Blue on blue

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Nearly one in ten referrals to the General Dental Council (GDC) are from other registrants asking for an investigation into the behaviour or conduct of a colleague, which the military call friendly fire or blue on blue.

These referrals are not always to protect the public and are driven by other motives such as professional disputes or financial gain.

The GDC has a statutory obligation to investigate these blue on blue cases but many of them should not have ended up there in the first place.

Abstract

This Opinion article looks at the surprising number of referrals to the General Dental Council (GDC) fitness-to-practise process by other colleagues. Whilst some of these are undoubtedly genuine referrals to protect the public, essentially whistleblowing, many others are used as weapons in inter-professional disagreements or as part of financial disputes. The GDC is unable to distinguish between these referrals on the basis of the complainant's motives. Registrants should think twice about using the GDC for this reason and the profession should offer alternative avenues to resolve these matters.

It may come as a surprise to learn that 9% of all cases referred to the General Dental Council's (GDC) fitness-to-practise process were from other registrants.[1] This figure has increased from 7% in 2015. In comparison, 57% of cases come from patients and 4% each from self-referrals and the NHS among other sources. (The total figures are 57% patient, 9% registrant, 7% GDC, 7% other informant type, 4% self-referral, 4% anonymous, 4% NHS, 3% member of the public, 3% employer, 1% other public body <1% police or other investigatory body.) This increase represents a great cost to the GDC and ultimately to the registrants.

This raises some challenging issues. At one end of the spectrum there is the well intentioned, virtuous whistle-blower raising concerns, driven by moral rectitude and desirous only for the protection of patients. Their motivation is never in any doubt and for a few there is some peril to themselves, their family or their livelihoods in raising these concerns so publicly. Recent history has demonstrated serious failures in healthcare that have that have only seen the light of day through the courage of whistleblowers where silence and inaction have otherwise prevailed.[2,3] Whistleblowers do not fare well in the NHS.[4,5] There are more notorious whistleblowers in wider society that claim the moral high ground and justify their self-sacrificing actions as being for the greater good. We can debate at length whether Edward Snowden[6] and Julian Assange[7] are heroes or villains.

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Whistleblowing

The real whistleblowers don't necessarily recognise or articulate the course of action they are taking on moral terms or in terms that appreciate the risks they are taking. They do it because instinctively they know it is the right thing to do. They don't want recognition, praise or plaudits. This Opinion article is not about those people who struggle with their conscience and the everyday real ethical dilemmas they face. I have the utmost respect for them and celebrate the good faith in which they make their referral.

What is more problematic is where referrals to the GDC's fitness-to-practise procedures are made by registrants about other registrants and the motive and patient safety concerns are spuriously intertwined to lend credence to a complaint. The challenge for the GDC is to disentangle these disingenuous referrals from the real ones because at face value they look the same. Motivation is what distinguishes them from each other but no one ever really gets to make that judgement until the case is well on its way. And even then it is hard, partly because of the rigid statutory nature of the ways in which the GDC can currently deal with such cases.

'Impure' referrals

In a number of cases investigated recently and in some on-going instances, the motivation behind the referrals is far from pure. Three practices together have generated over 30 cases (many of which remain live) that have cost the GDC more than £230,000 in fitness-to-practise costs alone and include DCPs and dentists referring each other. In one particular practice there have been 12 referrals regarding three practice registrants over a three-year period. While one of these cases has resulted in a warning, none of the others have, as yet, resulted in any sanction.[8] These don't involve patients raising complaints directly.

There are a number of variations of the same theme that characterise these referrals. In essence it is not purity of patients' best interests or the concern for the public at large or indeed

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the reputation of the profession but less noble reasons – such as revenge, greed, self-defence, malice, hatred, pecuniary advantage and anger.

Not emotions you might necessarily associate with reasons for referral to the GDC – not from other registrants in any case.

But when you take even a cursory look at the cases currently on the books of the GDC occupying this blue on blue space it is not difficult to discern the underlying motives when you have several registrants in the same practice referring each other sequentially. These are ostensibly colleagues working with each other in the same practice using the GDC as a potent weapon in an armoury employed to intimidate, cower or retaliate in a local professional dispute using patients, personal conduct and morals as the ammunition in the war.

What is the cost?

It cannot be right that professionals, in a dispute with each other for whatever reason, should, by way of the GDC, up the ante in their internecine battles. This is wrong on so many fronts. The first and most obvious is the flagrant abuse of the funding provided by registrants for the regulation of the profession. The annual retention fee has been challenged on many occasions and while its quantum has always been the source of irritation for the profession, in most cases, its purpose has not. In the arena of regulation, it is directed at protecting the public from registrants whose fitnesstopractice is impaired for reasons mostly to do with patient care. It is not there to weaponise a professional dispute.

The difficulty for the GDC is how they discriminate between the genuine referral by a registrant for investigation where harm or potential harm has occurred and those driven by other motives.

They start the same way and enter into the GDC system along an identical route. A well-worded, persuasive letter setting out the transgressions of another fellow registrant, citing numerous breaches of the Standards for the dental team guidance and imploring the GDC for the sake of the public, patients and profession to do their lawful duty to investigate and preferably punish the wrongdoer. Or at least remove them from doing any (further) damage to the public at large. There is a veneer of plausibility in these referrals. Hard then to tell which is genuine and which has at its heart other less virtuous reasons than the altruism the referral claims for itself. There is often no specific patient's complaint that accompanies the referral. Sometimes, in particularly toxic disputes, a patient, normally a friend, relative or colleague is enlisted to be the lever in ramping up the emotional temperature and moral hazard of the case. These complaints are well crafted to trigger the buttons that take this through the assessment stage and into the fitness-to-practise machinery,

In these situations, the GDC is powerless to do anything else but exercise their statutory duty to investigate the case. Justice is blind to the motivation of these cases and while case workers and senior members of the fitness-to-practise team may suspect foul play, it might only be a full hearing of the Professional Conduct Committee that could come anywhere close to cross examining the various parties to establish the rationale and evidence behind the referral. Airing dirty laundry is not the most edifying spectacle for the public or other registrants to witness.

Rules as a profession

Perhaps we ought to establish some ground rules for ourselves as a profession. If we have a particular concern about the conduct, performance or capability of a colleague and patient safety is genuinely at risk from any objective perspective, then go ahead and consider a referral to the GDC. But only do so after consulting other colleagues, your indemnity provider and professional organisation, such as Faculty of General Dental Practice and British Dental Association (BDA). Obviously address the issue directly with the registrant themselves or use an intermediary where appropriate such as a colleague from the Local Dental Committee or a PASS programme (Practitioner Advice and Support scheme) where a such a scheme exists. If, having canvassed sufficient opinion you feel the weight of opinion leans towards a referral to the GDC and your motives for doing so are not self-interest then consider making the referral. If on the other hand there is a way to manage this locally and patient safety is really not an issue or is a remote risk, then this ought not to be referred to the GDC. Talk to your colleagues and try and find a more professional way to resolve what admittedly may be very difficult interpersonal conflicts.

The government response to the consultation *Promoting professionalism reforming regulation*[9] recognises that dispute resolution or mediation could resolve cases at an earlier stage where a full fitness-to-practise investigation is not required. While the government is anticipating this refers to patients' complaints this may well be the route for solving these inter-professional referrals. Other organisations such as Simply Health and the BDA have well established protocols to organise mediation between disputing parties.

The solution does not really lie with the GDC unpicking these cases as they come through the door though with more flexibility provided by reforming primary legislation this might be easier. The answer lies instead with the profession itself dealing with its own problems without getting the regulator involved. It behoves us right-thinking dentists to get our own house in order and change these statistics for the good of patients, the public and the dental profession.

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