you think DBCs (dental bodies corporate) should have a majority of dental registrants on their boards? Or do you think this is too restrictive?

- 6.1. As stated elsewhere, AvMA would argue that it would be irresponsible and against the interests of patient safety to consider opening the market

unless and until systems are in place for the effective regulation of the non-NHS dental sector. It is therefore not possible to respond to this question in the absence of a regulatory framework for DBCs.

Q7. Do you think that the requirement that all DBC operating staff must be registrants is unnecessary, and should be repealed?

7.1. No. We believe that any operating staff whose role requires skills or knowledge of dentistry or who have some responsibility for care / treatment of patients should be registered.

Q8. Are proposals for the non-NHS complaints system sufficient?

8.1. No. Whilst AvMA welcomes the introduction of a complaints procedure for non-NHS treatment, we do not believe the proposals are adequate. The lack of a complaints procedure for non-NHS dental treatment has long been a major failing of the present system of regulation of dentistry. This is both in terms of the inability of patients to obtain redress but also because systems of healthcare regulation including clinical governance, can only be effective if the patients' experience and in particular, the lessons arising from complaints, are included as an integral part of the regulatory mechanism.

8.2. AvMA believes that any healthcare complaints system must be linked to systems for clinical governance, monitoring and inspection. Therefore a complaints system which is administered by an 'independent body' would fail to provide the necessary link between complaints and regulation.

8.3. AvMA would propose that the regulation of this sector should come under the Healthcare Commission and that as with other independent sector complaints, patients should have recourse to an independent review of their complaint by the Commission. This would help to resolve the difficulty faced by an increasing number of patients making a complaint where part of their treatment has been provided under the NHS and part privately. It makes little sense in terms of protection of the public and redress for the patient, to separate out NHS and non-NHS components of a course of treatment performed by the same practitioner and expect the patient to pursue two separate complaints through two entirely different routes.

Q9. Does the provision for raising the status of PCDs (Professionals Complementary to Dentistry) give enough flexibility for practitioners and adequate protection for patients?

- 9.1. AvMA would not oppose raising the status of PCDs providing this is in the context of an effective regulatory framework, particularly with respect to non-NHS treatment. Raising the status must be accompanied by corresponding changes to the levels of professional training and accreditation. It would be against the interests of patient safety if PCDs were able to carry out the 'business of dentistry' without these safeguards in place.
- 9.2. Whilst practitioners would have a professional duty to practice only within 'the limits of their competence', this provides limited safeguards for patients in terms of patients being able to identify when a practitioner is practicing outside their competency, particularly given the array of sub-specialities within dentistry. (Many cases coming before professional conduct committees involve practitioners who have limited insight which is precisely why other systems need to be in place to identify these individuals at an earlier stage.). There are clearly risks attached to introducing these two major reforms at the same time i.e. removing the restrictions on establishing DBCs and enabling PCDs to carry out the 'business of dentistry', particularly where there may be significant financial incentives in a competitive marketplace.
- 9.3. Lessons could be drawn from the sort of problems that have been encountered in other sections of the non-NHS healthcare market. A good example would be that of cosmetic surgery where parallels could be drawn with an expanded non-NHS dental sector. There are significant patient safety issues surrounding the provision of private cosmetic surgery arising from a failure in regulation and it is important that the same failings are not allowed to be repeated in dentistry.

Q10. As a whole, are the provisions flexible enough to ensure that the devolved administrations can develop unique services most suitable for local needs?

- 10.1. Flexibility should not be at the expense of failing to ensure that the same minimum professional standards and safeguards for patient safety apply across all the devolved administrations.

Q11. Should we require by law that dentists have indemnity insurance before registration?

- 11.1. AvMA would strongly support the proposal that registration is only granted when practitioners have appropriate indemnity in place. The GDC will need to establish an approved list of schemes providing indemnity cover for registrants to ensure that they provide adequate cover.

11.2. With respect to patients being treated under the NHS, AvMA would recommend that along with General Practitioners, NHS indemnity should be introduced for NHS dentists as part of the clinical governance and patient safety strategy.

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