TABLE OF CONTENTS

KEY POINTS

PART A – RESPONSE TO DPBV QUESTIONS

1 Relationships and Definitions 5
2 DPBV Question 1 – What is the purpose of the Codes of Practice? 7
3 DPBV Question 2 – What health outcomes are being sought? 8
4 DPBV Question 3 – What type of regulatory framework should exist for dental auxiliaries? 9
5 DPBV Question 3.1 – What role should each auxiliary have? 9
6 DPBV Question 3.2 – Should the role be defined by a prescribed list of duties or defined by education and training? Is there another method? 11
7 DPBV Question 3.3 – Is supervision of dental auxiliaries necessary? If so what form should it take? 12
8 DPBV Question 3.4 – Is it necessary to define patient groups for each auxiliary? 13
9 DPBV Question 4 – How could flexibility be built into the model? 14
10 DPBV Question 5 – How could the resulting Code of Practice be evaluated? 14
11 DPBV Question 6 – What review period should apply to the recommended model? 15
12 Other matters 15

PART B - CODES ARE QUASI-REGULATION

1 DPBV Question 1 - What is the purpose of the Codes of Practice? 19
2 The Codes and Objectives under the Act 19
3 Codes not mandatory 20
4 Are Codes legislative instruments? 22
5 Regulatory Structure 23
6 The Parliament's view 23
7 Prescriptive Standards 25
8 Does a problem exist? 26
9 Accepted Standards 27
10 Regulatory flexibility 28
11 Compliance Costs 29
12 Legislated Powers 29
13 Codes and Guidelines 31
14 Standards under the New Dental Practice Act 1999 32

TABLE OF CONTENTS (cont'd)

APPENDIX 1 - Evidence based on sound clinical research

1 Proving no harm 35
2 Treatment of School Children 35
3 The evidence based approach 35
4 Periodontal issues 36
5 Other Epidemiological Trends 38
6 Labourforce Reviews 38

APPENDIX 2 – Future Employment Intentions 41

APPENDIX 3 – Possible template for dental risk management guidelines or codes 43

APPENDIX 4 – Selected extracts from the Dental Practice Act 1999 45

APPENDIX 5 – Extracts: Occupational Health and Safety Act 1985 49

APPENDIX 6 – Extracts from OHS Code of Practice re Manual Handling 51

KEY POINTS

The ADAVB commends the Dental Practice Board of Victoria (DPBV) for undertaking a consultative approach to the development of Codes of Practice to be promulgated under the Dental Practice Act 1999[1]. We welcome the opportunity to make this first submission regarding the Codes generally, and the Review of the Interim Codes of Practice for Dental Auxiliaries in particular.

Key Issues:

- Auxiliaries are officially recognised as registered persons and their permissible range of activities should be **defined** in the delegated legislation. Additional duties beyond those presently prescribed, should only occur if there is adequate training, including clinical skills assessment.
- The Auxiliary Codes need to **prescribe** duties. There was very strong support from ADAVB members responding to the Branch survey, for maintenance of the requirement that both dental hygienists and dental therapists work as key members of a dental team, to a dentist's prescription. If there is no prescription and no requirement for on-site supervision, how could a dentist be held liable for the treatment provided by an auxiliary?
- Promotion of "access to dental care" is too limited an objective, since it fails to take account of whether that care is appropriate. "**Access to oral health**" would be a more suitable objective for the community to aspire to.

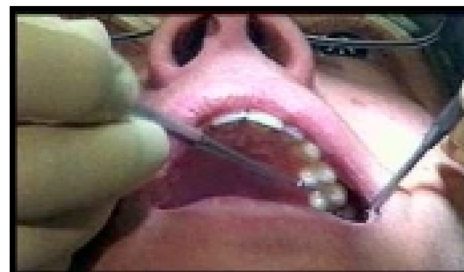
We argue that:

- A dental practice should provide patients with the most comprehensive examination, diagnosis and treatment plan options available before determining direct treatment by the dentist or the involvement of a specialist, an auxiliary, or other health service (e.g. medical practitioner, smoking cessation counsellor, physiotherapist or other relevant service provider). The complexity of dental conditions, and of the interaction of factors affecting the oral and general health of each person, requires that diagnosis and treatment planning be performed by the practitioner with the broadest scientific training – the dentist. It could also be dangerous to use a limited examination rather than formal diagnosis before determining the appropriate treatment/s. A limited examination cannot determine a complete diagnosis.
- NHMRC guidelines[2] on consent indicate that a patient must be provided with the information necessary to assist them in consenting to their treatment. Information concerning treatment options, risks and likely outcomes, needs to be provided.
- We have consistently maintained that because of the information asymmetry between the public and the dental profession, a high level of regulation is required in the interests of public health and safety. There is a **public risk** associated with lack of definition of duties, because the auxiliaries may, either voluntarily or under direction, perform procedures that are beyond their skill and training, and which compromise the health of the patient. This form of self-regulation has failed in other areas, such as cosmetic surgery.

- Only 2 out of 633 ADAVB survey respondents supported hygienists working without prescription and supervision by a dentist, whilst only 10 out of 623 supported this for dental therapists.
- The training provided to auxiliaries is limited in its scope, and these limits should be reflected in a clearly defined list of the duties they may perform under specified conditions. As it is difficult for the public to assess the claims to expertise of "dental professionals", regulatory provisions need to make their work boundaries clear.
- Under the definition of unprofessional conduct within the Dental Practice Act 1999[1], it will be an offence if a person provides "dental care that the provider is not registered to provide". Unless the Board defines those duties that each operative is registered to provide, there will be no basis for such a charge being brought. If no one knows what the operative is meant to do, then anyone can provide whatever treatment they like, and allege that this was not a breach of the Act.
- While prescription and supervision apply, dentists can exercise a risk management role under our professional indemnity arrangements, and accept joint liability for patient treatment. If not, dentists will not pick up the pieces, and should not be held accountable by the Board for auxiliary work.
- The definition of unprofessional conduct includes "*influencing or attempting to influence the conduct of a dental care provider's practice in such a way that patient care may be compromised*". In our view, failure to require dentists to prescribe patient care and to supervise an auxiliary would constitute **regulatory neglect**, and a failure to influence the conduct of an auxiliary dental care provider in such a way that patient care may be compromised. We should ensure that the future dental workforce is comprised of teams that use the skills and knowledge of their members effectively in patients' interests. If the Codes do not define dentists as leaders of such teams, there will be no team approach.
- The needs of elderly people as regards access to dental care, especially those in residential care, require attention. The ADAVB supports additional preventive duties for dental hygienists and special supervision arrangements to address this problem.
- Fragmentation of dental care providers is ultimately against the public interest, and promotion of an effective dental team, with appropriately defined relationships between the various operatives should be our focus. The small cost gains achieved by introducing competition are ultimately lost, as is the continual exchange of scientific knowledge necessary to improve public health outcomes.

We recommend

- **That auxiliary duties be listed in the Code, and that auxiliaries work to the written prescription and under the supervision of a dentist.**
- Adjustment of dental hygienist duties and supervision to make them more responsive to community access needs, especially for the elderly. (See Part A, section 5 for details).



PART A – RESPONSE TO DPBV QUESTIONS

1 Relationships and Definitions

Before responding to the Board's focusing questions, it is necessary to establish the ADAVB view about the relationship between auxiliaries and dentists, as a basis for defining key terms and concepts referred to throughout this discussion.

1.1 Roles and Relationships

- The needs of the patient and the protection of the public are of paramount importance. Patients are entitled to have access to high quality care, and should not receive inferior or unsafe treatment due to lack of workforce planning or inadequate labourforce management.
- Auxiliaries are complementary to, and not a substitute for, dentists. They perform valuable work in the dental team, helping patients to achieve optimal oral health.
- The overall quality of treatment received by patients should be distinguished from the quality of delivery of particular services. The ADAVB recognises that auxiliaries do perform services of quality.
- A dentist is responsible for the safety and well-being of each patient undergoing treatment and for both the quality of the dental service provided and its outcome, whether it is provided personally or delegated to an auxiliary.
- As the leader of the dental team, and the person ultimately responsible for the patient's diagnosis, treatment and welfare, the dentist may delegate some elements of treatment by prescription to auxiliaries under direct supervision. Alternatively, they may choose to treat the patient themselves, to refer the patient to a specialist or to another health care provider appropriate to the patient's particular needs.
- Dentists and auxiliaries must have an understanding of each other's roles within the dental team. The dentist's role as team leader, and as the practitioner with the broadest diagnostic and treatment skills, should be recognised by auxiliaries as guiding the oral health care of patients in their best interests. Equally, the training and skill of auxiliaries should be recognised by dentists as entitling auxiliaries to respect and acknowledgment as health practitioners. This understanding must preclude auxiliaries performing duties for which they have not been trained.
- Auxiliaries are officially recognised by registration, and their permissible range of activities should be defined in the delegated legislation. Extension of duties beyond those presently prescribed, should only occur if there is adequate training, including clinical skills assessment. See also comments under section 4 of this Part below.

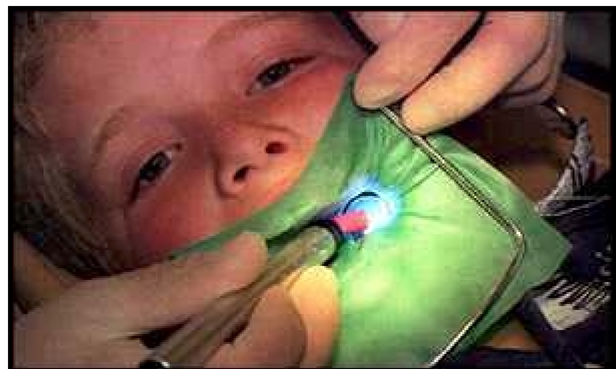
In the interests of patient health and safety, the dentist should prescribe and supervise in the following manner

- **only delegate procedures the auxiliary is registered, and so trained, to perform**
- **give adequate written instructions to the auxiliary to ensure that the procedures and treatment to be performed are documented and understood**
- **check the patient after the course of treatment to ensure that all delegated procedures have been performed satisfactorily, and**
- **be available for consultation and management of complications that may occur.**

1.2 Definitions

The evidence to be presented has to be based on **"sound clinical research"**. Clinical research we take to mean, studies that have monitored the health impact of various approaches to treatment by different operatives, working under differing regimes. There is no authority in Australia that performs such research, and only occasionally will a study appear either locally or overseas, that might have some bearing on the issues under consideration. Sound clinical research means that the studies should be double blind refereed studies, that conclude with objective findings, unaffected by political bias.

The other key phrase within the quoted remark is that the evidence must show that "removing the restriction will **not** endanger the public health and safety". The clinical research, in which health outcomes for a large number of patients have been assessed, must therefore have measured the extent to which people were **not harmed** when restrictions were removed. Benchmark data is not going to be easy to find for any such study. (Further comments about research appear in Appendix 1).



An approach based on clinical evidence was used when the original restrictive provisions were imposed, and indeed there was agreement at the time that operative auxiliaries were necessary to help deal with the caries epidemic then plaguing the community. The dental profession supported the use of dental therapists to address the treatment needs of children and we had to wait until 1977 before fluoridation was implemented for most Victorian water supplies, and the next most significant attack on dental disease rates occurred. Since that time, with the benefits of fluoridation in most parts of the State, and improved oral hygiene generally in the community, caries rates have dropped significantly, so that the need for a restorative auxiliary is now pretty much isolated to areas that are not fluoridated, or where socio-economic factors contribute to poor oral hygiene.

"**Prescription**" means the written instructions provided by the dentist, including directions on the treatment to be provided by auxiliaries to particular teeth and their supporting structures. It also includes written instructions for the construction of a prosthetic dental appliance by a laboratory, and for the preparation, composition and administration of medications by a pharmacy.

Such prescription of treatment requires that the dentist has first performed the initial examination, provided a diagnosis and treatment plan, and obtained patient consent. It also requires that the dentist will check the work undertaken by the auxiliary (or laboratory) on its completion.

"**Direct Supervision**" means supervision of dental treatment provided by auxiliaries following the written prescription of a registered dentist, and with a registered dentist physically present in the treatment facility during the performance of those procedures.

2 DPBV Question 1 – What is the purpose of the Codes of Practice?

Following consultation with the CEO of the Board, the ADAVB understands this question is intended to deal with any and all Codes of Practice that may be adopted by the Board under the provisions of the Dental Practice Act 1999[1], rather than being limited to the Interim Codes for Dental Auxiliaries. The Board has also advised in personal communications, that the present Issues Paper[3] is a prelude to the distribution of new draft Codes of Practice regarding Dental Auxiliaries, which will be subject to a further round of consultation later.

One interpretation of the purpose of Codes of Practice is that they are risk management guidelines, designed to explain to practitioners means by which "to minimise the community's exposure to health risks in dental care" as the Board is required to do under s 69 of the Dental Practice Act 1999. Further discussion of the principles and dimensions on which such risk management guidelines might be constructed appears at Appendix 3.

In Principles of Good Regulation[4], published by the Victorian Office of Regulation Reform, the need for regulatory action is discussed in terms of the following guidelines:

> *"the Government's regulatory reform policy is based on the premise that governments should not use regulation unless it has clear evidence that:*
>
> 1. *a problem exists*
> 2. *government action is justified, and*
> 3. *regulation is the best alternative open to the Government".* (p. 4)

In order to answer the question about the purpose of the Auxiliary Code therefore, we offer the following definition of the problems justifying regulatory action in the form of a Code, and an objective by which to focus its development.

THE PROBLEMS

- **In seeking and obtaining dental treatment, the public needs to be adequately informed about who is treating them, and any limitations on the duties able to be performed by auxiliary personnel.**
- **They also need to know that their dental health care will take into account their general health, and that any dental disease or condition requiring treatment will be accurately diagnosed and advised.**
- **The public must have confidence that if their treatment needs are more complex than those that can be addressed by an auxiliary, they will be safely treated by a more appropriately qualified dental care provider or referred to another appropriate health service provider.**
- **The public needs to be protected from opportunistic behaviour by unscrupulous operators, and clear boundaries need to be set to avoid over-servicing and/or fraud.**
- **Nursing home residents, and other special needs groups who cannot attend dental surgeries, require access to mobile or domiciliary services.**

THE OBJECTIVE

- **To specify and limit the duties able to be performed by dental auxiliaries and the prescription and supervision arrangements under which they may safely operate, whilst not unduly restricting access to care.**

In the light of these problems, we believe that government action, in the form of a Code of Practice determined by the Board, is justified in the public interest.

The ADAVB's consideration of the question regarding the purposes of Codes of Practice generally, revealed a range of complex issues. Rather than addressing these within the main part of the submission, a separate paper has been prepared, and provided as Part B of this submission. Our strong view that the Codes are legislative instruments because of their nature and effect, is argued at length in Part B.

3 DPBV Question 2 – What health outcomes are being sought?

We assume this question applies to the dental auxiliary code in particular rather than to all codes (as was the case in Question 1).

The objectives enshrined in the Dental Practice Act[1] determine the key health outcomes that can be addressed by the Codes, since the Codes can only legally address matters justified under the regulatory delegation by Parliament to the Board. Further comment on this appears in Part B section 2 - The Codes and Objectives under the Act.

Obviously, dental care providers all seek good quality dentistry for everyone, and would therefore abhor the provision of unequal standards of care for the disadvantaged. It is not possible to regulate for this however, so the Act seeks instead to minimise the risk to public health and safety, and to promote access to care.

In terms of public health objectives, we would also agree that provision of comprehensive oral health care is a desirable outcome, along with reductions in edentulous, dmft and DMFT rates, and enhancement of the control people exercise over their own dental and therefore general health, in line with the Ottawa Charter for Health Promotion[5]. Discussion of periodontal and other epidemiological issues affecting desired health outcomes appears in Appendix 1.

4 DPBV Question 3 – What type of regulatory framework should exist for dental auxiliaries?

The regulatory framework should be built on the foundation provided by the Act and Regulations, since a Code can only be used under the authority granted by these legislative instruments. The approach required to the Code is one predicated on the concept of an effective dental team lead by a dentist, who is responsible for the overall welfare of the patient.

The ADAVB argues that the Auxiliary Code of Practice must provide that:

- the two types of operative dental auxiliary are defined
- two-year courses of training are prescribed
- the dental auxiliary's duties in relation to dentistry are clearly specified in a listing of prescribed duties and that there is an obligation upon employers to ensure prescription and supervision by a dentist, and that a dentist is on the premises at the time treatment is provided.

5 DPBV Question 3.1 – What role should each auxiliary have?

The dominant message from the ADAVB survey responses concerning duties to be assigned to each of dental hygienists and dental therapists, is that **the present listing of duties should be retained**. This was supported by an overwhelming majority of respondents to the survey. The highest level of support for the elimination of any of the current duties from the lists assigned to hygienists and therapists, was less than one third.

A. Dental Hygienist Training. Duties and Conditions

- The training of a dental hygienist should comprise a two-year, post year 12 Diploma, with prevention, fissure sealing and periodontology as the main areas of training.
- The duties of a dental hygienist must be directed towards prevention and control of dental disease. Recommended changes to current duties are highlighted below.
- Treatment services provided by a dental hygienist must be provided in accordance with a written prescription which has been signed and dated by a dentist who has personally examined the patient. The treatment plan embodied within the prescription should be effective for not more than twelve months. Patients treated by a dental hygienist must be examined by a dentist at appropriate intervals.

Interim Code of Practice 004: Duties of a Dental Hygienist

Subject to the provisions of the Dental Practice Act a registered hygienist may under the **prescription and** supervision~~, direction and control~~ of a dentist, do the following:

(a) carry out established procedures associated with chairside assisting and practice management
(b) dental health education
(c) topical application of solutions to teeth or oral tissues
(d) pre and post operative instructions

(e) measurement and recording of periodontal disease
(f) removal of plaque, extrinsic staining and calculus from teeth
(g) root planing
(h) cleaning and polishing of teeth and restorations
(i) application and removal of periodontal packs
(j) orthodontic band selection
(k) removal of orthodontic archwire
(l) placement of non-metallic separators
(m) preparation of teeth for bonding by scaling and polishing but not etching
(n) removal of orthodontic cement
(o) routine checking for loose bands and broken appliances
(p) taking of impressions for study casts
(q) taking of peri-apical and bitewing radiographs
(r) application and removal of rubber dam - ADDED
(s) application of non-invasive fissure sealants - ADDED
(t) maintenance of accurate and contemporaneous treatment records - ADDED
(u) irrigation of the mouth - ADDED

B. Dental Therapist Training. Duties and Conditions

Survey results indicate that those duties that are most supported for dental therapists are those that are preventively oriented, whilst those that were suggested for elimination from the list, are those involving higher risk to the patients such as administration of analgesia, extractions, cavity preparation, restoration of teeth. We recommend that the examination duty should be replaced with the collection of data following initial examination, as directed by the dentist who performs the initial examination and provides the patient with information about the options, risks and prognosis, on which they will base their consent.

- A dental therapist must work under the supervision of a dentist. Treatment services provided by a dental therapist must be provided in accordance with a written prescription, which has been signed and dated by a dentist who has personally examined the patient. As for the dental hygienists, such a treatment plan should be effective for not more than twelve months. Patients treated by dental therapists, must be examined by a dentist at appropriate intervals.
- The duties of a dental therapist should be directed towards prevention and control of dental caries in pre- and primary school children.

Interim Code of Practice 002: Duties of Dental Therapists

A registered dental therapist may, under the **prescription and** supervision~~, direction and control~~ of a dentist, do the following:
(a) carry out established procedures associated with chairside assisting **and practice management - AMENDED**
(b) dental health education
(c) ~~dental examination~~ **collection and recording of data following initial examination by a dentist**, ~~including the taking of dental radiographs~~ (see p. below) - **AMENDED**
(d) removal of plaque, extrinsic staining and calculus from teeth

(e) topical application of solutions to teeth or oral tissues
(f) administration of infiltration and inferior dental nerve block local analgesia
(g) application of rubber dam
(h) preparation of cavitis in teeth
(i) restoration of teeth by dental amalgam, cement or composite resins, excluding endodontics
(j) recontouring and polishing of dental restorations
(k) **direct** restoration of deciduous teeth by preformed crowns - **AMENDED**
(l) forceps extraction of deciduous teeth under local analgesia
(m) pulp capping of teeth and pulpotomy of deciduous teeth
(n) placement of pit and fissure sealants
(o) pre- and post-operative care
(p) **taking of periapical and bitewing dental radiographs** - **AMENDED**
(q) **maintenance of accurate and contemporaneous treatment records** - **ADDED**

6 DPBV Question 3.2 – Should the role be defined by a prescribed list of duties or defined by education and training? Is there another method?

If the Interim Code regarding infection control requirements had not incorporated the NHMRC[6] and Standards Australia[7,8] **prescriptive** standards it would be difficult to prosecute practitioners for a breach. As regards the setting of precedents therefore, had the Board commenced the development of Codes by publishing the Infection Control Code, all remaining Codes might have become prescriptive in nature.

Prescription of treatment by a dentist after their own initial examination, diagnosis and treatment planning is strongly supported by the dental profession, but this depends on regulatory prescription of the duties able to be performed. The operatives themselves, and their employers would find it difficult to be clear about the duties they were trained to perform without reference to a regulated list.

Some stakeholders have expressed the view that the Auxiliary Codes should be principles based, so that they simply suggest that the auxiliary personnel undertake the duties they have been trained to perform. We contend that this would be a mistake, since it would lead to a lack of clarity and certainty, and would also result in numerous practical and legal difficulties.

Rather than leaving the creation of this list to the training institutions (who might choose to vary them from time to time without consultation), the community needs the regulator to define the permissible duties with certainty. If it were left to training institutions to determine what auxiliaries **can** and **should** do, this would effectively move the regulatory function from the Board to the training institutions.

It would be inappropriate for a training institute to take upon itself the decision as what the auxiliaries should do. That task has been given to the regulatory body, so that they can decide how best the auxiliary can complement the work of the dentist. The Board is responsible for registering auxiliaries and for deciding what duties and tasks they **should** do, and this will permit training institutions to prepare auxiliaries who can do what has been set down in (quasi) regulation.

The above alternatives to defined duties would in fact be a form of self-regulation, which has been proven unsuccessful in areas such diverse areas as the airline industry, air-conditioning regulation and cosmetic surgery.

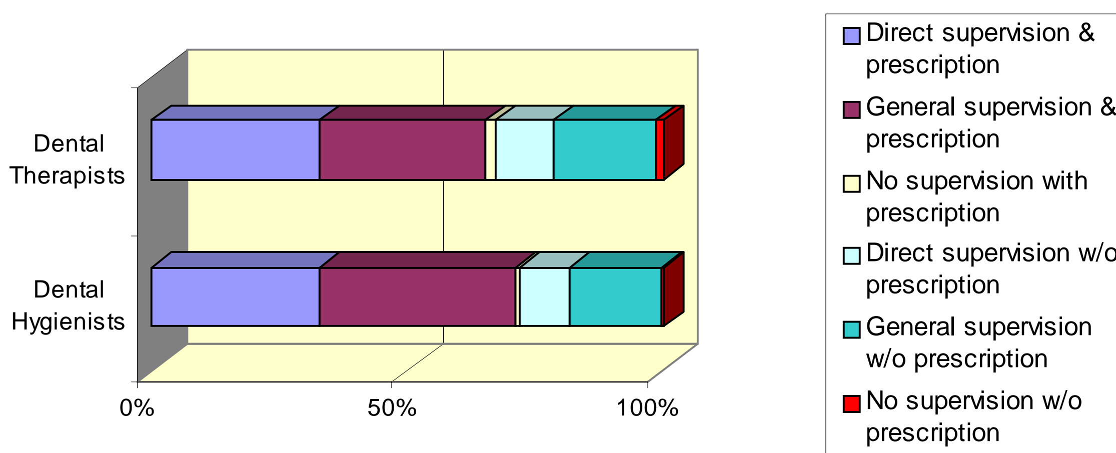
7 DPBV Question 3.3 – Is supervision of dental auxiliaries necessary? If so what form should it take?

Some form of supervision is required, so that any auxiliary who gets "out of their depth" is able to call upon a dentist to take over the treatment or to advise on the best course of action given the patient's particular circumstances.

The Interim Code 001 mirrors the previous Dentists Regulations[9], which required dental auxiliaries to provide treatment under the supervision direction and control of a dentist. The control element of this supervisory structure has been viewed with suspicion by some commentators, and the ADAVB is happy to replace this language with terms that more appropriately reflect the dentist's overall responsibility for the patient's welfare.

The dentist needs to conduct the initial examination and diagnosis as a basis for treatment planning, obtaining patient consent, and subsequent monitoring of the patient's condition. If they delegate some treatment to an auxiliary, they need to complete a thorough examination themselves as a basis for prescribing the treatment to be provided.

Respondents to the ADAVB survey very strongly supported both hygienists (71.88%) and therapists (67.26%) working to a dentist's prescription. There was almost universal support for supervision, with only 1.27% of respondents supporting no supervision for hygienists, while only 3.7% supporting this for dental therapists. Of 633 responses, only 2 (0.32%) supported dental hygienists working without either supervision or prescription. Of 623 responses, only 10 (1.6%) supported dental therapists working without either supervision or prescription. (Further comment on flexibility appears in section 9 below).



Based on this feedback we recommend amendment of Interim Code 001 as follows:

Interim Code of Practice 001: Dental Auxiliary Supervision

In regard to the **prescription and** supervision~~, direction and control~~ by dentists of the duties of dental therapists and hygienists ~~as defined in Regulations 501 and 505 respectively of the former Dentists Regulations 1992.~~

Prescription means the written instructions provided by the dentist, including directions on the treatment to be provided by auxiliaries to particular teeth and their supporting structures. It also includes written instructions for the construction of a prosthetic dental appliance by a laboratory, and for the preparation, composition and administration of medications by a pharmacy.

Such prescription of treatment requires that the dentist has first performed the initial examination, provided a diagnosis and treatment plan, and obtained patient consent. It also requires that the dentist will check the work undertaken by the auxiliary (or laboratory) on its completion.

Supervision means the general oversight of the performance of duties **by auxiliaries based on the written prescription of a registered dentist, and with a registered dentist physically present in the treatment facility during the performance of those procedures** ~~requiring the physical presence of the person responsible for the oversight]~~

~~Direction is the action of aiming, guiding, prescribing, instructing and administering the performance of the duties by dental auxiliaries.~~

~~Control is the checking, verification and regulation of the performance of the duties y dental auxiliaries.~~

8 DPBV Question 3.4 – Is it necessary to define patient groups for each auxiliary?

Yes. The Codes should limit dental therapists to treatment of children in order to minimise risk of adverse outcomes for adolescents and adults. It would be entirely inappropriate for dental therapists to be involved in complex restorations in adults or for that matter extraction of permanent teeth. Their lack of diagnostic skills and understanding of pharmacological issues underpinning the treatment of medically compromised patients would make their use in adult populations too risky. This would also apply to their treatment of adolescent patients who are involved in drug taking.

There are many different ways of defining patient groups. All patient groups, including those who are “institutionalised”, “elderly”, “homeless”, “indigenous”, and “non-English speaking” etc., deserve the same level of care. That is why dentists should be involved in their examination diagnosis and treatment planning.

9 DPBV Question 4 – How could flexibility be built into the model?

It is unclear whether this question relates to the generic model the Board may have in mind for the development of all Codes of Practice, or the specific model applicable to the Auxiliaries Code.

The Board has chosen to commence the development of a range of Codes by addressing the issue of auxiliary supervision and duties. This may set precedents for future Codes in terms of whether they are principles based, performance based or prescriptive. The commitment to flexibility in Parliamentary discussion of the Codes was, both in our view and that of Mr Doyle (see Hansard extract[10] in Part B), about the capacity of the Board to review the detail of any Code as required, rather than making all Codes so open-ended that their interpretation became difficult.

The flexibility sought by Parliament was to assign the Board the responsibility for developing and maintaining a Code of Practice. That level of flexibility meant that the need to change a particular Code was not unduly delayed because of Parliamentary procedures or competing priorities on the Bill List. The Board has been given responsibility for maintaining the Codes so that they remain relevant to emerging needs. This arrangement is far more flexible than would be the case if the requirements were embedded in Regulations (Statutory Rules), requiring Parliamentary review.

The profession and all employees want clarity and certainty rather than vague and confusing arrangements. They want clarity in the roles and responsibilities of auxiliary personnel so they do not find themselves inadvertently in breach of the Board's later interpretation of something they were obliged to interpret themselves in their practice.

Where patients in special and prescribed circumstances need greater access to care, the Board could permit auxiliaries to work under "**General Supervision**", involving supervision of auxiliary dental procedures based on the prescription of a registered dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures. These services may be provided on the premises of long term residential care, either government or licensed under local government legislation for the elderly or persons with physical or intellectual disability, provided that a medical practitioner or registered nurse is at close call (on the premises) to assist in the event of a medical (or dental) emergency.

10 DPBV Question 5 – How could the resulting Code of Practice be evaluated?

Evaluation of the efficacy of a regulatory regime would require resources that the Board may not have access to. The definition of the objectives addressed by any given regulatory measure is open to wide interpretation, and a range of objective measurements would need to be established along with a clear causal relationship between the objectives and the methods of achieving them. This is particularly problematic in relation to the access objective, although perhaps less of a problem as regards the public health and safety objective.

We note that the Board has adopted the NHMRC's Guide to the Development, Implementation and Evaluation of Clinical Practice Guidelines (1999)[11], and that this document defines evaluative mechanisms that should be employed.

11 DPBV Question 6 – What review period should apply to the recommended model?

A period of five years should be set for the application of any Code before it may become subject to review. Even then, it may be necessary to show cause why the Code needs to be opened to amendment. Recognising the need for flexibility however, the ADAVB acknowledges that the Board may need to modify some elements of particular Codes from time to time, based on changing public expectations or external circumstances.

12 Other matters

12.1 Strong survey response

The total of 681 responses to this special survey is one of the highest results for a single-issue survey in the history of the Branch. Whilst response rates of around 70% have been achieved for large-scale membership surveys concerning the operations of the Association, customarily response rates of between 200 and 400 are normally received for more narrowly targeted surveys. This strong response, especially from private sector general practitioners (81% of respondents), is almost twice that of recent surveys on other topics.

Key conclusions from the survey were as follows:

- Over 70% of respondents supported auxiliaries working to the written prescription and under the supervision of a dentist
- **Almost none supported removal of both prescription and supervision**
- **Almost all respondents supported the detailed listing of duties for both dental hygienists and therapists**.
- Where suggestions were made for modification of duties these were generally to increase the preventive orientation of either the dental hygienist or the dental therapist.
- Most respondents supported dental assistants providing oral hygiene instruction to patients
- Demand for private sector employment of dental hygienists during the coming five years will grow to more than 1050 sessions (equivalent to over 50 extra hygienists), far exceeding demand for additional dental therapists, for whom a total of 210 sessions is expected (equivalent to an extra 16 dental therapists)

12.2 Preferred Auxiliary

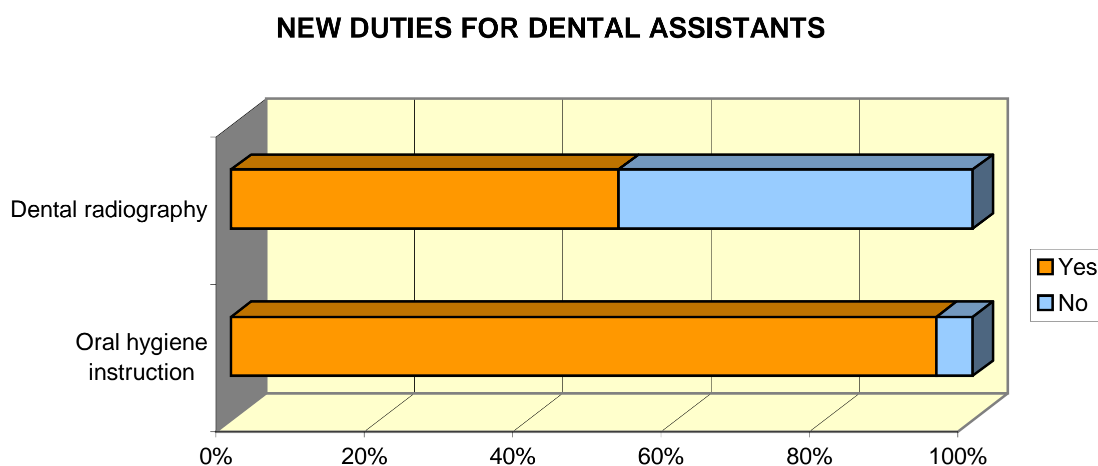
The Australian Dental Association has long argued that the auxiliary required is a preventive one. This is consistent with the primary health care philosophy supported by the current and previous State Governments. It is our contention that we will never solve the needs of the disadvantaged with a restorative auxiliary. The community needs a preventive auxiliary, and this is a measure we fully support.

The ADAVB recommends conversion of dental therapists to become hygienists. We support the promotion of this expanded duties hygienist, able to undertake preventive treatment in both public and private sector practice settings.

12.3 Dental Assistant Duties

The ADAVB acknowledges that dental assistant duties are not specified, and since these employees are non-operative auxiliaries they do not require registration. There was overwhelming support in our survey however for dental assistants with suitable training being permitted to do oral hygiene instruction (95%). The results of the Dental Assistants Survey conducted by the Branch in 2000 also supports this wish for an enhanced career path, and for assignment of duties that offer greater direct involvement with patients.

This would permit dental assistants to provide instruction in the practice, but also in various external locations, such as pre-schools, schools, nursing homes, and other institutional settings. Such provisions would also assist with access to care.



The respondents were divided however, on the involvement of dental assistants in radiography, with only 52% supporting, and nearly 48% rejecting this proposal. Some responses noted that our question on this matter could have been more specific, since it may have related to anything from bitewings to cephalometric radiographs. We note that dental assistants in other States are able to perform certain radiographic procedures, after completion of required training of course.

The 1993 Nuffield Report (UK) noted that dental surgery assistants, after completion of additional training in specific modules of oral care, could undertake an expanded role and a career path in their current work environment, or provide a career path into the expanded duties of an oral health therapist/auxiliary.

The ADAVB would therefore encourage the DPBV to consider the work that may be done by dental assistants so that these employees are not considered to be practicing dentistry illegally, and both they and their employers are not charged with a breach of the Act. This is an access issue.

PART A - REFERENCES

1. *Dental Practice Act 1999*, Information Victoria 2000
2. NHMRC *Guidelines on Patient Information*
3. *Issues Paper re Review of Interim Codes of Practice for Dental Auxiliaries*, DPBV, March 2001, Melbourne
4. *Principles of Good Regulation*, Victorian Office of Regulation Reform, 1999
5. *Ottawa Charter for Health Promotion*, issued by the First International Conference on Health Promotion, Ottawa, Canada, 17-21 November 1986, published on the DHS Victoria website.
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7. AS/NZS 4187 – 1998: Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities, 2nd edition, Standards, Australia, Homebush, 1998
8. AS/NZS 4815 – 2001: Office –based health care facilities not involved in complex patient procedures and processes – Cleaning disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of the associated environment. Standards, Australia, Homebush, 2001
9. *Dentists Regulations 1992*, Information Victoria, 1999
10. Doyle, R., second reading speech on the Dental Practice Bill, Hansard, Victorian Legislative Assembly, 12 May 1999
11. NHMRC, *A guide to the development, implementation and evaluation of clinical practice guidelines*, endorsed 16 November 1998, Cth of Aust., Canberra, 1999

PART B – CODES REPRESENT QUASI-REGULATION

1 DPBV Question 1 - What is the purpose of the Codes of Practice?

There remains much confusion as to the relative status of Regulations, Codes and Guidelines, all of which are authorised under the Dental Practice Act (1999)[1]. On each occasion we have expressed our views about these matters, we have received informal Board feedback suggesting that we hold different views, but the Board has not published its intentions regarding the relative status and purposes of the range of instruments available to it.

The following analysis examines a range of issues regarding the status of Codes, their relationship to other instruments and Board functions, and the obligations of the Board in promulgating such instruments.

2 The Codes and Objectives under the Act

The Framework offered by the Board for response includes both matters of general principle about Codes of Practice, and more specific issues affecting the approach to be taken to the Auxiliary Code.

The Board has asked respondents to present their comments with regard to the objectives contained in the Act. Section 69 (3) (c) of the new Act states that:

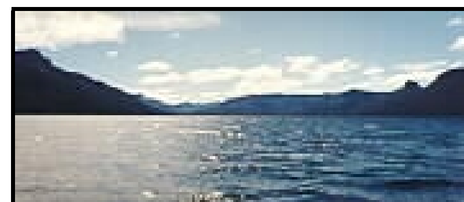
> "(3) In carrying out its functions and exercising its powers, the Board must—
> (a) consult with the Minister and have regard to the Minister's advice; and
> (b) have regard to the following objectives—
> (i) to minimise the community's exposure to health risks in dental care;
> (ii) to **promote** the community's **access to dental care**." (emphasis added)

While we understand the general thrust of the first of these, since it is consistent with the historical emphasis on public health and safety, no definition is offered regarding the more obscure second objective.

The ADA has scanned statute books in all Australian jurisdictions and has found no other health practitioner registration board charged with achieving an objective remotely resembling this. Indeed, we have recently reviewed four new dental Bills in other States, and none make any similar reference to such an objective.

At first glance, it seems unobjectionable to include such an objective. The problem arises when we consider the Board's capacity to achieve measurable outcomes in relation to such an objective. Whilst it can be argued that professional misconduct hearings and penalties are measurable ways of assessing the Board's achievement in protecting the public from risk, there is no similarly simple measure available for access to care.

The key difficulty for the Board of course, is that it is a small statutory body primarily responsible for registering health care providers, and regulating their behaviour. Whilst the new Board can advise the Minister on issues such as funding of public dental programs, it has no capacity to deliver any such program.



There are other areas the Board could choose to address however, including fluoridation of water supplies, and other efficient means of preventing dental disease. It is generally recognised that preventive measures are far more cost effective in the long run, and that in fact, they are the only means likely to have a serious impact on dental disease rates. An overemphasis on restorative care at the expense of sound preventive maintenance programs would be bad public health policy. This kind of program might emphasise a more global objective related to **access to oral health**, rather than overemphasising any single access issue, such as workforce deployment.

It is our contention that we will never solve the access to care problem with a restorative auxiliary. The community needs a preventive auxiliary as part of the dental team, and we fully support this measure since it is consistent with primary health care objectives.

This is where the Board's policy position is likely to be important however, in considering the shape of the dental workforce and its regulation. The Board has been charged with administering an Act, which establishes that there will be dental operatives known as dentists, dental specialists, dental prosthetists, dental hygienists and dental therapists. It has no choice about the fact of these registered dental care providers existing and being regulated. The Board does have the power and responsibility however, to determine the shape of the service profile offered by these operatives.

3 Codes not mandatory

The Board's Issues Paper[2] indicates that the purpose of the Codes "is development of the detail of interpretation in the legislation". If this were all that the codes were intended to do, then there would be no infection control code and no code relating to use of rubber dam for routine endodontic treatment. For such codes to be developed, the Principal Act would need to make some specific reference to these areas, allowing the Board to interpret the requirements of the Act in more detail by adoption of a code. Unlike the Occupational Health and Safety legislation[3], the Dental Practice Act[1] and Regulations[4] are silent on all such matters, and it is left to the Board, in consultation with dental stakeholders and the community, to decide what matters warrant the use of codes.

The only aspect of the legislation being detailed under the proposed codes appears to be the interpretation of what constitutes "unprofessional conduct". The Board's Issues Paper states that

> *"Codes of Practice do not have the same legal force as an Act or Regulations and failure to observe a provision of a promulgated Code of Practice is not in itself a breach of the Act. However in proceedings under the Act, particularly in relation to an offence of unprofessional conduct, the relevant approved Code of Practice is admissible as evidence. Therefore, the DPBV may initiate an inquiry on the grounds of unprofessional conduct where a Code of Practice were contravened."*

The second sentence in this extract is footnoted in the Issues Paper with a reference to the Victorian Occupational Health and Safety Act 1985, What is a Code of Practice? Information Sheet[5]. The Board therefore appears to have accepted that similar provisions will apply in the use of Dental Practice Codes to those that apply to OHS Codes.

The OHS Act 1985[3] specifies the way in which OHS Codes may be used, whereas the Dental Practice Act 1999[1] does not. The following extract from the OHS Act demonstrates that a person can satisfy the court that they complied with the relevant provision of the Act or Regulations by some other means than direct compliance with the Code.

> *56. Use of codes of practice in proceedings*
> *Where in any proceedings under this Act it is alleged that a person contravened or failed to comply with a provision of this Act or the regulations in relation to which an approved code of practice was in effect at the time of the alleged contravention or failure—*
> *(a) the approved code of practice shall be admissible in evidence in those proceedings; and*
> *(b) if the court is satisfied in relation to any matter which it is necessary for the prosecution to prove in order to establish the alleged contravention or failure that—*
> *(i) any provision of the approved code of practice is relevant to that matter; and*
> *(ii) the person failed at any material time to observe that provision of the approved code of practice—*
> *that matter shall be taken as proved unless the court is satisfied that in respect of that matter the person complied with that provision of this Act or the regulations otherwise than by way of observance of that provision of the approved code of practice.*

A registered dental care provider charged with unprofessional conduct would have no opportunity to defend their behaviour on the grounds of employing some other acceptable method of complying with the relevant provision in the Act or Regulations, firstly because they are not being charged with any specific breach of the Act or Regulations, and secondly because they must comply with narrowly prescriptive requirements in a Code. In fact, any dental care provider charged with unprofessional conduct will be judged against a range of vague references to compliance with standards expected by the community or their peers.

The Board appears to be seeking legitimacy for its Codes by reference to legislation other than its own, and yet the reference used does not actually support the Board's contention that breach of a Code is grounds for prosecution.

Under s.55(8) of the OHS Act 1985[3] *"A person shall not be liable to any civil or criminal proceedings by reason only that the person has failed to observe any provision of an approved code of practice."* In our view, there is a contradiction in suggesting that, as with the OHS Codes, a person is not liable to prosecution due to contravention of a Code, while the DPBV Issues Paper[2] states that "*the DPBV may initiate an inquiry on the grounds of unprofessional conduct where a Code of Practice were contravened*".

On the one hand the Board has declined to accept our earlier submissions that the Codes are legislative instruments, whilst on the other the Board has stated that contravention of a Code is grounds for initiating an inquiry. It has used the OHS Act as a reference, and this Act makes it clear that OHS Codes are not mandatory. Whilst a Code may be used in evidence, a breach of a Code may not be used as a basis for prosecution. This is contradictory, and needs to be resolved before registered persons are subject to improper prosecution.

4 Are Codes legislative instruments?

The ADAVB believes that the effect of the Board's arguments about the admissibility of Codes as evidence and contravention of a Code constituting grounds for initiating an inquiry, is to elevate the Codes to the status of statutory rules. Unlike the OHS Act, there are no provisions in the Dental Practice Act[1] or Regulations[4] that the Codes can be linked to – except unprofessional conduct.

The Subordinate Legislation Act 1994 Guidelines[6] contain a section addressing the types of matters for inclusion in statutory rules as opposed to acts or instruments which are not of a legislative character. These Guidelines highlight the following distinctions between legislative and executive instruments.

> *"Legislative instruments differ from executive instruments in that they:*
> - *determine the content of the law rather than simply apply the law*
> - *make new law or change existing law rather than simply applying criteria to a set of facts*
> - *contain binding rules rather than guidelines*
> - *usually have a general application rather than applying solely to a particular case.*
>
> *The following criteria can be used to assist in determining whether an instrument is legislative in character:*
> - *whether the instrument can be traced back to a delegation of legislative power*
> - *whether the instrument is of a general application rather than applying in a particular case*
> - *whether the instrument creates legally enforceable rights and obligations*
> - *whether the instrument contains a binding rule rather than being a guideline for decision-making or conduct.*
>
> (Subordinate Legislation Guidelines, ORR, Dec. 1997)

In our view, the range of matters the Board has advised it will be addressing through Codes of Practice, or which it has already addressed via Interim Codes of Practice essentially form binding rules, which impose enforceable obligations on all registered persons. Even the Board's Guidelines regarding minimum terms and conditions for professional indemnity cover are binding on all registered persons. In our view therefore, the Codes of Practice are legislative rather than executive instruments.

As remarked by Mr Stephen Argument at a recent Australian Institute of Administrative Law seminar[7] – "it is the effect of an instrument rather than its name, that determines whether it is legislative rather than administrative."

5 Regulatory Structure

Appendix 4 highlights extracts from the Dental Practice Act 1999 regarding the powers delegated by the Victorian Parliament to the Dental Practice Board "to regulate standards of practice" [s.69(1)(c)], "to promulgate Codes about the practice of dentistry" [s. 69(1)(e)], and "to issue guidelines" [s. 69(1)f)]. This appendix also includes the definition of unprofessional conduct and provisions regarding the making of Regulations.

In addition, section 66 of the Act provides for the issuing of advertising guidelines prepared by the Board, and which are subject to approval by the Governor in Council. The new Act therefore appears to define 5 different types or levels of regulation of registered persons.

1. The Dental Practice Act 1999
2. The Dental Practice Regulations 1999
3. Advertising Guidelines approved by the Governor in Council
4. Codes of Practice adopted by the Board, which the Board advises will address such matters as infection control, dental records, use of rubber dam for routine endodontic treatment, requirements for anaesthesia and sedation in connection with dental treatment, supervision and duties of dental auxiliary personnel, requirements for registration of dental specialists in the various branches of dentistry, sexual harassment, and other matters as judged necessary by the Board
5. Guidelines issued by The Board, including minimum terms and conditions for professional indemnity insurance.

There is no explanation in the legislation, or indeed elsewhere, regarding the relative status of these five regulatory tiers, and the relationship between them all. The status of the Act and Regulations does not need amplification, since the community generally understands the significance attached to principal and subordinate legislation (statutory rules). The other three tiers are somewhat mysterious however.

6 The Parliament's view

As we read the Board's power to adopt Codes under the Act, their purpose appears to be the definition of standards of practice to protect public health and safety. If this is the case, these standards should be considered minimum standards, rather than best practice.

When courts have difficulty deciding how to interpret legislation it is customary for them to refer to the second reading speech that defined the government view of the intent of the legislation. Upon introducing the Dental Practice Bill to the Legislative Assembly on 22 April 1999, the Hon. Alan Stockdale commented on the new Board's role in protecting the public and enhancing the quality of care (standards) by means of codes of practice.

"**The bill** *includes a comprehensive outline of what constitutes unprofessional conduct and contains wide-ranging disciplinary powers for the protection of the public. It* **enshrines the board's ability to promulgate codes of practice to enhance the best quality provision of dental care.** *(Emphasis added)*

The bill makes it an offence to direct an employee to provide dental care in a manner which could be detrimental to the welfare of a patient, or for anyone who is not a registered dental care provider to practise dentistry, or for anyone to use titles which may suggest that they are registered when they are not. There will also be protection of the titles of dental educational institutions. Such title and practice protection are measures through which the government can protect the public from unregistered people practising dentistry.

The bill, in terms of qualifications, **duties** *and registration, is the immediate successor to the old acts and so preserves the present levels of dental provider competencies and qualifications which have served the public so well.* **Boundaries of practice for all dental care workers will remain as they are and only through clinical trialling, training and rigorous evaluation could changes be considered**.

A further measure to enhance public safety is the board's ability to promulgate codes of practice. These codes may outline what is acceptable care -- for example, a relevant code for the purchase of dental technicians' work should be that dentists may only contract with laboratories which employ qualified staff and follow appropriate infection control standards. Breaches of codes of practice will be considered as possible unprofessional conduct and may attract a range of penalties up to deregistration for dental care providers and substantial penalties for commercial operators. *(Emphasis added)*

Development of codes will be done through appropriate consultation with the professions and be based on sound evidence. The broader membership of the new board, with all registered members of the dental profession represented, will provide for wide-ranging input. Currently, Victoria is leading the way in Australia in infection control management because of promulgation of a relevant code of practice.

Stringent advertising provisions are included in the bill to further facilitate protection of the public. The bill also creates a power for the board to prepare guidelines for minimum acceptable standards for advertising dental services."
Hansard, Victorian Legislative Assembly, 22 April 1999[8].

(We note in passing that the reference to dentists' liability for dental laboratory standards is contentious. This will be the subject of a future submission to the Board).

These views were amplified in later comments to the House, when Mr Robert Doyle, Parliamentary Secretary to the Minister for Health at that time, spoke on the Dental Practice Bill.

"The bill is a model for health profession registrations. I take up some of the issues mentioned by the Deputy Leader of the Opposition.

The first concerns the codes of practice and the kind of thinking developed in the health portfolio which, if I may put it bluntly and perhaps inelegantly, views the legislation as a generic instrument. And so it should be, because governments should not be amending legislation at every turn. **The work of dental professionals will be covered by specific regulations when the act is proclaimed** *and the Dental Board will oversee the codes of practice.*

The Deputy Leader of the Opposition mentioned one aspect -- infection control -- which I believe is a fine example of what can be achieved after proper consultation with the profession. It is not unfair to say that a contrary example put to the government followed the process in New South Wales where the government attempted through legislation and regulation to define the regimes for infection control. It got into terrible trouble.

In Victoria a head of power under the regulations and the codes of practice has provided compliance and a rigour unmatched and envied throughout Australia. It is through that mechanism that the government gives effect to the codes of practice. The codes of practice will be developed by the board in full consultation with the profession so that it can move forward in a way that protects the public but also ensures that the profession develops a quality that the clinicians will monitor rather than the politicians and the lawyers.

If there is one effect the government hopes the bill will have it would have to be to keep the politicians and the lawyers out of clinical evaluation and regulation and to leave that for the clinicians."
Hansard, Victorian Legislative Assembly, 12 May 1999[9].

The Act was supported on a bipartisan basis, and we believe that the present government shared the views of the previous one, in relation to the use of Codes as a more flexible regulatory mechanism by which to enhance standards.

7 Prescriptive Standards

In the ADAVB submission to the Inquiry into the Subordinate Legislation Act 1994[10], we noted that standards of practice can be defined in three main categories, namely, principles based, performance based and prescriptive. Quoting the Commonwealth Office of Regulation Review's publication, A Guide to Regulation (December 1998)[11], these three approaches to both mandatory and voluntary standards are defined as follows:

"Principles based standards describe the objective sought in general terms, and require interpretation according to the circumstances.

Performance based standards specify the desired outcome in precise terms, but allow individual organisations to determine how they achieve the outcome.

Prescriptive standards specify the technical means for attaining the specified outcome." (Page E20)

This same Guide cautions that: "standards should not be used where they are overly complicated or impose unnecessarily high compliance costs. They should only be used where they are the most effective and efficient way of achieving an objective".

The Board has chosen to commence the development of a range of Codes by addressing the issue of auxiliary supervision and duties. This may set precedents for future Codes in terms of whether they are principles based, performance based or prescriptive. The commitment to flexibility in Parliamentary discussion of the Codes was, both in our view and that of Mr Doyle (see Hansard[9] extract above), about the capacity of the Board to review the detail of any Code as required, rather than making all Codes so open-ended that their interpretation became difficult. This arrangement is far more flexible than would be the case if the requirements were embedded in Regulations (Statutory Rules), requiring Parliamentary review.

If the Code regarding infection control requirements were not to incorporate the NHMRC[12] and Standards Australia[13,14] prescriptive standards it could be difficult to prosecute practitioners for a breach. As regards the setting of precedents therefore, had the Board commenced the development of Codes by publishing the Infection Control Code, all remaining Codes might have become prescriptive in nature. There are some stakeholders who have expressed the view that the auxiliaries Codes should be principles based, so that they simply suggest that the auxiliary personnel undertake the duties they have been trained to perform. We contend that this would be a mistake, since it would lead to a lack of clarity and certainty, and would also result in numerous practical and legal difficulties.

8 Does a problem exist?

The removal of Regulations protecting public health and safety and defining the supervision and duties required for dental auxiliaries, and the replacement of these with powers granted to the Board to devise and promulgate Codes of Practice and Guidelines, is the key focus of our attention here.

According to the Commonwealth Government publication "Design Principles for Small Business Programs and Regulations"

> *"… the supporting material for any Regulation should state clearly the underlying problem which the Regulation is intended to overcome(such as a particular social, environmental, equity or economic problem), and not just the objective of the Regulation. It should not prescribe the mechanisms for alleviating the problem, since there may be many possible options.*
>
> *If there is no such rationale, clearly Regulations should be avoided". (p.195)*

In Part A, we have described the problems justifying creation of the Auxiliaries Code and the objective we believe should be addressed in its promulgation.

Governments seek to regulate the behaviour of groups within the community because otherwise, some people will take advantage of an open-ended situation at the expense of public welfare. Both Parliament and the infrastructure of Government use legislative instruments to define what can and cannot be done, because if they did not, there would be no sanctions to prevent some operators from behaving in unscrupulous or dangerous ways. Defining the duties that can be performed by auxiliaries is as much about stopping certain employers from exploiting the public and the dental workforce, as it is about ensuring the effective operation of the dental team.

9 Accepted Standards

The Board's Issues Paper notes that "Codes of Practice do not have the same legal force as an Act or Regulations, and failure to observe a provision of a promulgated Code of Practice is not in itself a breach of the Act. However, in proceedings under the Act, particularly in relation to an offence of unprofessional conduct, the relevant approved Code of Practice is admissible as evidence".

The definition of unprofessional conduct in the Act does not refer to any breach of a Code of Practice or Guidelines, so that a failure to comply with the Code would not ipso facto satisfy the definition. The Board's approach may be to rely on the codes as establishing standards, which the Board would say are standards which the public or the provider's peers might reasonably expect of a registered provider. However, given their present status, the codes could probably only be viewed as evidence of appropriate standards.

There is a range of ways in which standards can be set, but the conventional manner is to specify behaviours, protocols, limits and benchmark targets which should be employed. This suggests that the Codes may resemble Standards Australia publications, which are usually very detailed. This is certainly the case with regard to infection control requirements.

In forming a view as to what is reasonable, the Board itself and witnesses called before it could have regard to any Code, not just those promulgated directly by the Board. It would be open to a provider to lead evidence to suggest that a given standard was inappropriate and should not be relied upon. It would then be a matter for the judgement of the Board, based on the evidence before it in the circumstances of a given case.

Alternatively, when forming a view during a hearing as to the standard which the public or the provider's peers might reasonably expect (S.3 (a) and (b)), the Board will inevitably draw on its own "expertise". In particular cases, it will also call expert evidence. Whilst, on the same basis, it could call evidence from an ordinary member of the public as to reasonable expectations, in practical terms it seems unlikely to do so. Quite often in the past such evidence has been led from the complainant. However, we suggest that a complainant could hardly be in a position to give objective evidence.

If any code was developed without consultative processes and promulgated without the general support of those affected by it, it is difficult to see how that code could be used as evidence of the "accepted" standard.

Under the definition of unprofessional conduct within the Dental Practice Act 1999, it will be an offence if a person provides "dental care that the provider is not registered to provide". The ADAVB argues that unless the Board defines those duties that each operative is registered to provide, there will be no basis for such a charge being brought. The alternative concern here is that the Board may create a set of vague requirements, without specifying objective and observable benchmarks, so that the bringing of a charge becomes more a matter of inconsistent whim than clear and predictable responsibility.

The Board may not place great reliance on sections (a) and (b) of the definition of "unprofessional conduct" in S.3 of the Dental Practice Act. It may instead, continue to focus upon the professional misconduct test. We argue that this test should require far more than professional incompetence. The misconduct should constitute a deliberate departure from accepted standards or such serious negligence as, although not deliberate, would portray indifference and an abuse of the privileges that accompany registration as a practitioner.

10 Regulatory flexibility

Matters previously addressed by Regulations that were subject to parliamentary scrutiny have now been referred to statutory boards to deal with via codes of practice. The most significant example of this is the removal of the Dentists Regulation regarding dental practices being kept in a clean and hygienic manner. Regulation 401 of the Dentists Regulations 1992[16] had been used by the Dental Board of Victoria, as the basis for using the NHMRC Guidelines on Infection Control[12] to protect public health and safety in connection with dental treatment. No equivalent Regulation now exists in the Dental Practice Regulations 1999[4].

In his second reading speech[9] to Parliament when the Dental Practice Bill was before the House in early 1999, the Hon Robert Doyle made the point that the approach previously taken to infection control would be a model for the use of Codes of Practice under the new Act. The Dental Practice Board would be able to update the Infection Control Code of Practice as required in the light of research or policy development in the field, rather than slowing down the process by requiring a Regulation to go through Parliamentary processes.

The Commonwealth Office of Regulation Review's publication, *A Guide to Regulation*[11] (December 1998), offers the following observations about **codes of practice or conduct**

> "Codes are generally adopted and administered by the industry to which they relate, although they often complement government laws and regulations. Codes may deal with a range of issues such as: membership eligibility; standards for processes, practice or products/services; and complaint handling procedures. The advantages of codes are that they are industry specific, flexible and can be quickly amended. Also, the industry is often best placed to police conduct.
>
> Codes may be either voluntary or mandatory (covering all members). Voluntary codes may be more flexible than mandatory requirements, but outcomes may be more uncertain. If there is some involvement by government in the development, implementation or endorsement of industry codes, then such codes are defined as quasi-regulation." *(p. E19)*

Clearly, the Victorian Parliament intended that the dental Codes of Practice would be a form of quasi-regulation including mandatory requirements. The infection control example was praised by Mr Doyle as an illustration of the effectiveness of a Code of Practice in achieving the desired objective of protecting public health and safety. This example mandates a range of quite specific protocols and benchmark standards, which the previous Board used very

effectively to prosecute dentists who failed to comply. The ADAVB supports the actions taken in the interests of public health and safety, but we note that those prosecutions could not have proceeded without the level of specificity contained in the NHMRC Guidelines and AS4187, which were adopted into the Code by the Board. This same approach has been adopted for the Interim Code of Practice on Infection Control by the DPBV.

11 Compliance Costs

A Guide to Regulation also makes the point that "Where regulatory options under consideration involve the incorporation of standards, any reports, statements and RISs should examine the costs associated with particular standards, and demonstrate that they are the most effective way of achieving the relevant policy objective." The Guide then cautions that "Standards should not be used where they are overly complicated or impose unnecessarily high compliance costs. They should only be used where they are the most effective and efficient way of achieving an objective." (p. E20)

> *"Codes of conduct have variously been called codes of ethics and* **codes of practice**. *Codes can range from setting out general statements of principle about how an industry or business will operate, to listing specific business practices which are guaranteed. They can either contain minimum standards or standards which are aimed at best practice. Codes can also differ in other respects, including whether or not they provide a method of dispute resolution or any sanctions for non-compliance with the code. In addition, compliance by industry with a code of conduct can be mandatory or voluntary.*
>
> *… A code of conduct is a document which sets out specific standards of conduct for an industry in relation to its customers."*
>
> Codes of Conduct: Policy Framework[17], Commonwealth Department. of Industry, Science and Tourism (Consumer Affairs) March 1998

The Victorian Office of Regulation Reform has published *Principles of Good Regulation*[18], which are intended

> "to provide departments with a clearly defined methodology for designing regulation and a checklist which will allow the merits of all options to be fully considered and assessed." (p. 2)

According to these guidelines "excessive or poorly developed regulation which impose net costs on society can have negative implications for overall economic performance, including investment and employment opportunities."

12 Legislated Powers

Clearly, the Board has the power under S.69 of the Dental Practice Act, to regulate standards of practice and promulgate codes about the practice of dentistry. The ADAVB accepts that the adoption and promulgation of so-called 'codes of practice', fall within those powers. The question is what is the status of these codes?

As we highlighted in our recent submission to the Inquiry into the Subordinate Legislation Act 1994, the codes of practice do not currently constitute Statutory Rules, and so none of the obligations and protective mechanisms under the Subordinate Legislation Act 1994 applies. In the Victorian Acts where codes of practice are used as regulatory mechanisms, such as in the Occupational Health and Safety Act, there are proper controls over the development and enforcement of such codes. Indeed, in at least a couple of instances those codes effectively become Statutory Rules by reason of the processes involved.
On the other hand, comments appear in the OHS Codes indicating that they are not mandatory and that they usually contain a number of options for achieving the desired objective. If a practitioner can show that there is another way of safely achieving the expressed objective than those illustrated in the relevant Code, then they can do so without sanction.

> *"The provisions in a code are not mandatory. That is, a person may choose to comply with the relevant provision of the Act or Regulations in some other way, provided that the method used also fulfils the requirements of the Act or Regulations. A person or company cannot be prosecuted simply for failing to comply with an approved code of practice."*

The OHS Codes are approved by the relevant Minister rather than by a Board, however it is interesting to note that reference to Codes of Practice in the OHS Act is almost identical to that used in s.98(2) of the Dental Practice Act to define dental Regulations. Is it possible that the drafting of the Dental Practice Act intended to refer to dental codes of practice rather than regulations in s.98? This may be an area warranting amendment when the operation of the Act is reviewed around July 2001.

> *"55. Codes of practice*
> *(1) For the purpose of providing practical guidance to employers, self-employed people, employees, occupiers, designers, manufacturers, importers, suppliers or any other person who may be placed under an obligation by or under this Act, the Minister may approve any code of practice.*
> *(2) A code of practice may consist of any code, standard, rule, specification or provision relating to occupational health or safety and may apply incorporate or refer to any document formulated or published by any body or authority as in force at the time the code of practice is approved or as amended formulated or published from time to time."*
> (OHS Act 1985)

> *"98(2) The* **regulations**—
> *(a) may be of general or limited application; and*
> *(b) may differ according to differences in time, place or circumstance; and*
> *(c) may apply, adopt or incorporate any matter contained in any document, code, standard, rule, specification or method, formulated, issued, prescribed or published by any person whether—*
> *(i) wholly or partially or as amended by the regulations; or*
> *(ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or*
> *(iii) as formulated, issued, prescribed or published from time to time; and*
> *(d) may confer a discretionary authority on a specified person."*
> *(Dental Practice Act 1999)*

Changing the Act to refer to codes instead of regulations at s.98 would be more consistent with wishes expressed in second reading speeches: allowing the Board, rather than politicians or lawyers, to vary the details of standards required.

In the case of the Dental Practice Board's prescribed codes though, there is no control or consultation **process** prescribed by Parliament for the development and promulgation of the codes. The Board has been left to determine its own processes, models and timelines. It has also been left with some uncertainty about how it can use the codes of practice in relation to any inquiry as to whether or not the conduct of a provider constitutes "unprofessional conduct".

13 Codes and Guidelines

The term ‘guideline’ implies a suggested approach in which tolerances and ranges are indicated according to current scientific understandings. Those who practice outside such guidelines would not necessarily be practicing illegally or unsafely, but would need to exercise caution, since their approach would be considered beyond normally accepted quality standards of good practice. No research developments would ever occur if such guidelines were applied too strictly, and so the capacity for change within the guidelines over time needs to be built in.

Regulatory codes on the other hand need to establish **minimum** acceptable levels of practice for the health, safety and welfare of the public and practitioners. Since codes may not be limited to clinical matters, but may also apply to business matters, the notion of ‘welfare’ needs to encompass economic issues as well. Where codes are applied to clinical matters however, the obligation of the statutory body is to define and promote minimum safe practice standards, and to police those standards where practitioners or others seek to ignore them.

In our view, it is not up to a statutory body to define best practice, or to set the highest possible standards, so that barriers are created for entry to practice or to the provision of services. It is important however, that education and information programs are instituted by the regulator, to ensure that minimum standards are acknowledged and understood by registered practitioners. There is also an obligation to the public and to the science of dentistry, to refute the plaintiff lawyer’s view that all treatments can and must have perfect outcomes.

As remarked in the Commonwealth’s Grey Letter Law[19] report,

> “Should a best practice approach be built into mandatory requirements, either quasi-regulation or government regulation, they may impose a significantly higher compliance burden than would be justified by the principle that mandatory regulation should be the minimum necessary to achieve set objectives.” (p. xiv)

Regulatory codes of practice and guidelines for good practice should not compete with each other; rather they should be complimentary. Each will need to acknowledge the other from time to time as they undergo regular review in the light of research developments or experience in hearings.

So what are the criteria by which those involved in the development of each can distinguish between Codes and Guidelines? We suggest that these criteria can be defined in structural, procedural and substantive terms along the following lines.

CODES	GUIDELINES
• Consultation required with all affected parties	• Consultation occurs within the profession
• Accessible to a lay audience	• Addressed to a professional audience
• Minimum standards specified	• Normal ranges described
• Safety rationale explained and limits or minimum requirements justified	• Risk management issues discussed
• Penalties for breach indicated	• No sanctions
• Evaluation measures and schedules specified	• Evaluation measures and schedules specified
• Short and to the point, with emphasis in minimum requirements	• More discursive, with emphasis on best practice and continuous quality improvement
• Expressed chiefly in terms of "Dos and Don'ts"	• Usually expressed in more positive terms, primarily describing what is desirable

14 Standards under the New Dental Practice Act 1999

There are three key references to 'standards' under the Dental Practice Act 1999. These occur in the definition of unprofessional conduct, in S.66 regarding advertising guidelines, and in S.69 regarding the powers of the Board. (See extracts attached in Appendix 4).

As noted above, the Board has advised that it intends to regulate duties and supervision of auxiliaries, infection control, dental record keeping, use of rubber dam for routine endodontic work, and other matters under such 'standards'. This will be done by means of Codes of Practice that define the standards expected.

The ADAVB expended considerable energy in 1999 arguing the need for regulatory "hooks" from which to hang Codes of Practice [under section 98(2)(c)], so that a head of power was associated with any requirement under a Code. The DHS Legislation Unit responded to those arguments by noting that linking of codes of practice into Regulations would not provide opportunity for the new Board to utilise the full range of sanctions, from caution and reprimand up to suspension and deregistration. A breach of Regulations only warrants a $1000 penalty, whereas unprofessional conduct can attract the full range of penalties up to and including removal of a registered person's livelihood.

It is noteworthy that one of the new Board's functions under S.69 is "*to regulate the standards of practice of dental care providers*". This implies that the Board will adopt standards into regulation, and indeed this understanding had been reinforced by the wording of S.98(2)(c), in which the regulations "may apply, adopt or incorporate any matter contained in any … standard" on the following terms (emphasis added in bold):

"(2) The **regulations**—

(a) may be of general or limited application; and

(b) may differ according to differences in time, place or circumstance; and

(c) may apply, adopt or incorporate any matter contained in any document, code**, standard,** rule, specification or method, formulated, issued, prescribed or published by any person whether—

(i) wholly or partially or as amended by the regulations; or

(ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or

(iii) as formulated, issued, prescribed or published from time to time;"

We query why S.98(2)(c) appears in the Act at all, given that the Dental Practice Regulations 1999 are minimalist, and are not linked in any way to standards and codes. The use of codes of practice to regulate adherence to practice standards will not involve the adoption of those codes within statutory rules. S.98(2) would therefore appear to be superfluous.

One problem area relates to the mechanism by which duties of registered persons are to be specified. Under the definition of unprofessional conduct it will be an offence if a person provides "dental care that the provider is not registered to provide". Unless the Board defines those duties that each operative is registered to provide, there will be no basis for such a charge to be brought. Where then are they to define these duties, if not via Codes?

The relationship between standards and codes is not clear, and the mechanism by which the new Board will ensure that proof is provided regarding what "might reasonably be expected of a registered dental care provider by his or her peers", or by the public for that matter, is unspecified. This provision is new, and the ADAVB could find no equivalent in previous legislation.

Historically, the previous Board led evidence regarding such expectations regarding professional standards, by placing the Registrar on the witness stand, and asking him what could reasonably be expected of a practitioner. This has not yet resulted in any challenge by defence solicitors by reference to other opinion. If the new standards are not produced by means of a process of consultation however, the new Board will have no basis for asserting that either the public or peers hold a particular expectation about a practitioner's behaviour.

Codes of Practice adopted under other legislation (such as OHS legislation), especially when linked to regulations, have been subject to Regulatory Impact Statements and consultative processes. This allows all affected parties the opportunity to do a reality check on proposed restrictions. Such mechanisms also help to ensure that the wider community 'owns' the code or standard, and recognises its validity. This should also apply to any codes or standards associated with the Dental Practice Act.

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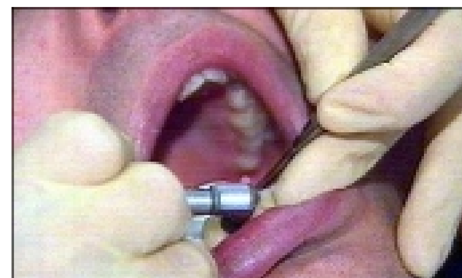
APPENDIX 1. Evidence based on sound clinical research

1 Proving no harm

The DPBV Issues Paper is accompanied by an extract from the report of the Review of the Dentists Act 1972 and the Dental Technicians Act 1972[2], in which reference is made to the continuation of certain arrangements "until evidence based on sound clinical research shows that removing the restriction will not endanger public health and safety". The precise meaning of this statement needs to be established before any change to the restrictive mechanisms is contemplated.



Two of the measures recommended by the review were implemented when the new Act was proclaimed. The remaining three measures confirm that restrictive provisions should continue to apply. They should only be contemplated for removal if sound clinical research proves that **the public will not be harmed**.

2 Treatment of School Children

The opening of employment opportunity for therapists in the private sector has also seen a number of them employed outside the School Dental Service, and indeed there are now serious concerns about the future viability of that service.

Caries rates having dropped so that our 12 year-old children enjoy dmft rates of around 1, as at 1999, so that the community can now expect emphasis to be placed on the preventative roles – chiefly those performed by dental hygienists.

The restrictions recommended for retention by the Review of dental legislation were that dental hygienists and dental therapists should work under the supervision of a dentist, and that therapists should only treat children up to the age of 17 years. Were the Board to contemplate varying the prescribed duties able to be performed by each of the auxiliaries, this would of course create medico-legal complications for any consideration of change to supervision by a dentist.

3 The evidence based approach

The evidence-based approach is a systematic process involving the evaluation of scientific information relevant to the clinical disciplines of examination, diagnosis, prognosis treatment planning and treatment. The systematic incorporation of new information with clinical judgement has improved treatment results and reduced variations in outcomes. Decision-making is enhanced as a result of an understanding of the realistic estimates of predicability outcomes.

4 Periodontal issues

Numerous studies support the importance of a preventively oriented auxiliary as a member of the dental team. These findings have direct bearing on the Interim Codes of Practice regarding dental auxiliaries, as they reinforce the need to place greater emphasis on preventive, and especially periodontal, treatment. In our view, both the pattern of periodontal disease, and the risk posed by potential development of periodontal conditions, constitute "sound clinical evidence" that auxiliary duties should be preventively oriented.

A large US based population study[4] reported an estimate of the prevalence of moderate levels of periodontitis, defined as one or more sites with attachment loss greater than or equal to 3mm was 44%. This ranged from 15 to 80% for ages 18 to 54 years old. Corresponding values in the same study for advanced levels of periodontitis, defined as one or more sites with attachment loss greater than or equal to 5mm were also age dependant and affected 15% of the population. For the US this figure constitutes at least 20 million people affected by advanced periodontitis.

This study and others underestimate the true prevalence of periodontal disease in our community, as they do not account for tooth loss as a result of the disease. Studies looking at tooth loss estimate that periodontal disease accounts for 30-35% of tooth loss[5].

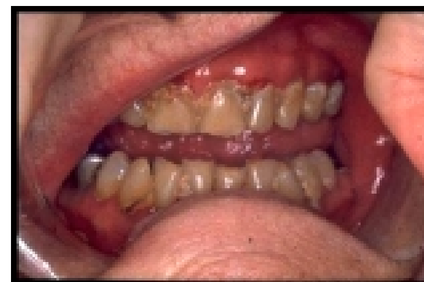
Gingivitis and periodontitis are bacterial plaque associated diseases, however their occurrence and progression may be modified by risk factors. In order to adopt an appropriate preventive strategy the aetiologic factors and risk factors must be identified and minimised. Prevention has two dimensions: prevention of occurrence and prevention of progression.

The preventive measures in periodontics ultimately rely on the removal of bacterial plaque. A number of scientific studies have provided evidence in support of currently adopted preventive measures. A 15 year longitudinal study by Axelsson et al[6] looked at three preventive regimens provided to 375 patients. These consisted of

1. instruction and practice in effective self-performed tooth cleaning with emphasis on interproximal cleaning;
2. dental prophylaxis including scaling and polishing; and
3. application of topical fluoride.

Patients were recalled every two months for the first two years of the study. During the next 4 years the recall interval was 3 months, while for the next 9 years it varied from once a year to 6 times a year. A control group was seen on an annual basis for the first 6 years with the emphasis on recall on caries detection. After 6 years of the study there was a marked difference between the experimental and control groups. The experimental group demonstrated a mean gain of 0.2mm of attachment, while the control group presented a

mean loss of attachment of 1.2mm. Similar marked differences were noted for caries experience. For ethical reasons the control group was discontinued at year 6.
The maintenance program was varied according to individual need for the remainder of the study, this ranged from visits at every 2 months to once a year. The measured parameters continued to improve over the 15 years. Tooth loss was in 59 subjects, 42 of these persons losing a tooth as a result of root fracture.



The periodontal literature is replete with evidence supporting maintenance therapy. Wilson et al[7] found that tooth loss in treated periodontal patients was inversely proportional to the frequency of their maintenance visits. **It is axiomatic that maintenance therapy is necessary to maintain periodontal and oral health in general.**

However, what are the most appropriate intervals. A number of studies have shown that the microbial repopulation of subgingival sites can be inhibited by regular maintenance. By contrast the presence of supragingival microbial plaque appears to facilitate the repopulation of subgingival sites within 4-8 weeks with a percentage of spirochetes and motile rods.[8,9]

Intervals for recall should be set according to risk for disease activity. We know that various risk factors are associated with an individual's propensity to develop disease. These risk factors need to be identified in individual cases, and used in association with the type of disease present and its' previous activity, to help determine intervals between recall visits.

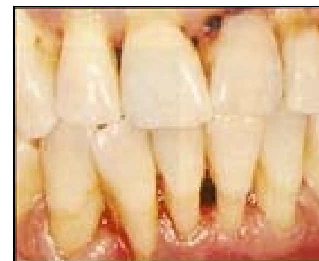
Various large-scale clinical studies have linked periodontal disease to increase risk of heart disease, stroke, diabetes, respiratory disease and premature babies. Recent BBC News reports illustrate these research developments:

- Research conducted by the Centres for Disease Control and Prevention in the US reported in April 2000, that current smokers are about four times more likely than people who have never smoked to have advanced periodontal disease. This study examined data on 13,650 people in the US aged 18 and older who had their own teeth[10].
- A study completed in 2000 by researchers at the University of Buffalo found a strong link between gum disease and long-term problems with the respiratory system. The research team analysed data on 13,792 people from across the US for their study into health and nutrition.[11]
- The findings from a study of more than 2000 pregnant women in the US, reported at a major periodontology conference in Washington in May 2000, indicated that mothers with gum disease were up to seven times more likely to give birth prematurely. Babies born prematurely are at greater risk of a range of health problems[12].

5 Other Epidemiological Trends

No policy initiative occurs in a vacuum. The discussion of the Codes of Practice required for Dental Auxiliaries therefore needs to consider epidemiological and socio-economic factors affecting the provision of dental services.

Our aging population is retaining more of their teeth and they therefore require more complex restorative care. This problem will increase over the coming years. This necessitates dentists and dental specialists providing such care. There is an apparent need to increase the number of graduates. For older people confined to nursing homes, or receiving HACC funded care at home, access to dental services is extremely difficult. The general health of aging and often highly medicated people, is directly affected by high levels of periodontal and other oral diseases, and this indicates that dentists and dental hygienists should be more extensively involved in providing preventive care to this disadvantaged group.



In fluoridated areas, a younger generation will experience less decay, and preventive care will be a priority. Declining average dmft (and DMFT) rates are being recorded in most areas, and only isolated high-risk groups are likely to require restorative care of the kind that was customary for all members of the community before fluoridation.

6 Labourforce Reviews

The ADAVB firmly believes that the future dental workforce should be de-centralised, have a preventive focus, and involve effective use of treatment teams lead by dentists. The ADAVB supports a dental workforce that consists of dental assistants, dental technicians, dental hygienists, dental therapists working in the public sector, and dentists.

The Labourforce Review paper[13] prepared by Prof. John Spencer for the Department of Human Services in 2000, indicates that there is limited use of the School Dental Therapist (restorative auxiliary) in the future with the current roles and responsibilities. The ADAVB supports this view, however recognises the current need to use Dental Therapists in the School Dental Service to treat school children. Given the risks associated with irreversible dental procedures, such an auxiliary should be limited to treatment of deciduous teeth in children, however the current duties include the treatment of secondary students. Currently Dental Therapists are working in private practice and DHSV provide scholarships for their training.

The Nuffield Report[14] (UK 1993) supported the concept of the appropriately skilled dental team led by the dentist, and team work as an effective way to improve the oral health of the community generally. We argue, in common with international inquiries, that the “diagnosis, treatment planning and quality control of the “Team” should be the responsibility of the dentist”. Aspects of prevention and treatment should be delegated, including oral health education, to other members of the team.

All people involved in clinical care (Grace[15], 1993) should work closely together and the 'us and them" attitude which still pervades some areas of dentistry should be removed to enable better patient care.

The most important role of the dentist is in the examination, treatment planning and prescription of patient care. The dentist should determine when delegation is appropriate to suitably trained and competent auxiliaries (Butler[16], 1975) and be responsible for and monitor treatment outcomes. As auxiliaries necessarily undergo limited training in specific areas of dentistry, which leaves large voids in their knowledge and their ability to fully assess the comprehensive treatment needs of the patient. Continued support from the dentist is imperative.

Job descriptions and guidelines should be established in light of current knowledge of the epidemiology of dental disease and critical appraisal and summary of the scientific literature in support of dental health care modalities (Burman[17], 1987, Leake et al[18], 1997) e.g. the decline in prevalence and severity of dental caries in a large proportion of the young population, with the emergence of specific at risk groups including lower socio-economic groups, the debilitated and the dentate elderly, will impact on the effectiveness of clinical practices and the areas of focus of the dental team.

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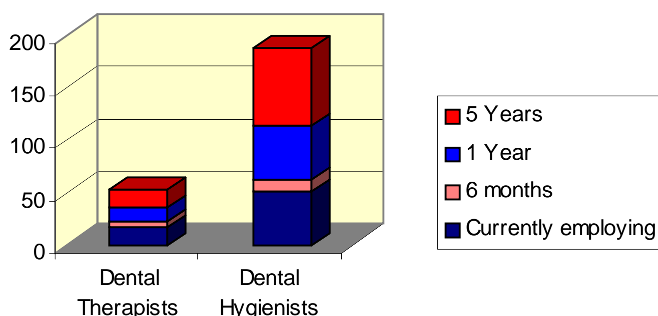
APPENDIX 2. Future Employment Intentions

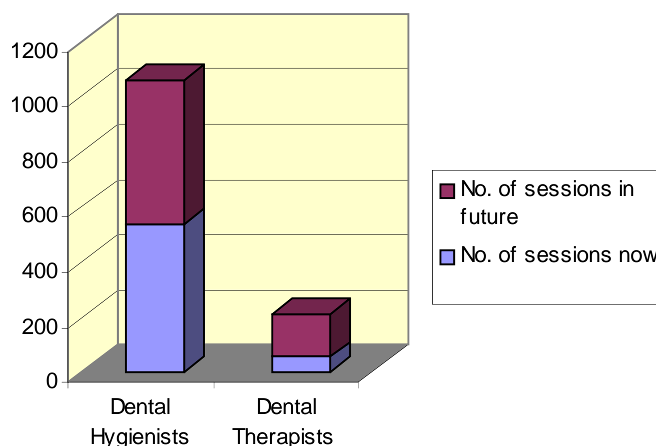
Given that there are only approximately 20 graduates from the Diploma of Oral Health Therapy each year, of which only 6 are dental hygienists this year, there may be a problem in meeting a very strong demand for future employment of these auxiliaries. In addition to the 86 respondents who advised that they currently employ a dental hygienist, a further 150 have indicated their intention to employ one at some time in the future. Projected demand is 12 in the next six months, 55 within the year and 75 within five years, for a total of 187.

Expressed in sessional terms, respondents indicated that they currently employ hygienists for 533 half-day sessions, and that they would employ them an additional 523 sessions within 5 years, bringing total employment to 1056 half-day sessions. This is equivalent to an additional 53 full time dental hygienists, or just over 10 per annum.



Demand exceeding supply is also evident in relation to dental therapists, with an additional 42 respondents above the current 16 indicating that they would intend to employ such an auxiliary in the future. Seven look to do so within six months, while 13 would do so within twelve months, and 19 within five years, for a total of 37.

Expressed in sessional terms, respondents indicated that they currently employ dental therapists in the private sector for 52 half-day sessions, and that they would employ them an additional 158 sessions within 5 years, bringing total employment to 210 half-day sessions. This is equivalent to an additional 16 full time dental therapists, or just over 3 per annum.



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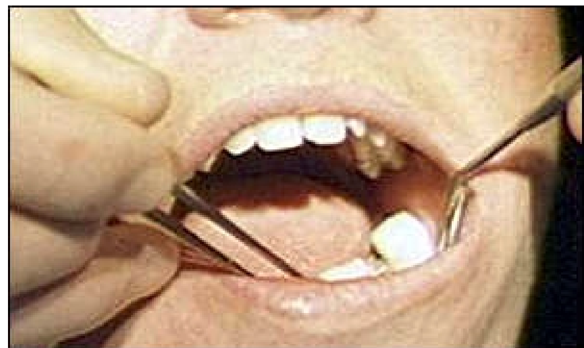
APPENDIX 3 – Possible Template for Dental Risk Management Guidelines Or Codes

Given that the primary object of the Dental Practice Act 1999 is "to minimise the community's exposure to health risks in dental care", Codes of Practice can be seen to be risk management guidelines.

The dimensions within which dental risk management guidelines are devised could include the following as a template structure.

- Description of the risk situation, including participants and circumstances, treatment modality, stage in the total treatment process, and the physical environment in which the situation arises (usually chairside)
- Key terms and concepts related to the issue or problem situation
- Description of the specific issue and comments on the risk exposure faced by the patient and/or dental personnel
- Action recommended to minimise risk associated with each aspect of the situation
- Any specific legal obligation that needs to be taken into account e.g. radiation safety or drugs and poisons obligations
- Specific warnings or other information that should normally be provided to a patient in connection with the treatment
- Ethical considerations arising from the risk involving relationships with the patient and other people
- Resources that practitioners may use to assist them in development of deeper understanding of the issues associated with the risk
- Record formats and pro-formas which might aid documentation and administration of situations such as those addressed
- Any educational modules or courses which may be available to assist practitioners in addressing developmental, competency or skill requirements for themselves or their staff.



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APPENDIX 4 Selected Extracts From The Dental Practice Act 1999

3. Definitions

In this Act— …

"**Board**" means the Dental Practice Board of Victoria established under Part 6;

"**dental care**" includes dentistry;

"**dentistry**" means the diagnosis or management of conditions of the mouth of a person, the performance of any invasive or irreversible procedure on the natural teeth or the parts of a person's body associated with their natural teeth or the provision to a patient or the insertion or intraoral adjustment of artificial teeth or dental appliances for a patient;

…

"**register**" means the register of dental care providers and dental students kept under Part 2;

"**registered dental auxiliary**" means a person registered under Part 2 in the dental auxiliaries division of the register;

"**registered dental care provider**" means a person registered under Part 2 other than a registered dental student;

…

"unprofessional conduct" means all or any of the following—

(a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered dental care provider;

(b) professional conduct which is of a lesser **standard** than that which might reasonably be expected of a registered dental care provider by his or her peers;

(c) professional misconduct;

(d) infamous conduct in a professional respect;

(e) providing a person with dental services of a kind that is excessive, unnecessary or not reasonably required for that person's well-being;

(f) influencing or attempting to influence the conduct of a dental care provider's practice in such a way that patient care may be compromised;

(g) the failure to act as a dental care provider when required under an Act or regulations to do so;

(h) providing dental care that the provider is not registered to provide;

(i) the contravention of or failure to comply with a condition, limitation or restriction on the registration of the dental care provider imposed by or under this Act;

(j) the contravention of a provision of this Act or the regulations; or

(k) a finding of guilt of—

(i) an indictable offence in Victoria, or an equivalent offence in another jurisdiction; or

(ii) an offence if the dental care provider's ability to continue to practise is likely to be affected because of the finding of guilt or if it is not in the public interest to allow the dental care provider to continue to practise because of the finding of guilt; or

(iii) an offence as a dental care provider under any other Act or regulations.

66. Advertising guidelines

(1) The Governor in Council may, on the recommendation of the Board, by notice published in the Government Gazette, issue guidelines about the minimum **standards** acceptable to the Board for or with respect to the advertising of dental services.
(2) The Board must consult with any person nominated by the Minister in formulating guidelines for the purposes of this section.
(3) The Board must ensure that any guidelines that it has formulated for recommendation to the Governor in Council have been notified with a request for public comment in the Government Gazette, a newspaper circulating generally throughout Victoria and in any professional magazine, newsletter or journal circulating amongst dental care providers in Victoria at least 60 days before the recommendation is given to the Governor in Council.
(4) The Board must have regard to any comments received pursuant to a notice under this section in making a recommendation to the Governor in Council.
(5) The Board must have regard to any guidelines issued by the Governor in Council under this section.
(6) A court may have regard to any guidelines issued by the Governor in Council under this section.

69. Powers, functions and consultation requirements

(1) The Board has the following functions—
(a) to register persons in appropriate divisions or subdivisions of the register who comply with the requirements of this Act as to registration so that they may practise and hold themselves out as registered dental care providers;
(b) to approve courses and training which provide qualifications for each of the divisions or subdivisions of the register;
(c) to regulate the **standards** of practice of dental care providers;
(d) to investigate the professional conduct or fitness to practise of registered dental care providers and registered dental students and impose sanctions where necessary;
(e) to promulgate **Codes about the practice of dentistry**;
(f) to issue **guidelines** about—
(i) the minimum terms and conditions of insurance against civil liability in connection with the practice of dental care providers;
(ii) appropriate **standards of practice** of dental care providers;
(g) to recognise educational, training or research institutions for the purposes of this Act;
(h) to advise the Minister on any matters relating to its functions;
(i) when so requested by the Minister, give to the Minister any information reasonably required by the Minister;
(j) any other functions conferred on the Board by this Act.
(2) The Board has all the powers necessary to enable it to perform its functions.

(3) In carrying out its functions and exercising its powers, the Board must—
(a) consult with the Minister and have regard to the Minister's advice; and
(b) have regard to the following objectives—
(i) to minimise the community's exposure to health risks in dental care;
(ii) to promote the community's access to dental care.

98. Regulations

(1) The Governor in Council may make **regulations** for or with respect to—
(a) registration, including conditions of registration, periods of registration, and renewal of registration, and applications for registration, and renewal of registration;
(b) the register, including particulars to be noted on the register and the manner of keeping the register;
(c) forms for the purposes of this Act;
(d) time limits for the purposes of this Act;
(e) penalties, not exceeding 10 penalty units, for breaches of the regulations;
(f) any matter or thing required or permitted to be prescribed or necessary to be prescribed to give effect to this Act.
(2) The **regulations**—
(a) may be of general or limited application; and
(b) may differ according to differences in time, place or circumstance; and
(c) may apply, adopt or incorporate any matter contained in any document, **code, standard,** rule, specification or method, formulated, issued, prescribed or published by any person whether—
(i) wholly or partially or as amended by the regulations; or
(ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or
(iii) as formulated, issued, prescribed or published from time to time; and
(d) may confer a discretionary authority on a specified person.

(Emphasis added)

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Appendix 5 - Extracts: Occupational Health and Safety Act 1985

55. Codes of practice

(1) For the purpose of providing practical guidance to employers, self-employed people, employees, occupiers, designers, manufacturers, importers, suppliers or any other person who may be placed under an obligation by or under this Act, the Minister may approve any code of practice.
(2) A code of practice may consist of any code, standard, rule, specification or provision relating to occupational health or safety and may apply incorporate or refer to any document formulated or published by any body or authority as in force at the time the code of practice is approved or as amended formulated or published from time to time.
(3) The Minister may approve any revision of the whole or any part of a code of practice or revoke the approval of a code of practice.
(4) The Minister shall cause to be published in the Government Gazette notices of—
(a) the approval of a code of practice;
(b) the approval of a revision of the whole or any part of a code of practice; and
(c) the revocation of approval of a code of practice.
(5) The Minister shall cause a copy—
(a) of every approved code of practice;
(b) where an approved code of practice has been revised and that revision has been approved, of every approved code of practice as so revised; and
(c) where an approved code of practice applies incorporates or refers to any other document, of every such document—to be made available for inspection by members of the public without charge at the office of the Authority during normal office hours.
(6) An approved code of practice shall come into effect—
(a) on the day on which notice of approval of the code of practice is published in the Government Gazette
or on such later day as may be specified in the notice; and
(b) where the code of practice has been revised in whole or in part, to the extent of that revision on the
day on which notice of approval of that revision is published in the Government Gazette or on such
later day as may be specified in the notice.
(7) An approved code of practice shall cease to be of effect at the end of the day on which notice of the revocation of approval of the code of practice is published in the Government Gazette.
(8) A person shall not be liable to any civil or criminal proceedings by reason only that the person has failed to observe any provision of an approved code of practice.

56. Use of codes of practice in proceedings

Where in any proceedings under this Act it is alleged that a person contravened or failed to comply with a provision of this Act or the regulations in relation to which an approved code of practice was in effect at the time of the alleged contravention or failure—
(a) the approved code of practice shall be admissible in evidence in those proceedings; and
(b) if the court is satisfied in relation to any matter which it is necessary for the prosecution to prove in order to establish the alleged contravention or failure that—
(i) any provision of the approved code of practice is relevant to that matter; and
(ii) the person failed at any material time to observe that provision of the approved code of practice— that matter shall be taken as proved unless the court is satisfied that in respect of that matter the person complied with that provision of this Act or the regulations otherwise than by way of observance of that provision of the approved code of practice.

Appendix 6 – Extracts from OHS Code of Practice re Manual Handling

The Legislative Framework

Occupational Health and Safety Act 1985	The Act sets out general duties of care for employers, employees, designers, manufacturers, importers and suppliers. The Act also enables regulations to be made about the safety, health and welfare of people at work.
Occupational Health and Safety (Manual Handling) Regulations 1999	The aim of the Regulations is to protect people at work against musculoskeletal disorders caused by manual handling. The Regulations set out specific duties for employers and employees, and for designers, manufacturers, importers and suppliers of plant. Section 47(1) of the Act states that failure to comply with regulations made under the Act is an offence.
Code of Practice for Manual Handling	The code provides practical guidance on how to comply with the Regulations. The provisions in a code are not mandatory. That is, a person may choose to comply with the Regulations in some other way, as long as that method also fulfils the requirements of the Regulations. However, in legal proceedings, failure to follow an approved code of practice can be used as evidence that a person or company has not complied with provisions of the Act or Regulations.

Appendix 1 - What is a code of practice?

The Occupational Health and Safety Act 1985 (the Act) empowers the Minister to approve codes of practice.

What are they?

An approved code of practice gives practical guidance on how to comply with a general duty under the Act or a specific duty under the Regulations. Compliance with the provisions of an approved code of practice, where relevant, may constitute compliance with the provisions of the Act or Regulations on which the code is giving practical guidance.

Generally, an approved code of practice contains various courses of action which are designed to achieve health and safety standards required by the Act or Regulations. Codes usually contain a number of options for meeting standards.

Who do they apply to?

Codes of practice may be written to provide practical guidance for any person placed under obligation by the Act or its Regulations, for example, employers, manufacturers and employees.

Each approved code of practice will state the persons for whom the guidance is intended.

What is their legal status?

The provisions in a code are not mandatory. That is, a person may choose to comply with the relevant provision of the Act or Regulations in some other way, provided that the method used also fulfils the requirements of the Act or Regulations. A person or company cannot be prosecuted simply for failing to comply with an approved code of practice.

However, in legal proceedings, failure to observe a relevant approved code of practice can be used as evidence that a person or company has contravened or failed to comply with the provisions of the Act or Regulations. If a person has not adopted the method described in the code, it is up to that person to show that the legal requirement has been met by an alternative method. Therefore, an approved code of practice should be followed, unless there is an alternative course of action that would also fulfil the requirements of the Act or Regulations.

A WorkCover inspector may cite an approved code of practice as a means of remedying alleged non-compliance when issuing an improvement notice or a prohibition notice. Similarly, a health and safety representative may cite an approved code of practice in a provisional improvement notice when providing directions as to how to remedy an alleged non-compliance.