winter 2008

GDC gazette

THE NEWSLETTER FROM THE GENERAL DENTAL COUNCIL

PRESIDENT'S
MESSAGE

Hew Mathewson, GDC President

Hew Mathewson

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YOU SPOKE, **WE LISTENED**

Over the last few months we have sought the views of patients, dentists, dental care professionals and interested parties on issues ranging from awareness and views of the GDC to the future direction of the Council and the listing of additional skills and qualifications on our registers. Your views are important to both our policies and operational work as they help us make better decisions and deliver better services. Included below are updates on the subjects that we have recently asked your opinion on.

What do patients, the public and professionals think of the GDC?

Earlier this year we commissioned a series of focus groups with patients and the public alongside some in-depth telephone interviews with a sample of our registrants. The purpose of the research was to inform the current and future work of the Council and its communications.

We wanted to hear from patients and the public about their awareness of the GDC and its role, and their expectations regarding information provided by the Council.

Our research showed there was very little awareness amongst the general public of the GDC but there was an assumption that there would be a regulatory body overseeing dentists – this was expected of any professional. The GDC was primarily seen as a body which could deal with complaints and one that could act as a source of information and advice on the validity of a complaint. In addition, there was no awareness of the GDC's registers, though there was an assumption that a regulatory body would have a means of tracking professionals.

The public felt it was a good idea for the GDC to raise awareness of its existence as it would provide reassurance and peace of mind. It was noted that the Council should not promote itself purely as a way of making complaints, as this might generate a number of trivial complaints. Suggested ways of promoting the work of the GDC included distributing information in dental practices and the media.

The research amongst dental professionals focussed on their opinions of the GDC and what involvement they would like in the work of the Council.

The majority of the dental professionals interviewed felt the information currently provided on the registers was appropriate and did not see the need for change. This contrasted with the views of the public who wanted to see more information on the register including a key to explain the different qualifications, patient satisfaction scores and even photographs. One participant said;

"If I was changing my dentist I would really want to know every piece of information on that person – how old is this person, when did they qualify, where did they qualify, have you ever had a complaint against them…."

Attitudes to involvement in GDC consultations varied widely amongst the dental professionals interviewed. Some preferred to be involved at an early stage so they could have more influence in the outcome whilst others preferred receiving more developed proposals which they could accept or reject.

The research findings and their implications on our operations and external relations work will now be considered and taken forward by the Council. We would like to thank all those who took part in this invaluable research exercise.

Question time for the GDC in Belfast

In September the GDC held one of its quarterly Council meetings in Belfast. Members of the public and dental professionals were invited to attend a question and answer session as well as the Council meeting. A number of people took advantage of this opportunity and questioned the President and Chief Executive on issues such as the provision of dental technology training courses and continuing professional development for dental care professionals in Northern Ireland.

We also hosted a reception for representatives of educational, patient, professional and health organisations in Northern Ireland. The reception was an opportunity to gather the views of our colleagues on the future work of the Council and how we could better involve Northern Ireland in our activities.

Hew Mathewson, GDC President, and Duncan Rudkin, Chief Executive and Registrar, also found time to visit the School of Medicine and Dentistry at Queen's University to meet students and staff.

GDC HOLDS FIRST PUBLIC CONFERENCE

On Wednesday 1 October we held our first one-day public conference, ***Dental check-up – your views on protecting dental patients***. We invited 111 members of the public to this event which sought to gather their views on dentistry, dental professionals and professional regulation in order to help shape our corporate strategy for the new Council. The topics covered included:

- What are your dental professionals good at and what could they do better?;
- Dental professionals can be registered for many years – what should they have to do to remain registered?;
- How can we give you confidence that your safety is at the heart of everything we do?; and
- How should the public be involved in, or contribute to, our work?

We followed this on Friday 3 October with two events, ***Dental check-up – your views on your regulator***, at the BDTA Dental Showcase. These events provided dental professionals with an opportunity to comment on the draft corporate strategy. Questions at these events focussed on what they liked about the strategy, what they thought was missing or concerned them and what they would look for as evidence that the GDC is achieving what it outlined in the strategy.

The information gathered at these events will be used to develop the corporate strategy, and through other consultation activities. Please keep an eye on our website for further information.

What do patients need and want to know about dental professionals' additional skills and qualifications?

Earlier this year we held a consultation on additional qualifications. We sought your views on whether the GDC should have a policy on the regulation and listing of additional qualifications in the future and whether there was any clear benefit to patients in recording additional qualifications or skills on the registers. We also asked you to share your ideas on how a policy on additional qualifications might work.

The consultation paper was available on our website and was circulated to stakeholders, patient and public groups and dental professionals who requested a copy. We also conducted research with members of the public to feed into the consultation.

We received 180 responses from a variety of stakeholders. However, it was clear from the consultation that a number of respondents understood the questions and the role of the GDC in very different ways.

Further discussion on additional skills and qualifications was taken forward in a series of strategic workshops being run in relation to our Strategic Review of Education. As part of the workshops, we asked key stakeholders to consider the issues raised by respondents in the consultation and suggest workable outcomes.

Please visit our website, www.gdc-uk.org for further updates.

STRATEGIC REVIEW WORKSHOPS A SUCCESS

In October 2008, the Quality Assurance Team held a series of five workshops designed to build on the outcomes of the recent Strategic Review of Education. Three of the workshops concentrated on issues related to dentists and two focused on issues related to dental care professionals.

Around 150 attendees from across the dental profession participated in the lively yet focused discussion at these events. The goals of the workshops were to establish:

- an understanding of the GDC's intended role in relation to education;
- what the Strategic Review means for our future work and the way we work with our stakeholders; and
- the views of participants on specific policy issues to feed into a report of recommendations to Council from the Education Committee.

Full details of the outcomes of the workshops and the next steps for these projects will be available on our website shortly.

HAVE YOUR SAY

There are many ways for you to get involved in the work of the GDC. This includes responding to consultations, coming to meet us at Council meetings or events we are attending, or even working for us. We seek the views of patients, dentists, dental care professionals and others on GDC policies and operational work to help us make better decisions and deliver better results.

To find out more about getting involved and sharing your opinions with us, please visit our website, www.gdc-uk.org, or call our Stakeholder Relations Team on 020 7009 2794 or email stakeholderrelations@gdc-uk.org. You can also sign up to the content alerts system on our website to receive regular updates on the work of the GDC. To register for alerts please visit www.gdc-uk.org/AlertsLogin.

We currently have two consultations taking place on revalidation and indemnity. More information and details on how to take part are available on our website or by calling 0845 222 4141.

INDEMNITY

REVALIDATION – OPEN CONSULTATION

We continue to develop our plans for revalidation and welcome your views. Our proposals are not yet 'set in stone' so please take the time to review these and let us know your thoughts on what revalidation should include and how it should work. The open consultation is available on our website, www.gdc-uk.org/revalidation.

We will conduct a formal written consultation on concrete proposals in due course, but this is an opportunity to contribute to the development of the policy at an earlier stage. We will update the information on our website regularly so you can see how revalidation is developing.

COUNCIL MEETINGS

Our Council meetings are open to members of the public, dentists and dental care professionals. Each meeting begins with a public question and answer session which aims to give people an opportunity to find out more about the work of the GDC and the issues to be discussed at the meeting. More information, including the agenda and papers, is available on our website in advance of each meeting.

Our next Council meeting is due to take place on 3 March 2009 in London.

INVESTIGATING COMMITTEE: A LEARNING POINT

As part of our Standards Guidance, every registrant has a duty to maintain their professional knowledge and competence, which includes keeping up to date with therapeutic agents that affect dental treatment. This is especially important when dealing with bisphosphonates, as highlighted in a recent case heard by the GDC's Investigating Committee. Here, we highlight some of the issues registrants should be aware of when dealing with bisphosphonates to avoid potential fitness to practise investigations.

Bisphosphonates are prescribed principally for the treatment of osteoporosis, but are also used in the management of malignant disease where there is extensive metastatic bone invasion, for example malignant myelomas. The types of bisphosphonates used in the UK include:

Proprietary name	Generic name	Route of administration
Alenodronate	Fosamax	Oral
Clodronate	Bonefos	Oral
Etidronate	Didronal	Oral
Ibandronate	Bonviva	Oral or intravenous
Risedronate	Actonel	Oral
Tiludronate	Skeid	Oral
Pamidronate	Aredia	Intravenous
Zoledronate	Zometa	Intravenous

Oral prescriptions of bisphosphonates worldwide are huge and are estimated to reach 70 million by the end of 2008. Some patients who have had dental treatment involving extractions have developed post-operative bony lesions where the site fails to heal and exposed bone is visible. This condition has been called ostenecrosis (or sometimes bisphosphonate-associated osteonecrosis) and is more common in patients who have received intravenous bisphosphonates. Ostenecrosis is painful, debilitating for the patient and can become secondarily infected. It is not resolved by further surgery or discontinuation of the bisphosphonates and treatment is usually palliative.

The risk of osteonecrosis increases with the length of time the patient has been taking the bisphosphonates. Estimates of the risk of osteonecrosis associated with oral bisphosphonates varies from 1 in 10,000 to 1 in 100,000 patients, but the precise risk will not be known until reliable long-term studies have been reported.

Dental professionals involved in the treatment of patients taking bisphosphonates must be aware of the risks of osteonecrosis following surgical treatment and in particular extractions. It is essential to liaise with the patient's physician or oncologist and if necessary refer the patient for specialist treatment. Many primary care trusts have issued detailed strategies for the management of patients taking bisphosphonates and these should be referred to. In all cases, the clinician must have enough knowledge of the bisphosphonates to explain the risks to patients and get their informed consent before surgical treatment, especially extractions.

DOING IMPLANTS?

MAKE SURE YOU'RE UP TO SCRATCH

In light of concerns being raised about implant dentistry standards, we would like to remind all dentists that they must only undertake procedures they are properly trained and competent to do.

Dentists currently doing implant dentistry, and those considering branching into that area, should read guidelines published by the Faculty of General Dental Practice (UK), 'Training Standards in Implant Dentistry'. The guidelines make clear the minimum training we would expect dentists to have successfully completed before undertaking implants. These guidelines will be referred to when assessing complaints against dentists who have allegedly practised implant dentistry beyond their competence.

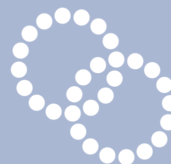
The guidelines make clear that inserting dental implants is a surgical procedure which should only be carried out by dentists with suitable training. This would normally involve a postgraduate training course in implant dentistry and an assessment of competence. Training can come from a variety of sources including university, royal college or hospital-based programmes, as well as from courses run by commercial groups or individuals.

To read the 'Training Standards in Implant Dentistry' in full, please visit our website, www.gdc-uk.org/Our+work/Education+and+quality+assurance/Policy+statement+on+implantology.htm

GDC gazette

dental
complaints service

Hugh Smith,
Head of the Dental Complaints Service



Dental Complaints Service UPDATE

helping you put things right...

Now into its third year, the Dental Complaints Service has already helped to resolve more than 3,750 complaints about private dental care, often within a week. The most intractable complaints are considered by panels of three trained volunteers – two lay and one dental professional.

So what's life like as a panellist? The Gazette asked dentist Jessica Bullen, who has sat as a dental professional panel member on three occasions, and Neil Ambrose, who has chaired four meetings.

"Speed, accessibility, support for both parties... From the off, we're there to help resolve a specific issue, fairly and transparently. I'm very enthusiastic about the Dental Complaints Service," says **Jessica Bullen**, who qualified in 1977 and recently set up her own practice in South Yorkshire.

"The thing about complaints is that if they're not acknowledged early and handled sensitively, they can become costly and time-consuming," says Jessica.

So what did her three panels have in common?

"They differed widely, but in each case the participants were grateful to discuss the issues constructively, in an impartial and informal setting.

"People may not realise how stressful it is bringing a complaint, and how stressful it is for the practitioner trying to resolve it. Once an outcome is reached, that can be the end of the matter. The participants can move on and get on with their lives."

Yes, Jessica provides advice as a professional, and that advice can be crucial, but she feels first and foremost part of a team, given "invaluable" support by DCS staff. Her last panel was "difficult and complex, but the chair was excellent.

"I remember vividly that there was a lot of movement towards the end of the day – it was 5pm on a Friday – and finally, to the relief of both, the parties achieved a resolution. Both felt satisfied with the outcome, and I think genuinely believed that the process had been fair. At the end of the day, that's what it's all about, really."

"I've taught healthcare ethics and law [at the University of Birmingham] so I was naturally drawn to the Dental Complaints Service," says **Neil Ambrose**, who has a PhD in Biomedical Science and Ethics. He lives in Sussex and his day job involves providing technology solutions to the pharmaceutical marketing industry.

"We lay panel members bring a useful non-professional perspective. You make a real difference to people, which is very satisfying. The process isn't legalistic, which means that the dental professional and the patient feel they can be open and discuss things, and compromise. Polarised attitudes soon mellow. There's always an element of negotiation to come up with a solution acceptable to both."

Informed consent – or lack of it – lay at the heart of two of the four complaints he chaired. "There was no full treatment plan, with ifs, buts and maybes, in either case," he notes. "If there had been, I doubt there would have been a complaint."

Each of Neil's panels has involved a dentist who was committed to the process, says Neil, and no dentist – as far as he can tell – ever felt they had "lost". In fact, he's been impressed that dentists "treated their panel as a learning experience."

To contact the Dental Complaints Service:
Phone: 08456 120 540 (local rate) Email: info@dentalcomplaints.org.uk Visit: www.dentalcomplaints.org.uk

FREEZE ON FEES
FOR DENTISTS AND DCPS

At it's meeting in Belfast in September, the Council agreed not to increase its registration fees for 2009.

The freeze on fees means the cost of annual registration renewal for dentists will remain at £438 and £96 for dental care professionals. The cost of being on one of the GDC's specialist lists stays at £52.

The Council also agreed to change the registration renewal date for four groups of dental care professionals – dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists – to July each year rather than December, to bring them into line with dental nurses and dental technicians.

Dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists will therefore be required to pay seven months registration of £56 in December 2008 to take them through to the end of July next year, when they will then pay a full year's registration through to the end of July 2010. This will synchronise all DCPs onto the same annual renewal cycle, in line with their CPD timetable.

Registrant	Annual retention fee (ARF)	Application fee
Dentist	£438 due in December 2008	£438 if registering in January. From February, £37 per month until December 2009 when ARF is due
Specialists	£52 due in December 2008	£250
Dental nurses and dental technicians	Dental nurses and dental technicians have paid for their first year of registration already. Their first ARF of £96 will be due in July 2009.	£8 per month until July 2009 when ARF is due
Dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists	£56 due in December 2008 for the seven months ending July 2009, to synchronise all DCPs onto same cycle. ARF of £96 will then be due in July 2009.	£8 per month until July 2009 when ARF is due

WELCOME TO THE **E-GDC**

Dental professionals can now pay their GDC annual retention fee, update their contact details and check the information on their practising certificate before it is printed, all via the web.

The new self-service website e-GDC at www.gdc-arf.com, which went live on 10 November, means GDC registrants can keep up to date and take care of their admin at any time, day or night, when it's convenient for them.

Edward Bannatyne, GDC Director of Operations, said, "The launch of e-GDC will make life a lot easier for our registrants. It should take the hassle out of simple things like updating your contact details and checking if your practising certificate has been sent out. Now you can manage your registration at your convenience – and not just during office hours.

"A range of additional online services are planned for next year too. You will soon be able to submit your annual CPD declarations online as well as set up a paperless Direct Debit to pay your annual retention fee. Meanwhile, I'd welcome your feedback on e-GDC. Please send your comments and suggestions to our Processing Manager, Anne Gerulat, on agerulat@gdc-uk.org"

To protect individuals' personal information, the GDC has built a number of security measures into the new system. New e-GDC users will need to create an account. You will then be sent an initial password and PIN which you will need to use when you first log in. Each time you log in after that, you will need to answer a security question.

CPD FOR DCPs:
WHAT IT MEANS IN PRACTICE

At the end of September, the GDC attended the BDTA's Dental Showcase, where we invited registrants to visit our stand and ask us questions. Many of these questions centred on continuing professional development (CPD) and the requirements for dental care professionals (DCP). Here, we try to answer some of those questions and provide practical advice on how you can make sure you're keeping up to date.

CPD requirements

All dental care professionals must complete, and keep records of, at least 150 hours of CPD over every five-year cycle. At least 50 of these hours must be verifiable.

If you first registered with us on or before 31 July 2008, your CPD cycle started on 1 August 2008. Only activities completed after this date can be counted towards the required hours of CPD. If you registered after 1 August 2008, please visit our website for information on your start date.

It is important to remember that the CPD requirements simply set out a formal policy for what DCPs everywhere are already doing. The underlying principle is that every member of the dental team is continuing to develop professionally to give patients the best possible treatment and care.

Verifiable or general?

There has been confusion about the difference between verifiable and non-verifiable (general) CPD. In order to count an activity as verifiable, it must have:

Concise educational aims and objectives	Does the activity have a clear purpose or goal?
Clear anticipated outcomes	What can you expect to gain as a result of taking part in the activity?
Quality controls	Do you have the opportunity to give feedback, with a view to improving quality?
Documentary proof	Will you be given a certificate to prove you took part in the activity?

General activities are those which contribute to your professional development, but do not meet all four of the criteria above for verifiable CPD.

We do not approve any educational provider or course for verifiable CPD. Instead, you are responsible for deciding whether or not to count an activity as verifiable. In your professional judgment, does the activity meet all four conditions above to be classed as verifiable? If you are satisfied that is does, count it towards the verifiable CPD requirement. If it doesn't, it isn't verifiable.

However, this does not necessarily mean the only way to achieve verifiable CPD is to go on a course. You may have regular staff training days or staff meetings. If you are able to schedule in a session on infection control or on radiography, you can count it as verifiable CPD as long as it meets the criteria described above. You may want to visit our website for further guidance on providing CPD activities.

Your own development

The important thing for you to remember is that the CPD activities you choose to carry out should be the most useful to your development. You may want to make a list of the activities you regularly undertake in your role and that have supported and informed your clinical activity. They might include:

Any activity that helps you to do your job, and to be better at it, has the potential to be considered as general CPD. What you can then consider is whether it is capable of being verifiable CPD.

Staff training	Peer review with colleagues	Participating in staff induction
Learning how new equipment works	Private study	Meeting with suppliers and customers
Formal courses and lectures	Journal reading	Attendance at conferences

Recommended core subjects

We have identified three areas of verifiable CPD that all dental care professionals should do as part of the 50-hour minimum amount. These are:

- medical emergencies (at least ten hours per cycle);
- disinfection and decontamination (at least five hours per cycle); and
- radiography and radiation protection (at least five hours per cycle).

Dental technicians will be able to substitute radiography and radiation protection with **materials and equipment** (at least five hours per cycle) as radiography is not within the dental technician curriculum.

We recommend that all dental care professionals do CPD in medical emergencies every year, and if you work in a clinical or laboratory environment, we also recommend that you undertake CPD (verifiable or general) in legal and ethical issues and complaints handling.

Although the core subjects identified in the CPD guidance are not compulsory, we think it is important that all dentists and dental care professionals are up to date on these fundamental issues, whatever their working environment. For example, we recommend radiography for dental nurses in the widest sense; even if you don't take radiographs yourself, you may work in an environment with radiography and as such should be aware of the health and safety aspects and of patient safety in relation to radiography. Therefore, if you do not undertake CPD in the core subjects, you should be able to justify why you have not, if asked to do so.

Supplying CPD evidence

Although supplying evidence of completed CPD may seem a little daunting, but there are a number of things you can do to make it as easy and straightforward as possible.

Use a personal development plan to help you decide how you will meet the minimum requirement of 150 hours of CPD, of which at least 50 hours must be verifiable.

Decide on a recording format for your CPD activity and stick to it. You can download a recording form from our website, or develop your own. Consider keeping separate records for verifiable and general activities.

Make sure you are up to date in core areas, including medical emergencies each year. You should carry out a minimum number of hours in each subject as part of your verifiable CPD.

For all verifiable CPD, make sure you have documentary proof of your involvement, for example, a signed certificate from a course.

Some final thoughts

Please remember that CPD is a legal requirement of registration. Your presence on the GDC registers gives a patient confidence that you are keeping up to date and that your professional development is ongoing. If you fail to meet the CPD requirements, we may take you off the register. If this happens, you won’t be allowed back on until you can show you have met the CPD requirements for rejoining.

GDC opens new specialist list **in special care dentistry**

The GDC opened its new Specialist List in special care dentistry on 1 October 2008. During a two-year “transitional period” (to 30 September 2010), interested dentists can apply to join the list on the basis of their specialist training, qualifications and experience. After that period, UK applicants will need to hold a Certificate of Completion in Specialist Training to join the list.

Special care dentistry is concerned with improving the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of a number of these.

The GDC holds 13 Specialist Lists. The purpose of them is to reassure the public that those using the title ‘Specialist’ have demonstrated they have met standards approved by the GDC for entry to the lists. Only dentists on the lists are entitled to use the title ‘Specialist’.

Dentists wishing to join the new list can download the application pack from our website, www.gdc-uk.org, or contact our Registration Team on 020 7344 3741 or assessments@gdc-uk.org.

For further information on CPD for dentists and dental care professionals:
Phone: 0845 2224141   Email: GDCregistration@gdc-uk.org

REGISTRATION DEADLINE:
GDC stays open until last minute

On 31 July 2008, registration became compulsory for all dental nurses and dental technicians. In the two years leading up to the registration deadline, we visited practices and laboratories, attended conferences and exhibitions and held workshops across the country. We even opened our offices until midnight on 30 July to receive last minute applications. As the clock struck 12 and the deadline passed, 36,225 dental nurses and 6,381 dental technicians were registered in the UK. These numbers have since risen to 41,843 and 7,279 respectively*.

The newly registered professionals join dentists, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists on the GDC's registers to bring the total number of registrants to over 90,000.*

*These figures were accurate on x November 2008

WHAT'S IN A NAME?

If you're working as a dental nurse or dental technician, you have to be registered or in training – whatever your job title.

The titles "dental nurse", "dental surgery assistant", "dental technician" and "dental technologist" are protected by law. So if a colleague is not registered with the GDC and is using one of these titles, or any other title which misleadingly implies that they are, they risk prosecution in a criminal court.

There are serious consequences for registrants too. If you are a registered dentist or dental care professional and you employ or manage an unregistered person to work as a dental nurse or dental technician (whatever job title you give them), you will be liable to fitness to practise proceedings and possible erasure from the register. As a registered dental professional, you have a duty to ensure that any person you employ is registered or in training.

Transitional arrangements that were in place for two years – allowing existing dental nurses and dental technicians to register on the basis of experience – are now closed, so that persons working as dental nurses and dental technicians can no longer apply for registration on that basis. The only way on to the Register now is with a recognised qualification.

If you have any questions regarding registration or need further advice, please contact our Registration Team on 0845 300 7794 or email GDCregistration@gdc-uk.org

REGISTERED ADDRESS

When registering with the GDC, we ask you to provide us with a registered address, which will then appear on our online registers on our website. Please bear in mind that your address does not need to be your home address; it can be where you work. It will be where we send all official correspondence and it is important that it is an address where you can access your post regularly. You must make sure you keep your registered address up to date and let us know if you change address.

NOW THAT YOU'RE REGISTERED...

So you've registered as a dental professional with the GDC. You've got your certificate and your name's on the register. But what happens now?

Earlier this year we entered a new era in dentistry. Registration with the GDC became compulsory for every member of the dental team. Patients can now feel confident that everyone involved in their dental care is regulated and that they uphold the standards of the profession. What this means for you is that your professionalism is fully recognised, and as such, you have certain responsibilities.

Being a registered professional

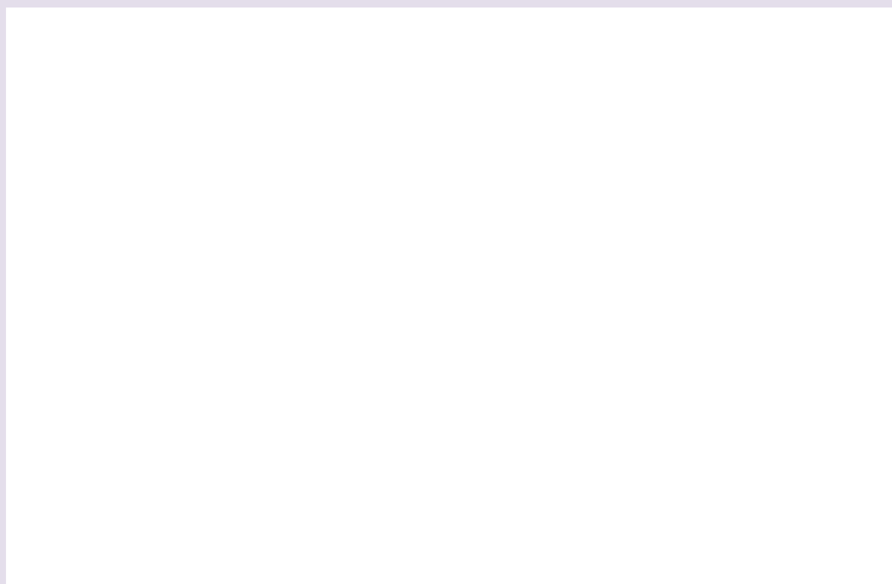
All patients are entitled to high standards of professional and personal behaviour from those providing their care. But these standards don't just protect patients – they also protect you and the integrity of your profession.

As a dental professional we entrust you with the responsibility of making the right decisions and judgments in your work. Patients and colleagues rely on you to make sure you're up to speed on the current standards affecting your work, the guidelines other organisations may set for you and to keep your skills up to date.

In 2005 we produced and published our core guidance, 'Standards for dental professionals'. This booklet, and the supplementary guidance booklets and statements which support it, doesn't tell you what to do or how to act in every possible situation. It explains the principles and values within which you should operate.

Our guidance states you are responsible for:

- putting patients' interests first and acting to protect them;
- respecting patients' dignity and choices;
- protecting the confidentiality of patients' information;



- cooperating with other members of the dental team and other healthcare colleagues in the interests of patients;
- maintaining your professional knowledge and competence; and
- being trustworthy.

These principles will influence any decision you make about a patient's treatment, a business relationship or your personal conduct. If something goes wrong and you find yourself the subject of a complaint to us about your fitness to practise, the decisions you took and how you arrived at them will be one of the main things a panel will consider.

Maintaining your professionalism

Registering as a dentist or dental care professional (DCP) is only the first step in your professional career. To maintain your professionalism, you have certain responsibilities that must be met each year. You have a responsibility to your patients to make sure your registration is renewed, that you're continuing to develop as a professional and that you have the necessary cover in place for them to claim compensation if anything should go wrong.

Renew your registration

Each year, you must pay an annual retention fee (ARF) to remain on our registers. This effectively renews your registration for another year and updates your details on our online registers so members of the public can check if you are registered.

The ARF is not a membership fee. It allows you to continue practising your profession in the UK. All dentists, dental therapists, dental hygienists, clinical dental technicians and orthodontic therapists are due to pay their ARF for next year by 31 December 2008. Dental technicians and dental nurses are due to pay their first ARF by 31 July 2009.

It is your responsibility to make sure you pay your annual retention fee on time. If you miss the payment deadline, your name will be removed from the relevant register and you will not be able to practise in the UK. Therefore it is vital you pay your fee on time.

Continue to learn

As a member of the dental team, you need to demonstrate that you are continuing to develop professionally.

Our core guidance booklet 'Standards for dental professionals' and associated, supplementary guidance, emphasise that all dental professionals are responsible for putting patients' interests first and acting to protect them. Central to this responsibility is the need for registrants to keep their skills and knowledge up to date in order to give patients the best possible treatment and care.

Compulsory continuing professional development (CPD) ensures that each year, registered dental professionals complete a certain amount of study, training, reading or other activity that advances their professional development. As a new registrant, you will need to start thinking about completing and recording CPD in line with GDC requirements. These requirements simply set out a formal policy for what dental professionals everywhere should already be doing.

By law, dentists must carry out – and keep records of – 250 hours of CPD over every five-year cycle, while dental care professionals must carry out 150 hours of CPD over every five-year cycle. At the end of each year of the five-year cycle, we will ask you to complete an annual return statement declaring the number of hours of CPD you have done the year before.

Activities can include attending courses or lectures, carrying out peer reviews, reading journals and distance learning. The purpose of CPD is to provide high-quality care to patients, so it's important that these activities take into account the needs of your patients and are relevant to your practice.

If you fail to meet these requirements, we may remove you from the register and you will not be allowed back on until you can show that you have met the CPD requirements for rejoining. More information on the CPD requirments and how to meet them is available on page 10.

Protect against claims

As part of our standards guidance, registrants must make sure patients are able to claim any compensation they may be entitled to by ensuring they are protected against claims at all times, including past periods of practice.

This means that if you have provided advice or treatment to patients, either now or in the past, you must have arrangements in place so that, should they suffer damage, they can recover any money due to them by way of compensation in the event of a successful claim, whenever the claim is made. The only appropriate arrangements recognised by the GDC are:

- dental defence organisation membership i.e. Dental Protection, Dental Defence Union and the Medical and Dental Defence Union of Scotland (whether your own membership or employer's membership);
- professional indemnity insurance held by yourself or your employer; or
- NHS indemnity.

If you are relying on arrangements made by your employer without arranging either a policy of your own or joining a dental defence organisation, you have a responsibility to check the position with your employer. At a minimum, you should check the issue is fully covered in your employment contract, and what the arrangements are.

You may find that you don't need your own professional indemnity arrangements as the risk of patient litigation against you personally is zero, when judged objectively. In which case, as long as you have reached this decision conscientiously, prudently and on a reasonable basis, you will have upheld your professional standards.

In all cases, the primary responsibility rests with you to evaluate and understand the litigation risks you may face. If your situation changes, you must make sure that you review your arrangements and take appropriate steps to protect patients whose current or future claims may be affected.

Regulating the dental profession

Independent professional regulation means that you are closely involved in determining the standards dental professionals must meet to join, and remain on, our registers. It also means you are accountable for your actions as a dental professional.

This is not only vital for patient protection, but also for protecting the integrity of your profession. If a registrant is falling seriously short of the standards expected of them, are you happy for them to continue working and to call themselves a dental professional? Protection of your profession ensures and underpins the reputation of every member of the dental team. It brings trust in what you do and how you work.

Getting involved

This is an exciting time for the GDC and for our registrants. We are looking to recruit a new, fully appointed Council made up of twelve registrant members and twelve lay members. The new Council will help to continue to raise standards in healthcare regulation and inspire confidence and trust in dental professionals.

But if the Council is not for you, there are lots of other ways you can get involved in regulating your profession. This could be replying to consultations we hold throughout the year or attending workshops or focus groups to share your views with us. We are committed to consulting on key policy decisions and modernisation initiatives and will always ensure we take into account the views and expectations of patients, the public and the profession.

For more information on any of the areas mentioned, please visit our website, www.gdc-uk.org, or contact us on 0845 222 4141.

Your questions answered

If you have any questions about any aspect of our work, we would like to encourage you to send them in and we will endeavour to answer as many as we can here in the Gazette.

As a dental technician, am I required to have indemnity?
All GDC registrants are required to make sure they have adequate professional indemnity cover so that patients can claim any compensation they may be entitled to from you.

As a dental technician, you may think you will never be affected by this. You may think that because you are not giving advice or working directly in a patient's mouth, you will never have a claim made against you. But are you sure? You have a professional responsibility to make sure you're covered. And it can only make sense from a risk management point of view.

More information on indemnity is available on page 14 and on our website, www.gdc-uk.org. We are currently holding a consultation on indemnity and the requirements of appropriate cover. More information is available on page 6 and if you would like to share your views with us, please visit the 'GDC consultation' section of our website.

My dental nurse of 17 years decided to retire this year and not register with the GDC. However, she has since agreed to provide cover during busy periods and now needs to be registered. Can she still register on the basis of her experience?
All dental nurses you work with must now be registered with us, or in training. The transitional arrangements that were in place for two years – allowing existing dental nurses and dental technicians to register on the basis of experience – are now closed. This means that persons working as dental nurses and dental technicians can no longer apply for registration on that basis. The only way on to the Register now is with a currently recognised qualification.

If your dental nurse wishes to continue working as a dental nurse, she will need to acquire a GDC-approved qualification. Once 'in training' and working towards a registrable qualification, she won't need to register with us until she has finished her studies.

A full list of qualifications recognised for registration with the GDC is available on our website, www.gdc-uk.org.

I have just completed my specialist training and as such am entitled to use the term 'specialist'. However, I have noticed that some dentists are using this term without the necessary qualifications. Is this allowed?
All registrants must make sure that their use of titles and descriptions of all kinds are accurate and not misleading to the public. Only dentists on the GDC's Specialist Lists can call themselves a 'specialist'. Any dentist who uses that title or description without a specialist listing could face fitness to practise proceedings.

GDC still to finalise guidance on **non-surgical cosmetic procedures**

The GDC will be continuing its work on guidance for dental professionals carrying out non-surgical cosmetic procedures, including Botox. The Council aims to have the final guidance available early next year.

Duncan Rudkin, Chief Executive and Registrar of the GDC, said, "It was clear from feedback we received that there were some concerns about how registrants would implement the initial guidance practically. In light of that, the Council has decided to further develop the guidance into something more usable for registrants and stakeholders.

"Until then, registrants choosing to offer Botox or other non-surgical cosmetic procedures should note that the GDC expects the same high standards of them, whatever the type of treatment they are carrying out. In particular, they are advised to work within their knowledge and professional competence and be prepared to back up the decisions they make. Careful thought also needs to be given to maintaining professional standards in relation to advertising these services, and to the need to be indemnified."

The guidance on non-surgical cosmetic procedures was the result of our public consultation on the scope of practice of the dental team earlier this year. The consultation sought views on what different groups of professionals could do as part of their work and what would be valid additions to conventional dentistry.

News in brief

Scope of practice – who is allowed to do what?

Earlier this year, we consulted on draft guidance on scope of practice and what different dental professionals are, or are not, allowed to do.

This resulted in each registrant group having a list of skills which they should be competent to carry out upon qualification. Each group also has a list of skills which they might go on to develop later in their careers and tasks each particular group of registrant will not do without training for a registrable qualification in a different area.

We will be publishing these outcomes as a new guidance document in the new year. In the meantime, you can visit our website, www.gdc-uk.org, for further information.

GDC statement on bone harvesting

A new statement from the GDC sets out that only dentists who have completed appropriate post graduate surgical training or those enrolled on an appropriate post graduate surgical training programme can carry out the harvesting of bone from sites outside the mouth.

Those who are considering carrying out bone harvesting from extra oral areas must also check with their defence organisation that they have appropriate indemnity cover.

The full statement on bone harvesting is available on our website, www.gdc-uk.org.

Pandemic flu (still to some)

Registrant information

GDC ISSUES CHECKLIST FOR ‘DENTAL TOURISTS’

With more and more people considering dental treatment abroad, the GDC has issued guidance and advice to dental patients with a checklist of questions to ask before travelling abroad for treatment.

The aim of the checklist, produced in association with the British Dental Health Foundation (BDHF), is to help dental patients make informed decisions about their dental care, wherever they receive treatment.

The checklist is available on our website, www.gdc-uk.org

Obituaries

The GDC is very sad to have received news that former Council member Ian Smith and leading oral and maxillofacial surgeon Professor John Lowry have died.

Ian was appointed to the GDC's independent Appointments Committee in January 2003 and was serving his last year in that position.

Professor Lowry…

GDC HIGHLY EFFECTIVE AND WELL MANAGED

The GDC has been found to be a highly effective and well managed regulator with a consistent focus on public protection and a commitment to continuous improvement. That’s the view of healthcare regulator watchdog the Council for Healthcare Regulatory Excellence (CHRE) in its annual performance review, which was published in August.

Hew Mathewson, President of the GDC, said, “We welcome the scrutiny that the review process provides and the opportunity for us to demonstrate accountability. I’m delighted the results show we are on the right track.”

Although the report also highlighted some areas of work where improvements are needed, steps have already been introduced to build on our successes. This includes launching a system for regularly ‘revalidating’ dental professionals, continuing to drive down the time it takes to deal with fitness to practise cases, and streamlining our registration processes.

The full performance review report is available on the CHRE website, www.chre.org.uk/news/40/

A NEW PROFESSION **IS OBORN**

"What does registration mean to me? That I'm a professional. And as a professional, it's up to me to take ethical and legal and practical responsibility for everything I do for a patient."

That's the view of Mark Oborn, a dental technician and a director of SBO Dental Laboratory in Marylebone, London.

If that sounds demanding, it isn't to Mark. He has seen the future, and it works: members of the new fully-registered dental team work together to put the patient first. For him, that means working with dentists and clinical dental technicians (CDT).

"Prior to registration, it was always possible for me to argue that a patient was the responsibility of the dentist, not mine. Now, I take responsibility, too."

To Mark, part of being registered is that his skill in managing the process of manufacturing is being recognised. What he would like to see – and he claims he is increasingly seeing it – is dentists managing outcomes, rather than processes, and trusting technicians to understand and manage the process of, say, preparing a crown, so as to achieve the best outcome for each patient.

That means technicians need to understand clinically how the patient presents, and the challenges the dentist must overcome. But it also means that they have to understand the key outcome: what a patient wants – the aesthetic they are looking for, how a prosthetic should feel, how long it might be expected to last, whether it is manufactured using traditional or novel materials, etc.

"A dentist's specific prescription may result in an excellent outcome. But they don't necessarily know all the options, because many options may be new. I'm aware of *all* available options, including the novel ones. It's my job to know them. No dentist would argue that the technical options with which I'm so familiar are his or her core competency. And now, as a professional, the buck stops with me."

Registration, and new courses creating clinical dental technicians, created the climate for Mark, who qualified in 1987 and registered a year ago, to pilot a new business model where dentists and technicians worked together as a team – putting the patient firmly at the centre of their team working.

He formed an alliance with a clinical dental technician and rented a chair in a dentist's surgery, marketing the operation directly to patients through the Internet, with some referrals from existing customers of his who were dentists.

"As professionals, we all learned a lot. Because patients came straight to us, my CDT colleague and I had a much more patient-focused approach than we'd had before. Of course, we insisted that patients who were partially dentate, with existing teeth, saw our dentist partner, or another dentist, first. Often they would work on a patient's teeth, then refer them back to us with a prescription for a denture. The patient would then come to us for work on the prosthetic side."

Where the patient lacked teeth of their own, the clinical dental technician would carry out an inspection while Mark looked on and was briefed there and then.

Mark's enterprise was a pilot, but he is keen to build on it, and see others do so. Whether that truly is the future for dentistry, only time will tell. But it does illustrate how registering the entire clinical dental team has encouraged a greater focus on the person at the heart of the dental experience – the dental patients themselves.

If you would like to share your story with us, whether it be about registration, team working or continuing professional development, please contact our Communications Team on 020 7009 2784 or communication@gdc-uk.org.

GDC gazette

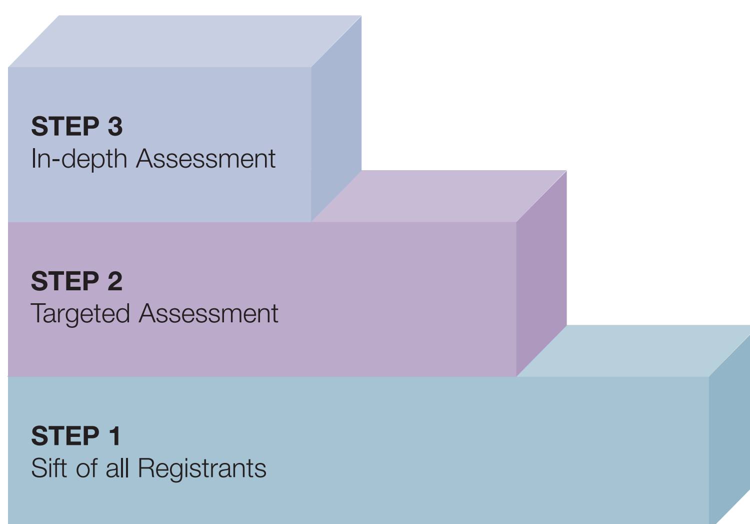
REVALIDATION:
WHAT DOES IT MEAN?

As a registered dentist or dental care professional, you know that you have to keep your knowledge up-to-date to stay on the GDC register. You do this already by carrying out continuing professional development (CPD). But keeping up-to-date through CPD is only one aspect of showing that the standard of your practice is up to the level required by the GDC and expected by your patients.

Revalidation will be based on a set of standards, against which we will ask you to collect evidence. The standards will be focused on four headings:

- Professionalism
- Clinical
- Communication
- Management and leadership

A three stage process is proposed:



Why is the GDC introducing revalidation?
Patients need to have confidence that the professionals providing their dental care have not just shown that they meet our standards when they join our registers, but can show they continue to meet the standards expected of them over the course of their working lives.

This doesn't mean that dental professionals who already do a lot of work to make sure their performance is up to scratch will be bombarded with a lot of unnecessary paperwork – we want revalidation to be as simple and flexible as possible. We are committed to making use of existing and forthcoming quality assurance systems and locally gathered evidence wherever available and appropriate. This could include, for example, material you collect as part of a good practice scheme or practice development planning process.

We are going to pilot our proposals extensively to see if they work. This means that they are not 'set in stone' – you have the opportunity to make suggestions on what revalidation should include and how it should work. An open consultation began in September and will run throughout 2009. Please take the opportunity to look at the consultation on our website and let us know your suggestions and views.

What does revalidation involve?
We are currently drafting the standards and evidence framework proposed for stage 1 of the revalidation process, and would particularly welcome your thoughts on how we can develop this into a final workable tool.

As part of our proposals, you will be required to produce a portfolio of evidence for Stage 1, which could include (but might not be limited to) any of the following:

- Clinical audit / peer review
- Patient satisfaction surveys
- Personal and practice development plans
- Evidence of CPD compliance
- Anonymised patient records
- Practice accreditation schemes
- Significant event analysis
- Appraisal

The framework will be flexible so you can select the type of evidence you provide for each of the standards from a menu of options. At the end of your revalidation cycle, you will need to submit a declaration of the evidence you have collected to show you meet our standards for continued registration. This would determine whether you pass the threshold for revalidation (we expect that most of our registrants would pass the threshold at this stage). Stage 1 is intended to be a sift to determine who requires a 'further look'. It is not a guarantee that those not put through to Stage 2 are fit to practise, we can never 'guarantee' this.

What if I don't (or can't) provide adequate evidence?
We are working with professional bodies to make sure our requirements for revalidation are not unnecessarily time consuming and they make use of evidence you already have access to wherever possible. In fact, you may already have all the information we will be looking for. As with CPD, we expect there will be a small minority of you who do not comply with the requirements to produce evidence. If you simply do not comply, you risk removal from the register. If you try to comply, but struggle to do so, we will ask you to take part in Stage 2. Stage 2 may involve peer assessment in the practice against a check list, examining patient records, medical histories, radiographs and so on. A comprehensive check list will be developed for this purpose. At this stage, if you do not appear to meet the standards required, you may be allowed additional time (perhaps working with a mentor) to bring your performance up to standard. If you were unable to do that (or there were serious concerns about your performance from the assessment) you would have to go into Stage 3 of our process.

At Stage 3, we expect that there would be a menu of assessment routes and tools available, but you would have to show through a robust assessment process that you met our requirements to remain on the Register. If you could not do so, you would not be allowed to continue practising. We would hope to see as few as possible dental professionals in Stage 3, as it is much better for you and your patients to seek help from colleagues and professional bodies at an early stage if you think that you are having difficulties, rather than avoiding problems until the last minute.

When will revalidation start?
We expect the first revalidation cycle to begin for some dentists in 2011. There will be much more consultation and discussion between now and then, so look out for regular updates as we develop our plans.

Who will it apply to? Will it be the same for everyone?
Ultimately, revalidation will apply to all registered dentists and dental care professionals, but our work so far has concentrated on dentists in general dental practice in the first instance. Everyone will have to provide evidence that they continue to meet a set of standards under the four domains. Most of these will be common to everyone, but as we develop them we will consider whether some should be tailored to your own individual type of practice.

What are your plans for people who don't work in general dental practice?
We are looking at ways in which individuals who work outside the general practice setting (for example, those who work in teaching roles) can meet the requirements for revalidation. We are also looking at how specialists will revalidate in their specialties, so please let us know your thoughts.

Is there anything I can be doing now to gear up for revalidation?
Yes, you may be doing plenty already! You can use personal and/or practice development plans to highlight areas of development that would keep your standards up to date and benefit your patients (and get into the habit of keeping evidence of what you are doing). You might also consider joining a good practice scheme.

How will the piloting work?
We will be piloting Stage 1 of revalidation in 2009 with volunteers in three pilot sites across the UK. One pilot will take place in Scotland (in partnership with NHS Education for Scotland), one in an English postgraduate deanery, and one with a group of dentists in non-NHS practice. The pilots will be run at a local level, and will be independently evaluated by a research company.

We want to work with these groups to establish what the time commitment might be for the process, whether the process we have outlined will work in practice and if not, how it needs to be changed, and whether we are asking for the right kind of information. This feedback will help to develop the final version of our standards and evidence framework for revalidation.

If you would like any further information regarding the pilots or development of revalidation, please visit our website, www.gdc-uk.org/revalidation, or contact us on 0207 887 3819 or email revalidation@gdc-uk.org.

FITNESS TO PRACTISE – HOW TO AVOID TROUBLE

Sarah Manuel, Fitness to Practise Operations Manager, explains the simple steps you can take to avoid a fitness to practise investigation.

An issue which repeatedly comes to the attention of our Fitness to Practise Team is that of advertising, whether in a newspaper, the Yellow Pages, or on the internet. The types of adverts brought to our attention can vary from supplying misleading information, suggesting one form of treatment is superior to another, or using a protected specialist title when a dentist is not entitled to do so. Up until October 2008, we have issued 20 published warning letters regarding misleading advertising. This highlights how widespread this issue is and the potential concerns it could cause for the patient. However, it could so easily be avoided.

We understand that registrants want their surgeries, the skills of their team and the services provided to stand out and appeal to potential patients. But with a little careful thought about the wording used in advertising, there would be no need for us to investigate. You can avoid involving your defence organisation and the subsequent risk that your premium may go up, the cost involved in redesigning your advertising material, and the unnecessary stress of a fitness to practise investigation.

So how easy is it for your advertisement to be considered by our Fitness to Practise Team? Easier than you think! Here's a scenario:

Mr Smith has run a successful dental clinic in a busy town for 20 years. He has just moved to a new site, and the surgery has all the latest dental equipment. Mr Smith has also decided to branch out into more advanced areas of dentistry, such as implantology, and is considering offering cosmetic treatments in the future. Mr Smith's dental team has recently expanded to 23, including eight dentists, two dental hygienists, ten dental nurses and three reception staff.

To promote the opening of his new surgery, Mr Smith decides to place an advert in his local paper. As this is big news for the town, the paper also decides to write an article.

Three of the dentists, Mr Jones, Mr Patel and Miss Brown, have been extensively trained in the provision of implants and he tells the journalist that they are "specialists in implantology". The newspaper article also makes reference to all "his specialist staff".

The following week a complaint is received by the GDC from an anonymous source about the article and its misuse of the term "specialist". The concerned informant points out that none of the staff are registered with the Council on one of its Specialist Lists and that no specialist list in implantology exists.

What happens next?

The case will be allocated to one of our 14 Caseworkers, such as Caroline Carson, who will review the information provided and prepare an assessment on the material. It is Caroline's role to write a factual analysis of the information and then identify if and where a breach of the Council's standards guidance may have occurred.

In this instance, Mr Smith should have taken into account principle 1 – to put his patients' interests first and acting to protect them. More specifically, Mr Smith should have put his patients' interest before his own or those of his business and should not have made any claims which could mislead patients.

Caroline would present her findings at an assessment meeting which is attended by another Caseworker and an Operations

Manager. Caroline has to give full reasons for the decision she makes. As part of her analysis, Caroline would identify who the complaint was against. In this case, the issues would be against Mr Smith as the practice owner and Mr Jones, Mr Patel and Miss Brown as the individuals identified as specialists.

But that's not fair

We understand that advertisements are seldom intended to mislead the public, but we have a duty to deal with all cases which breach our standards and those which could mislead the public, in the same impartial way. Each individual registrant has a responsibility to ensure that any interaction with the media is truthful and could not be considered to be misleading.

Although Mr Smith does not himself provide treatment to patients and has not described himself as a specialist, he was the instigator of the article and has a responsibility as an employer to ensure that information about his staff is accurate. The GDC issued supplementary guidance 'Principles of Management Responsibility' in February of this year.

What happens next?

Each registrant will be written to, notifying them of the concern which has been raised and will be given the opportunity to provide the Investigating Committee with any comments they may have. The registrant will also be advised to seek assistance from their defence organisation and to provide us with a copy of their current indemnity certificate and details of their employers or anyone with whom they hold a contract. At this point, when a registrant is referred to the Investigating Committee, the GDC has a statutory obligation to inform the NHS Primary Care Organisations in the UK. We also notify them when people are no longer subject to an investigation by us.

The Investigating Committee naturally takes a dim view of anything which may mislead patients, whether this is intended or not. It is the perception which can be just as important. Registrants who are found to have breached the Council's guidance on advertising are most likely to find themselves being issued with a warning letter. It is possible that the warning will also be published against their name on our online registers for a period of up to twelve months. If any further issues came to our attention, that registrant's previous fitness to practise history would be reviewed.

So, is it worth it?

In short, no.

We don't have the power to deal with these cases administratively and so they go through the formal fitness to practise process, which takes around six months (up to the Investigating Committee). In Mr Smith's case, all four dentists would also have a fitness to practise history with the Council, which would be disclosable to any NHS Primary Care Organisation making enquiries to the GDC, should they apply for a contract in a different area.

For what seems like a minor breach of the standards guidance, you can see for yourself the consequences for the individuals.

So next time you are placing adverts or updating your website, please take a few moments to consider whether someone could find your choice of words misleading.

The principles of practise in dentistry

As a dental professional, you are responsible for doing the following:

1	Putting patients' interests first and acting to protect them.
2	Respecting patients' dignity and choices.
3	Protecting the confidentiality of patients' information
4	Co-operating with other members of the dental team and other healthcare colleagues in the interests of patients.
5	Maintaining your professional knowledge and competence.
6	Being trustworthy.

CONDUCT CASES REVIEWED

30 conduct cases were heard between May and August 2008. There were also three applications for restoration.

Conduct case outcomes May – August 2008 (All cases relate to dentists unless otherwise stated)

Conduct Cases	
Erased without immediate suspension	1
Suspended	7
Conditions	6
Admonished/reprimanded	4
Case concluded	1
Postponed judgment	1
Not guilty of serious professional misconduct/fitness to practise not impaired	5
Adjourned	1
Referred to Health Committee	1
Restoration Cases	
Not restored	3
Total	**30**

The registrants listed here may share identical or similar names with other registrants on our registers and confusion could cause serious distress and professional embarrassment to those who have not been involved in fitness to practise proceedings. To confirm the identity of the registrants involved in fitness to practise proceedings, we have listed their unique registration number next to their name.

Name	Registration Number	Type of Case	Outcome
ABBASSIAN, Ardeshir*	81602	Conduct	Serious professional misconduct: suspended for 6 months (with review)
AZARI, Mojgan	[74127]	Restoration: first application	Not restored
BAIN, Ian Graham	55569	Conduct	Case postponed prior to opening (after legal argument)
BARKER, Andrew John	81824	Conviction	Fitness to practise impaired: reprimanded
BEHNEJAD, Seyed Mohsen Behzad	73494	Conduct	Fitness to practise impaired: conditional registration for 2 years (with review)
BOYD, Andrew Weir	61041	Conduct: resumed following suspension	Re-suspended for a further period of 12 months
BOYD, Andrew Weir	61041	Conduct: resumed following suspension and an appeal by CHRE	Re-suspended for a further period of 12 months (with review)
BRAY, Stephen James*	52686	Conduct	Serious professional misconduct: judgment postponed for 12 months
BROWN, Roger Andrew[1]*	68413	Conduct: resumed following adjournment	Serious professional misconduct: case concluded with admonishment
BURGER, Schalk Petrus Phillipus	80064	Conduct	Fitness to practise impaired: conditions imposed for 6 months (with review)
BURNET, Alistair*	61487	Conduct	Not guilty of serious professional misconduct: facts insufficient to support a finding of serious professional misconduct
CROWE, Catherine Fiona*	61847	Conduct	Serious professional misconduct: suspended for 4 months (with review)
DAVIES, Josephine Isobel	1210 (DCP)	Conviction	Fitness to practise impaired: reprimanded
EDGAR, Martin John*	52320	Conduct	Serious professional misconduct: erased
FOROTAN FARD, Noushin	78302	Conduct: resumed following suspension	Case concluded
HENTHORN, David John	55201	Conduct	Fitness to practise impaired: conditional registration for 18 months (with review)
HOSSACK, Robert Julian	[52637]	Restoration: second application	Not restored: right to re-apply for restoration suspended indefinitely
KELFKENS, Claude Stephen	68804	Restoration: first application	Restored to the Register: conditional registration for 12 months

Name	Registration Number	Type of Case	Outcome
KIRK, Andrew Lister	65809	Conduct: initial and resumed	Fitness to practise impaired: conditions imposed for 2 years (with review)
KOPEK-GRZESIK, Anna	57942	Conduct	Fitness to practise impaired: suspended for 9 months (with review)
KOTZENBERG, Stephan Gustav[1]*	77380	Conduct: resumed following adjournment	Serious professional misconduct: case concluded
MAHONY, Gerard	[48634]	Restoration: first application	Not restored
MARSHALL, Iain Ralph	57228	Conduct: resumed following suspension appeal by CHRE	Re-suspended for a further period of 12 months (with review)
McMITCHELL, Robert Alexander	63432	Conduct	Fitness to practise not impaired
MILLER, Colin Errol[1]*	65715	Conduct: resumed following adjournment	Serious professional misconduct: case concluded with admonishment
OKUNIEK, Peter Gunter*	82652	Conduct: resumed following postponed judgment	Referred to the Health Committee
ROSE, Matthew David[1]*	68637	Conduct: resumed following adjournment	Not guilty of serious professional misconduct: case concluded
SCHNEIDER, Sophie Eve	47182	Conduct	Fitness to practise impaired: suspended for 3 months
SKVARKA, Ján	84622	Conduct	Not impaired: case concluded with expression of disapproval
ZIAIE-TABARI, Taraneh	81544	Conduct	Fitness to practise impaired: conditional registration for 12 months (with review)

1 These cases were heard jointly.
* These cases were initiated before our new fitness to practise rules came into force on 31 July 2006, and are therefore considered under the previous rules.

CASE DETAILS

The following are a selection of the cases considered by the Professional Conduct Committee between May and August 2008. All cases are listed in the table on pages 22 and 23 but limited space in the Gazette means we are unable to report in detail on all of them.

If you would like more details of any of the cases, including the full determination, please visit the 'General public' section of our website, www.gdc-uk.org, or contact our Hearings Team on 020 7887 3821 or hearings@gdc-uk.org.

BRAY, Stephen James (Registration number 52686)

During 2003 and 2004 Mr Bray provided dental treatment to patients A, B, C and D at the practice he operated with his colleague, Mr Visser. It was at this practice that Mr Bray chose to move progressively into the provision of neuro-muscular dentistry, whilst Mr Visser continued to provide general dental services.

Mr Bray admitted a large number of allegations and facts, and the majority of the remaining allegations were found proved regarding the treatment of the four patients, his approach to scanning, nutritional supplements and to the appropriate use of electromyography. The facts were not found proved with respect to the allegations concerning the provision of veneers to a fifth patient.

The Committee found that Mr Bray had used electromyography to measure the occlusion or "bite" of certain patients, but failed to explain any alternative, more orthodox methods. Furthermore, he had failed to provide adequate treatment plans or discuss alternative treatment options and costs and so failed to obtain informed patient consent.

The Committee concluded that Mr Bray allowed his "excitement" over certain diagnostic and treatment methods to cloud his professional judgment on more than one occasion. His patients were, on the whole, unaware of the lack of substantive evidence for the treatments and methods he operated. The Committee was very concerned that in some cases Mr Bray carried out extensive invasive treatment based on his strongly held personal philosophy, even when this was not in the best interests of his patients.

The Committee noted that Mr Bray had a pattern of making misleading statements, which had previously led to the issuing of a warning letter from the General Dental Council.

On his own admission, patient B's initial presenting complaint, as recorded in Mr Bray's notes, did not justify the subsequent occlusal investigation and prescription of full-mouth reconstruction. This was clearly not in the best interests of patient B. With regard to patient A, the Committee accepted that Mr Bray failed to diagnose and treat caries in several teeth despite the patient's requests.

Mr Bray admitted that he failed to keep adequate contemporaneous records. For example, failing to report on any radiographs that he took, as required in the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The Committee noted that use of electromyography for measuring the occlusion, whilst not in itself criticised by the

conduct cases reviewed

General Dental Council, is an unorthodox diagnostic method; the unconventional nature of which was not clearly explained to the patients, nor described in Mr Bray's own notes. The Committee found Mr Bray's own evidence on this diagnostic method, and on the rationale behind it, confused and unconvincing, and was concerned by his reliance on the results to provide extensive invasive treatment.

The Committee made it clear that it is not part of its function to pronounce on the clinical validity or otherwise of any particular treatment philosophy, and it is anxious to avoid stifling the development of new techniques. But it was the duty of the Committee to judge all practitioners against the same standards. These standards include the practitioner's inescapable obligations to act in the best interests of the patient, to provide a high standard of care, and to obtain informed consent. In particular, where dentists advocate forms of treatment which are out of the mainstream of professional opinion, are unsupported by an informed evidence base, or are otherwise unproven, they must meet the highest standards to ensure that the patient fully understands the treatment proposed, the risks involved, and the alternative treatment options. The Committee noted that all dentists must constantly question their own skills and knowledge base in relation to diagnosis, prescription and treatment. They must also consider whether invasive and irreversible courses of treatment which lie outside the mainstream of professional opinion may legitimately be embarked upon without prior consideration and clearance by a properly established Ethics Committee.

The consequence of Mr Brays failures was misconceived, lengthy and unnecessary treatment which was irreversible and of little or no benefit in terms of intended outcomes; which failed to resolve the patient's symptoms; and which cost some of the patients considerable sums of money. The Committee therefore found Mr Bray guilty of serious professional misconduct.

The Committee also noted that a large amount of Mr Bray's continuing professional development still focussed on the narrow field of practice in which Mr Bray had displayed a keen interest.

The Committee decided to postpone judgment giving Mr Bray the opportunity to prove on resumption of the case that his performance had improved. Accordingly, it postponed judgment for a period of twelve months, with a formal admonition.

At the resumed hearing, Mr Bray would be expected to provide the Committee with tangible evidence of:

- a personal development plan, arrived at in conjunction with his Postgraduate Dental Dean or Tutor. This should include an IRMER course, a Minimal Restorative Intervention course and an Ethics/Consent course;
- guidance in treatment planning, supervised by a consultant in restorative dentistry locally;
- evidence of interaction with mainstream colleagues locally, which may include involvement with BDA section meetings, independent practitioner groups and peer review groups in his area;
- an externally verified audit of radiography, especially bitewing radiographs, to include reports on the outcomes of the radiographs;
- an externally verified audit of clinical records;
- up-to-date information leaflets that are objectively justifiable, accurate and balanced; and
- up-to-date consent forms.

BROWN, Roger Andrew (Registration number 68413)
ROSE, Matthew David (Registration number 68637)
MILLER, Colin Errol (Registration number 65715)
KOTZENBERG, Stephan Gustav (Registration number 77380)

This was the largest and longest substantive case in the history of the General Dental Council, and took up 34 hearings days in six sessions from May 2007 to June 2008. The Committee also set a precedent by sitting on weekends for the first time in order to bring the case to a timely conclusion.

These four cases were heard jointly. The respondents all had involvement with the Cambridge Anaesthetic Centre for Dental Care (CAC) and St Marks Dental Practice. Mr Brown had a supervisory role in relation to Mr Miller and Mr Kotzenberg.

The charges essentially centred around the improper use of other dentists' NHS contract numbers, the inappropriate and unjustified use of panoral radiographs as a screening tool, failing to carry out clinical evaluations of radiographs, failing to follow the Ioninsing Radiation (Medical Exposure) Regulations (IRMER) 2000, and poor record keeping.

Mr Brown

In April 1998, Mr Brown entered into a partnership agreement for the provision of dental anaesthetic services with Dr Bassilious, a consultant anaesthetist, Mr Rose, another dentist, and the St Mark Anaesthetists Services Limited (sic). He contributed 15% to the initial capital of the partnership, but the management of the practice was the responsibility of Dr Bassilious, who had contributed 75%. Under the agreement, Dr Bassilious was 'responsible for all dental aspects of the Business' and Mr Brown was described as the 'Principle (sic) Dentist'.

As a principal and a signatory to the partnership agreement Mr Brown was assuming responsibility for supervising other dentists (and in particular Mr Miller and Mr Kotzenberg), who were employed by him as either assistants or as locums. They provided treatment and submitted claims for payment using Mr Brown's contract number. In due course Mr Brown also became responsible as an employer for ensuring compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

Mr Brown visited the practice only occasionally and left the management entirely to Dr Bassilious. By absenting himself in this way and taking no effective steps to inform himself of the clinical standards in the practice or to ensure that his assistants and locums were complying with their professional obligations, Mr Brown could not know the identities of all the dentists who may have been using his number. He was unable to prevent the adoption of clinical practices which were unprofessional and which could have caused harm to patients. On this basis the Committee found Mr Brown guilty of serious professional misconduct.

The Committee considered Mr Brown's failures to be serious. He should have been aware of the extent of his responsibilities as a principal and as a partner. He told the Committee that he was lulled into a false sense of security by his knowledge that, although Dr Bassilious was not a dentist, he was an experienced dental anaesthetist with an extensive knowledge of dentistry. He expressed regret over his lack of judgment.

No criticism was directed at Mr Brown's own clinical standards and it was accepted that he was generally conscientious and of good character. No question of dishonesty or deliberate wrong-doing was alleged or found against him, and his testimonials described him in very positive terms and as being 'very precise and professional'.

In these circumstances, the Committee decided to conclude this case without making an order affecting Mr Brown's registration. It was made clear to him, however, that as a principal and partner he had fallen well short of the standards expected within the profession. He should have recognised that as the most senior dentist in the partnership, he had a responsibility to both his patients and to his professional colleagues. Mr Brown's failure to recognise this warranted the Committee's

severe censure as a warning both to him and to the profession.

Mr Rose

Mr Rose was described as 'Mr Brown's Deputy' and contributed 10% to the initial capital of the partnership.

Mr Rose reluctantly agreed to allow another dentist (Mr A) to provide treatment and submit claims for payment under his contract number because he knew him to be a highly competent and conscientious dentist. His contact with him and knowledge of his clinical abilities enabled him to provide Mr A with appropriate levels of supervision. Mr Rose made it clear to Dr Bassilious and other members of staff that no other dentist was permitted to use his number. He was not aware of the misuse of his number when it occurred and was therefore not at fault. Accordingly, the Committee found that Mr Rose had not failed to supervise Mr A. Furthermore, Mr Rose's own practice was not criticised.

The Committee did find that, as a result of signing the partnership agreement, Mr Rose assumed some responsibility, both as a principal and (when IRMER subsequently came into force) as an 'employer'. As a partner and principal, it was Mr Rose's duty to ensure that proper procedures were in place. Mr Rose met occasionally with Dr Bassilious and in Mr Rose's own practise he observed and followed IRMER. Unfortunately Mr Rose failed to check and assure himself that this was the case in respect of the rest of the dentists working at the practice, and placed too much reliance on Dr Bassilious.

Mr Rose only attended the practice at weekends. It was understandable that as a young dentist he expected his senior colleagues to recognise and comply with their professional obligations. In these circumstances the Committee concluded that any falling short of proper professional standards was to a very great extent a result of inexperience and a failure to take appropriate advice; Mr Rose relied far too much on his senior colleagues. The Committee concluded that Mr Rose was not guilty of serious professional misconduct.

Mr Miller

Between 27 August 2002 and 9 September 2005, Mr Miller was employed as a locum to Mr Roger Brown at the CAC and as an assistant at St Marks Dental Practice. He attended the CAC for one Friday session per month and also saw patients at St Marks, carrying out a total of 16 sessions at the CAC, seeing on average 20 patients per session.

Mr Miller caused panoral radiographs to be taken of two patients before he had clinically examined them. He also caused an inappropriate claim to be submitted to the Dental Practice Board for them in Mr Brown's name. The Committee also found proved that four radiographs were taken without sufficient clinical justification. The dental records of two of the patients should have contained a clinical record of the radiographs taken, but did not do so. This raised the risk that further unnecessary radiographs would be taken.

While working at the CAC, Mr Miller acquiesced in a system whereby, in a significant number of cases, a patient would have a panoral radiograph taken before being clinically examined by a dentist, thereby risking unnecessary exposure to possibly harmful radiation without any diagnostic benefit. In permitting this, and taking radiographs which were not sufficiently justified, Mr Miller was not acting in the best interests of his patients.

The Committee found Mr Miller guilty of serious professional misconduct. However, the Committee also took into account the delay since these matters had arisen and the inevitable effect on him of such prolonged proceedings. It was clear that Mr Miller was not involved in establishing the inappropriate system and was let down by senior colleagues who should have ensured that he was informed about the requirements of good practice in this country. There were no concerns raised about his general standards of dentistry, and the Committee noted that his continuing professional development included courses related to radiography. The Committee decided it was appropriate to conclude the case without making any direction which would affect Mr Miller's registration.

Mr Kotzenberg

Between 7 May 2002 and 9 September 2005, Mr Kotzenberg was employed as an assistant to Mr Roger Brown at the CAC and the St Marks Dental Practice.

Mr Kotzenberg treated patients at the CAC and attended St Marks to treat patients on numerous occasions. He worked Monday to Thursday providing routine dentistry to the patients of the practice. He also worked some additional sessions (approximately three per month on Fridays and Saturdays) providing dentistry for sedated patients at the CAC.

The Committee found that in the case of two patients, one of which was a child under the age of ten, Mr Kotzenberg caused a panoral radiograph to be taken before he had clinically examined the patients.

It was determined that the radiographs were taken without sufficient clinical justification in eleven cases (five of whom were new patients). In respect of two of these patients, two panoral radiographs had already been taken within the previous three years, whilst in two other cases a panoral radiograph had been taken within the previous year. The dental records of three of the patients should have contained clinical records of the radiographs taken, but did not do so.

In relation to five patients, Mr Kotzenberg had caused to be submitted, in Mr Brown's name, a claim for payment to the Dental Practice Board which was inappropriate because the taking of the radiograph was not clinically necessary. In the cases of six patients, the radiographs taken were not of a satisfactory quality.

Finally, Mr Kotzenberg admitted that while working at the CAC, he had agreed to a system whereby, in a significant number of cases, a patient would have a panoral radiograph taken before being clinically examined by a dentist at the CAC.

At the beginning of the hearing, Mr Kotzenberg made full admissions on the great majority of the heads of charge and accepted responsibility for his actions. This was greatly to his credit. Mr Kotzenberg's failure to record the taking of radiographs and any evaluation of them in the patients' dental notes not only deprived any subsequent practitioner of important information, but also increased the risk that a further unnecessary radiograph would be taken. In the light of his failings, the Committee found Mr Kotzenberg guilty of serious professional misconduct.

The Committee took fully into account Mr Kotzenberg's frank acceptance that in many of the respects referred to above, his practice fell short of acceptable professional standards. This indicated full insight and gave the Committee confidence that having recognised his past shortcomings, he would in future observe the high standards required of all dentists in this country.

The Committee accepted evidence that Mr Kotzenberg had changed his approach and now followed best practice.

The Committee noted that Mr Kotzenberg was not responsible for instituting the policies and practices which led to his appearance before it. He was entitled to expect from his senior colleagues both guidance as to the appropriate standards that should be observed in this country, and an example which he could follow. He received neither. In those circumstances the Committee decided to conclude the case.

CROWE, Catherine Fiona (Registration number 61847)

This case concerned the treatment given by Mrs Crowe to one patient from September 2004 to March 2005. The complex nature of the case and the evidence presented to the Committee resulted in the case being heard over a period of 18 days in three separate sittings.

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The patient was referred to Mrs Crowe in September 2004 for treatment to resolve problems of pain in her jaw and concerns about the alignment of her teeth. Mrs Crowe provided treatment to the patient on a private basis over a period of more than six months, at a cost in the region of £12,000. The patient was a vulnerable patient who had sought treatment from a number of dental practitioners without resolution, prior to consulting Mrs Crowe.

Mrs Crowe admitted a number of the allegations against her, and the Committee found all but two of the other allegations proved. In summary, the Committee found it proved that Mrs Crowe:

- provided information about her practice which misleadingly implied she possessed specialist status;
- did not explain adequately to the patient that her treatment plan would use dentistry which was non-orthodox, not evidence-based and not mainstream;
- caused the patient to undergo a test procedure which did not provide diagnostic information relevant to the patient's presenting complaints;
- did not provide the patient with a written treatment plan for the investigations and treatment which were to be carried out, nor adequate information about the likely costs involved, when these were requested on several occasions;
- failed to gain the patient's informed consent to her use of techniques of somato-emotional release and 'PK' (psycho kinesiology) treatment, which Mrs Crowe was not adequately qualified or experienced to undertake;
- failed to gain the patient's informed consent for her investigation and treatment of the patient's abdominal pain, which Mrs Crowe was not adequately qualified or experienced to undertake;
- failed to gain the patient's informed consent to a mercury detoxification programme;
- provided advice which was inappropriate, irresponsible and not in the patient's best interest, with regard to the mercury detoxification programme and a dosage of a substance used in that programme; and
- gave the patient the misleading impression that she was communicating with the patient's deceased mother during the course of a 'PK' treatment procedure.

Given these substantial breaches of the ethical guidance applicable at that time, the Committee found Mrs Crowe guilty of serious professional misconduct. The Committee was concerned, not with the adjunctive treatments themselves, but with Mrs Crowe's failure to draw the boundaries between those treatments and dentistry. It was also concerned over the levels of her qualification and experience in identifying and treating conditions which may not have had their origins in dental problems.

There had been no criticism of the standards to which Mrs Crowe performed mainstream dental procedures, and other professionals and patients had spoken highly of her skills and approach. The Committee accepted that her motives were good and that in her own mind she was well-meaning and caring.

However, it was clear to the Committee that Mrs Crowe lacked insight into the failings in her practice. She did not adequately address the dental problems with which her patient presented, but sought to treat conditions which were outside her area of competence. The Committee neither saw nor heard from Mrs Crowe any acceptance of fault, nor any contrition or apology for her actions. It concluded that Mrs Crowe did not have a proper understanding of the appropriateness and the limitations of the procedures and techniques which she was applying, but accepted the teachings of others uncritically. The Committee considered that Mrs Crowe had an inflated and somewhat arrogant perception of her own competence in those areas. Taken together, those failings could put her patients at risk. The Committee believed that, although Mrs Crowe genuinely believed that adjunctive therapies would benefit her patient, she misguidedly allowed her enthusiasm for those therapies to cloud her judgment about the boundaries between those therapies and her responsibilities and role as a dentist.

The Committee decided to suspend Mrs Crowe's registration for a period of four months, with a review of her suspension at the end of that period. The Committee also made it clear that it expected Mrs Crowe to take relevant and suitable actions prior to the review hearing, and strongly advised her to:

- make arrangements to enter into the Adverse Risk Member programme of Dental Protection Limited at the earliest opportunity;
- liaise with her local Postgraduate Dental Dean to develop a personal development plan aimed at a programme of education and learning to remedy the deficiencies found in her practice;
- redraft her practice information; and
- consider how best she could convince the Committee at the next hearing that she would achieve an appropriate balance between mainstream dentistry and adjunctive treatments in her practice in future.

The Committee would then have the options of concluding the case, imposing conditions on her registration, or suspending her registration for a further period.

EDGAR, Martin John (Registration number 52320)

The allegations against Mr Edgar were founded on the treatment he provided to Patient A between March 2000 and October 2004 commencing with a failure to record or maintain an adequate medical history. At the first appointment he made a speedy diagnosis and advised the patient that her cranio-mandibular disorder (CMD) was the cause of her pain and dysfunction, that she would require appliances and composites and that it would take about 18 months to treat her condition.

Mr Edgar then treated Patient A by way of the application of composites, the use of orthodontic appliances, splints and abrasive occlusal adjustment (equilibration), without informing her of alternative approaches. He did not inform her of informed evidence-based opinion supporting either taking no action, or conservative non-invasive treatment. Neither did he inform her of all relevant risks involved in his chosen treatment.

Patient A was not told that many healthcare practitioners would not regard his approach as mainstream, nor that there was no informed evidence-based opinion to support his choice of treatment. Accordingly, the Committee determined that Mr Edgar carried out the treatment without obtaining the patient's informed consent. He was also found to have caused the patient prolonged and unnecessary pain.

Mr Edgar also told Patient A during the course of her treatment that she would get cancer because her system was compromised and without the provided treatment her scoliosis would have worsened. His statements were unprofessional, inappropriate and misleading and he caused alarm to Patient A.

Although Mr Edgar advised Patient A in April 2000 that the treatment would take about 18 months to address her problems, he continued to treat her for over 4 years. He carried out two processes at the same time, and stated in evidence that he was keen to push the boundaries. He accepted that he broke chirodontic protocols. He failed to carry out a reassessment of Patient A's condition.

When Patient A raised the possibility of obtaining a second opinion Mr Edgar informed her that other practitioners "did not understand CMD" and would not believe she was in pain.

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During early 2003 Mr Edgar took various radiographs which were not justified or evaluated and which the Committee found neither to be clinically indicated nor in the patient's best interests. In September he attempted to dissuade Patient A from attending an appointment at the Maxillo-facial Unit at Derbyshire Royal Infirmary. Early the following year he told Patient A not to take Nortryptilene which had been prescribed by Derbyshire Royal Infirmary. He also told Patient A that she could not stop seeing him for treatment (which she had by then suggested) because her splint needed to be equilibrated constantly.

The Committee found that Mr Edgar's conduct was, on numerous occasions, unprofessional and not in the best interests of the patient. He put her dental health at risk and at times misled her in relation to the knowledge and ability of other dental practitioners. The statements he made regarding the patient's risk of contracting cancer and in relation to her scoliosis worsening, were unprofessional, inappropriate, potentially alarming to the patient and misleading.

The Committee was not concerned with the merits of chirodontics against conventional dental practice, rather they focused on the extent to which Mr Edgar failed to adhere to appropriate protocols and standards.

In March 2004 Mr Edgar initiated an intimate relationship with Patient A at a time when she had become wholly dependent on him. He justified this relationship by claiming that he was in love with Patient A. Considering the vulnerability of the patient, the Committee held that Mr Edgar's conduct could not be justified, and accordingly found him guilty of serious professional misconduct. In light of Mr Edgar's numerous breaches of ethical standards and his inexcusable behaviour in relation to Patient A, the Committee further determined that he was fundamentally unsuitable to remain on the Dentists Register, and erased him.

ZIAIE-TABARI, Taraneh (Registration No 81544)

On 14 July 2005 Ms Ziaie-Tabari became aware that one of her patients was unable to pay for the treatment she had performed that day. She then removed crowns that she had just fitted on the patient's lower right 5 and lower right 6 teeth. A post and core also came out. Further allegations concerned a poor quality radiograph resulting in missed pathology, poor record keeping, substandard treatment in failing to identify decay, failing to ensure good root fillings for the two crowns and the provision of the poorly fitting crowns.

The Committee found that Miss Ziaie-Tabari did not act in the patient's best interests, nor did she provide the high standard of care the patient was entitled to expect. Removing the two crowns because the patient could not pay at that time was deemed by the Committee to be "grossly inappropriate, unprofessional and absolutely the wrong thing to do."

With regard to the other failings, at the first examination of the patient in September 2004 Miss Ziaie-Tabari should have taken a full medical history, inspected and charted the patient's teeth, carried out a basic periodontal examination, examined the patient's oral mucosa, assessed the occlusion and taken bite-wing radiographs. Had she done and recorded these, the failure to identify the presence of the patient's dental decay and adverse pathology, the quality of the root fillings and the poor fit of the crowns could have been avoided. Based on all the above, the Committee found Miss Ziaie-Tabari's fitness to practise impaired by reason of her conduct.

The Committee was told that in September 2004 Miss Ziaie-Tabari was a relatively inexperienced dentist unfamiliar with practice in the United Kingdom. She joined and subsequently purchased a practice in a deprived urban area. The negotiations and purchase of the practice placed her under considerable pressure. It was also clear from the evidence that Miss Ziaie-Tabari was dealing with a challenging patient. There was evidence from the primary care trust (PCT) that Miss Ziaie-Tabari had made efforts to develop her practice and that she was providing a valuable dental service to a deprived and challenging population. There was also evidence from the Associate Postgraduate Dental Dean about how Miss Ziaie-Tabari was addressing, with the Dean's advice and support, the clinical weaknesses in her practice.

The Committee gave Miss Ziaie-Tabari full credit both for her insight, unreserved apology to the patient and full and frank admissions. The Committee imposed a series of conditions on Miss Ziaie-Tabari's registration for a period of twelve months, with a hearing to review those conditions at the end of that period.

LEARNING POINTS

Unorthodox, unproven or non-mainstream treatments

Between May and August of this year, the Professional Conduct Committee dealt with two cases in which the use of unproven or unorthodox treatment of patients formed part of the charge.

The issue of the patient's informed consent was a feature in both cases. The Committee took the view that unless a patient is fully aware of the lack of evidence for, or the non-mainstream nature of a treatment, there can not be said to have been informed consent for the procedure.

The extent of the dentist's knowledge and experience in the area was also a concern. The issue was the risk that patients would present with problems that needed treatment, but that the dentist applying the non-mainstream approach might not have an adequate level of knowledge to apply it appropriately. Also, the mixing of alternative treatments with mainstream dentistry could potentially raise issues regarding how to properly police their use. The Committee tended to take the view that the lines between such treatments and dentistry must be clearly drawn.

Due to the particular circumstances in both cases, the Committee determined that the use of unorthodox treatments was not justified or suitably applied. However, it was not said that dentists are strictly prohibited from using such treatments; instead, they must ensure they are properly qualified, obtain full and informed consent, and keep such therapies separate and distinct from their licensed and mainstream practice of dentistry.

Radiography

The Professional Conduct Committee (PCC) repeatedly hears cases involving the lack of appropriate radiographs for diagnostic purposes. However, recently, the overuse of radiographs has been an issue. In recent determinations, Committees have stressed that radiographs must be clinically justified and should only be taken on the prescription of a dentist after clinical examination. They should always be evaluated and clinical records made.

The Ionising Radiation (Medical Exposure) Regulations are the governing guidelines in this area. The importance of knowing and applying these regulations has been repeatedly emphasised. It has been argued by some respondents that the risks of repeated exposure to the radiation levels involved in the taking of x-rays are overstated. Supporting authorities and studies have been presented to defend this standpoint. However, the determinations of the PCC have been clear in stating that radiographs must be taken after a clinical examination has occurred and a proper justification has been given. Radiographs should not be taken as a matter of routine.

The PCC is clear on the point that dentists must adhere to the guidance and regulations on radiography. Dentists must ensure the facilities used and processes applied are all geared towards identified treatment needs and the well-being of patients. Falling short of the standards and thereby putting patients at risk can often lead to a finding of misconduct and impairment of fitness to practise.

DATES FOR THE DIARY…

For more details of any of these meetings, hearings and events, please visit the events section of our website.

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