



Revised Draft Code of Practice: Practice of Dentistry by Dental Auxiliaries



**Submission to Dental Practice Board of Victoria by
Australian Dental Association Victorian Branch Inc.**

March 2007

**ADAVB Submission to DPBV re draft Code of Practice:
Practice of Dentistry by Dental Auxiliaries**

KEY POINTS

The ADAVB contends that the revised draft Auxiliaries Code is unworkable, failing to serve the purpose it is intended to address - to provide clear and helpful guidance to dental care providers and the public in the interests of protecting public health and safety.

This submission and its attached legal advice assert that the draft Code:

- fundamentally changes the relationship between the dentist and auxiliary
- will destroy the dental team which it seeks to promote
- allows and promotes independent practice rights for dental therapists and dental hygienists, and that we believe this will lead to a reduction in the standard of care provided to the community and increased professional indemnity insurance costs
- proposes a mechanism by which dentists would be held accountable for treatment outcomes achieved by auxiliaries, but that this mechanism is not defined, and therefore would be legally invalid once challenged
- sets out to offer guidance on standards of practice but leaves the question of what dental auxiliaries can or can't do almost entirely up to them or to educational institutions
- has the potential to result in supervised neglect of patients by not requiring that they undergo a regular and comprehensive examination by a dentist and encouraging dental therapists and hygienists to consider themselves the primary dental care providers
- allows and encourages educational institutions to determine the duties of auxiliaries leading to them becoming indistinguishable from dentists

Many ADAVB members have contacted the Branch to express their concerns that the draft code will reduce patient safety and lead to increased liability for dental care providers – both dentists and auxiliaries. The ADAVB vigorously opposes the draft code in its present form, and views it as a retrograde step for the provision of quality dental services in this State.

RECOMMENDATION

- **That the Board either retain the previous code, or make such further amendments to the new code that it addresses the above concerns.**



Definitional matters

Under the Dental Practice Act 1999, the Dental Practice Board of Victoria (DPBV) regulates “*the standards of practice of dental care providers*”.

A similar power is included in the Health Professions Registration Act, which is due to take effect from 1 July this year.

“to regulate the standards of practice in the health profession regulated by the board in the public interest”.

Under the Dental Practice Act 1999, the Board is also empowered:

- “(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;*”

Both Acts are silent however on the definition of a ‘standard’ or a ‘standard of practice’.

Standards Australia defines a standard as ‘a document, established by consensus and approved by a recognised body, that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context’. (Source: Standards Australia Standards Guide SG-001 Preparing Standards)

In its Discussion Paper on National Safety and Quality Accreditation Standards, the Australian Commission on Safety and Quality in Healthcare (ACSQH) notes this definition and observes that

“Standards therefore can provide standardisation of approach and achieve consistent outcomes which can be applied widely and repeatedly.” (p.5)

The ACSQH paper goes on to say that:

“In health, standards can be identified in policy, information bulletins, circulars, procedure, protocol, work instructions, guidelines, handbook, rules, statement, codes of conduct, regulation, benchmarks and Acts of parliament. The context can indicate the level of consensus or authority with which they are made or are intended to be used.

The definition ... adopted in this paper, is that standards are an agreed attribute or process designed to ensure that a product, service or method will perform consistently at a designated level. This definition was adopted by the former Council because it encompassed all standards that have an impact across the continuum of care whether specific to health care systems or not.” (p.5)

A key requirement of a standard is that it is an agreed set of arrangements, and the level of agreement signifies or equates to the level of authority attached to it.



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The ADAVB considers that these requirements of ‘standardisation’, ‘agreed attributes’, and the establishment of ‘rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order’, are not met by the draft Code of Practice. The flexibility offered by this draft is so great that it is likely to lead to a very wide range of outcomes rather than ‘consistency’ or ‘order’.

The following statement appears in the Introduction to the Australian Capital Territory Health Professionals (ACT Dental Board Standards Statements) Approval 2007 (No 1):

“Standards of practice are issued in the form of Standards by an appropriate authority under the Health Professions Regulation 2004 (the Regulation). Those Standards are intended to:

- *set a basis for the required standard of professional practice*
- *inform dental care providers within the ACT of the required standard of professional practice*
- *inform the community of the standard of professional practice for dental care providers*
- *provide the Board with a basis for decisions regarding professional misconduct or unprofessional conduct; and*
- *guide dental care providers towards formal or informal resolution of ethical violations when they arise.*

The Board will ensure, as far as practicable, that the profession-specific Standards developed or endorsed by the Board will be consistent with those standards developed by the professional representative bodies.”

If a similar approach was taken by the DPBV and the draft was to be assessed from the perspective of providing a basis for decisions regarding professional misconduct, it would quickly confirm the inadequacy of the draft code.

The Lack of a Statutory Framework

The DPBV draft Code appears to use similar language and in some cases similar concepts to those embodied in documents published by the General Dental Council (GDC) in the UK. Concepts such as the ‘dental team’, and the ‘dentist as team leader’ are common in publications from both organisations. Likewise the notion that auxiliaries should only perform those duties which they are trained and competent to do is common to both jurisdictions.

There are some notable differences between the approaches of the two regulatory bodies however, and a comparison reveals that the GDC has put in place measures by which the public and the dental care providers can be clear and confident about standards, while the DPBV has not.

The GDC has made explicit the statutory framework. It contains developed standards and guidelines to assist registered persons and patients to understand how the regulations work to achieve public interest objectives.

The reference to ‘PCDs’ in this extract means ‘Professionals Complementary to Dentistry’, a term later replaced by ‘Dental Care Professionals’.



“A STATUTORY FRAMEWORK FOR THE REGULATION OF ALL MEMBERS OF THE DENTAL TEAM

It is proposed that, in place of the current arrangements, there should be a comprehensive new statutory system for regulating the dental team, the key features of which would be:

- a) Only registrants of the GDC to be permitted to practise dentistry;*
- b) The GDC to hold two registers, one for dentists and one for PCDs;*
- c) Entry to the PCD register to be on the basis of curricula and qualifications recognised and regulated by the GDC (and, as a transitional measure for established PCD groups, relevant validated experience);*
- d) Certain titles (for example, dental hygienist, dental therapist, dental nurse, dental technician, clinical dental technician, orthodontic therapist) to be reserved by law to those who become registered on the basis of holding a recognised qualification or who have relevant validated experience;*
- e) PCDs to be permitted to practise dentistry in respect of those responsibilities for which they have received education and training **in accordance with the Council’s guidance and for which they have received clear and mutually accepted authorisation from a registered dentist;***
- f) Every registrant to be responsible to the GDC for practising within their limits of competence, and for the procedures undertaken;*
- g) **Dentists to be additionally responsible to the GDC for ensuring that colleagues in teams they lead are not asked to undertake practice beyond their competence;***
- h) PCD educational curricula to define the knowledge, skills and attitudes which a PCD must have on first registration;*
- i) No barriers to prevent PCDs expanding their range of skills through recognised training and experience. A modular approach across PCD training routes should be encouraged;*
- j) Clear ethical guidance to be issued to dentists and PCDs on their roles and responsibilities;*
- k) Integration of PCD regulation into the work of the GDC, to include regulation of all dental education, compulsory CPD, and common fitness to practise procedures (conduct, health and performance) for all registrants.”*

(See: http://www.gdc-uk.org/NR/rdonlyres/3029D7DD-81AE-41C6-973A-F39FE7287BF8/15135/developing_dental_team2004.pdf accessed on 8 March 2007)

No similar framework appears to underpin the draft Code of Practice, as there is no longer any requirement for a dentist to authorise work and to ensure that auxiliaries in a team led by that dentist are not asked to undertake practice beyond their competencies. The draft code includes no clauses equivalent to those highlighted in the GDC framework above, thereby making it considerably weaker.

Independent practice rights

The draft Code institutes a fundamental and unwarranted change to the relationship between the dentist and auxiliary, allowing for the dental auxiliary to practice as an independent practitioner, provided they have some unspecified form of written agreement with a dentist to be involved in a consulting/backup role. This Code, as was the case with the previous one, makes it clear that the written agreement is not an employment agreement. The previous code stated that “a dental

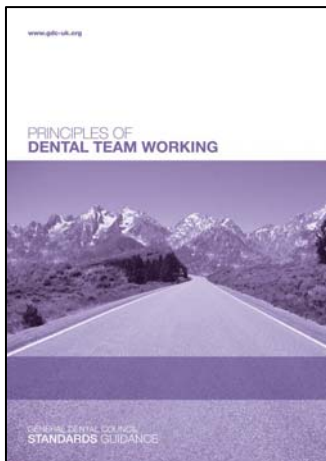


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auxiliary may not engage in independent practice”, however these words have been deleted in the new draft code.

A proposal from the DHAA that hygienists should be able to tender for work in hospitals, prisons, aged care residences, indigenous and rural communities, maternal and child health centres and schools, without the involvement of a dentist has also been noted. The wording of the draft Code appears to confirm that the Board has been persuaded to change the traditional model of care in which general practitioner dentists acted as care coordinators, and so create circumstances under which dentists may never have opportunity to see patients. With the Board’s blessing, a new type of dental operative will provide any type of preventive, restorative, periodontal and orthodontic care they wish, without a dentist ever having to see the patient. Potential dental students will question the value of a five-year degree or a seven-year dental graduate degree when they can do many dental activities with a three-year degree under the Board’s new Code. In an ageing population, where treatment complexity is increasing, the approach advocated by hygienists and apparently supported by the Board, will see reduced quality of care.

The private practice rights allowed under this Code raise the possibility of hygienists or therapists having a pool of patients, each of whom may have an established relationship with their own dentist, but choose to see a hygienist as well. The independently practising hygienist or therapist would be able to comply with the Code by having a number of separate agreements with various dentists. In fact, the wording of the draft code would also allow a single entrepreneur with a Bachelor of Dental Science degree to enter into agreements with **all** registered therapists and hygienists, under which they offer their services as a (remote) consultant. Is this what the Board intended?



The GDC has published a set of guidelines - called ‘Principles of Dental Team Working’ - in which they note a number of key requirements for the effective operation of a team and for the provision of safe and effective dental care. They define the dental team as:

“the group of people who together provide care for a patient. Teamwork means working together to provide good-quality dental care.” (p.4)

The following extracts from their guidelines emphasise the importance of dentists acting as care coordinators and team leaders; roles which seem to have been eliminated in the Board’s new draft code. (Note: in the following extracts, the GDC refers to dental auxiliaries as DCPs – or ‘Dental Care Professionals’):

“2.1 Patients should be seen by a dentist before being treated by other members of the dental team. The only current exception to this is edentulous patients (patients with no teeth), who may be seen by a clinical dental technician without seeing a dentist first, for the supply and maintenance of full dentures only.



2.2 We may approve other cases if we are satisfied that dental care professionals (DCPs) have received the necessary training to be able to see patients without them seeing a dentist first.

2.3 Patients should have a full mouth assessment by a dentist. The dentist should then give the patient an outline treatment plan or full treatment plan if necessary, depending on the patient's needs.

2.4 The treatment plan could be as simple as a statement that the patient has good oral health, and needs no more than routine oral care for the next three years, or a detailed plan for complex treatment and reassessment in three months.

2.5 The treatment plan (whether an outline plan or full treatment plan) should include:

- *recall intervals, depending on the patient's clinical needs;*
- *a date for a full mouth reassessment by a dentist; and*
- *a referral if necessary.*

(The reassessment date is the date when the patient must return to be seen by a dentist for a full-mouth examination and treatment plan.)

(The recall interval is how often the patient should return to be seen by a member of the dental team.)

2.6 The recalls might not be recalls to the dentist, and the dentist can ask the DCP to set the intervals.

2.7 Until the date of the full-mouth reassessment by a dentist, the patient may take the treatment plan to any appropriate registered dental professional who can, within the overall limits of the plan and the limits of their competence, treat the patient (and make any further appropriate referrals) until that date."

(See: http://www.gdc-uk.org/NR/rdonlyres/79B1032C-4B07-460E-A2BA-D7A388D7754E/31247/Dental_Working_Team.pdf, accessed on 8 March 2007)

In dealing with the issue of response to medical emergencies and home visits, the following guidance is provided:

"3.7 When treating patients, make sure there is someone else – preferably a registered team member – present in the room, who is trained to deal with medical emergencies.

3.8 There may be circumstances in which it is not possible for a trained person to be present – for example, if you are treating a patient in an out-of-hours emergency or on a home visit. If this is the case, you are responsible for assessing the possible risk to the patient of continuing with treatment in the absence of a trained person."

In the section on 'Communicating with Patients', the GDC is at pains to ensure that there is direct advice to patients about who will be treating them and where they fit in the overall dental team. No equivalent consideration for patients occurs in the draft code.

"4.1 Make sure patients know who makes up the team providing their care.

4.2 Give patients a clear picture of the important relationships within that team. This includes telling patients who has overall responsibility for their treatment.

4.3 When a patient's care is being delivered by several members of a team, make sure that a clear written treatment plan is kept, and that clinical records are maintained and updated, and shared with everyone involved."



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In relation to referrals between auxiliaries and dentists, the GDC offers the following sensible advice:

“4.10 If you are a DCP, make sure you understand the circumstances in which you should refer the patient to a dentist and that there is a procedure for doing this. Make this procedure clear to the patient. You have a responsibility to explain to the patient the importance of seeing a dentist regularly.”

The GDC makes the point that there are certain pre-conditions for the creation of a good team.

“5.1 A good team will have:

- *good leadership;*
- *clear, shared aims, and work together to achieve them; and*
- *different roles and responsibilities, and understand those roles and responsibilities.”*

Regrettably Victorian dental practices operating under the proposed code would not be able to say they have good dental teams, because none of these qualities are required.

No dentist examination

The draft Code includes no requirement that the dentist must have examined the patient at any stage, implying that the ‘auxiliary’ is now the primary care provider and that they may refer to a general practitioner dentist in the same way that historically dentists have referred to dental specialists. Our reading of the Code suggests that it allows for independent auxiliaries to bypass general practitioner dentists altogether and refer straight to specialists.

The model of care traditionally used, and still supported by the ADA, sees general practitioner dentists as the care coordinators who refer complex work to specialists and delegate simpler work to employee auxiliaries (see also pp 12-15 below).

Some auxiliaries are employed by specialist periodontists, paedodontists and orthodontists and in these cases it makes sense that they will work with their employer as their team leader. However, if auxiliaries can be independent practitioners under this code, they will be able to avoid referral to a general practitioner and enter into agreements only with specialists, including specialists outside areas such as periodontics and orthodontics. This is inappropriate, and measures such as those quoted above from the GDC’s standards paper, which require that a dentist examines the patient before any treatment is provided by an auxiliary, should be included in the DPBV code.

Training institutions to decide what auxiliaries can do

The Board uses a form of words similar to that adopted by the GDC in suggesting that auxiliaries should only do what they have been trained and are competent to do. The relevant text is similar to that which appeared in the previous Code, however in the context of other changes which have been made, it must now be read in a different light.



The Board does not itself accredit training courses leading to registration. It approves institutions and accepts the accreditation decisions of the Australian Dental Council regarding the suitability of courses as preparation for practice in each of the registered dental occupations.

The GDC is effectively the dental course accreditation body in the UK, and so it exercises control over what the training institutions do to prepare candidates for registration. The GDC therefore provides specific guidance to educational institutions as to what is expected in the curriculum for each of the training programs leading to registration as a dental care provider. The GDC can afford to use such a broad description of the scope of practice within its standards document, because it has been quite specific in setting the minimum educational standards required for registration. There is no equivalent guidance from the DPBV to educational bodies training dental therapists and dental hygienists in Victoria or indeed across Australia.

Specialists in the fields of periodontics and orthodontics might need to be aware that universities will now have the power to decide what these auxiliaries can do, and that under the Board's code there will be nothing to stop a university from establishing a Bachelor of Oral Health designed purely around one or other of these fields so that the operative will be able to claim that they are 'specialists' in these fields.

Increased liability for dentists and auxiliaries

Under the draft Code, the decision as to whether an auxiliary is competent to provide treatment appears to be theirs alone, and outside of an employment relationship, the only power a dentist might have to influence that judgment would be withdrawal of their participation in a written agreement and 'consulting support'. In our view, this exposes the dentist to far too high a risk of legal liability without appropriate risk management control over the nature and quality of treatment provided. It is possible that they will find out about a patient and their problem for the first time when a writ is served, and despite not ever having met the patient, will have no defence to avoid liability for something over which the Board's Code gave them no control. This should never be allowed to occur.

As highlighted in the attached legal advice from Guild Lawyers, dentists are being asked to take on an unreasonable liability for treatment outcomes over which they may have no input.

In the light of this advice, we asked our professional indemnity (PI) insurer whether a higher premium would be required under this code in circumstances where the auxiliary is in an employment relationship which is similar to the present code situation but without the clarity of a list of defined duties. The insurer advised:

"In this case, we feel there is unlikely to be any immediate increase to the premium payable by the auxiliary, but the impact would most likely be felt on the employing dental practitioners' own premium (eventually, based upon claims experience). This is because, under this arrangement, the dentist is still effectively supervising the auxiliary, and will therefore on most occasions be held to be vicariously liable for the activities of the auxiliary. We would expect the expanded range of auxiliary duties to bring additional claims for obvious reasons."



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We also asked whether a higher premium would be required under this code in circumstances where the auxiliary is practicing independently, where a dentist is somewhere else (outside the practice) providing consulting support. They indicated that claims experience would dictate the premium payable over the medium to longer term, but added:

*“Based on the increased exposure, **we would expect premium rates to initially increase by around 80%**, bringing the current premium for \$10m cover up from \$320 to around \$575.”* (Emphasis added)

They also noted that to the best of their knowledge, there is no other jurisdiction in Australia where independent practice has already occurred.

The agreement

The new approach to the agreement between an auxiliary and dentist is no clearer in this version of the code than in the previous one. It is made much less acceptable however by removal of the control measures that would permit the dentist to manage his or her risk.

With the other changes that have been incorporated into this draft, the notion in clause 21 that the agreement must be consistent with terms and conditions of PI insurance (which had appeared in similar form in the previous code) now seems to imply that as for curriculum decisions being left to the training institutions, the Board is happy to leave it up to insurers to decide how the risk to the public should be managed.

In our view the advice we and our PI insurer will need to give to dentists is that they should not sign an agreement with a dental hygienist or dental therapist unless they are employees of the practice. The effect of this will be to exclude from cover any treatment provided by an auxiliary outside an employment relationship.

The Board’s need to accommodate public dental agencies that wish to remove the problem of having a dentist available to examine and treat patients, and to use a cheaper and more readily available workforce, appears to be the cause of the open-endedness in the draft code, and the frustration felt by private practitioner dentists concerned about public health and safety. The Board has used a generic approach and removed all reference to employer-employee relationships in deference to the public sector, when it should in fact have two approaches - one for each of the public and private sectors.

Inconsistency with other jurisdictions

All other jurisdictions in Australia retain defined duties for dental auxiliaries and require that a dentist has direct control over the welfare of the patient and their overall oral health. At a time when COAG is seeking consistent arrangements across all jurisdictions, why is the Victorian Board making such a radical and pre-emptive change to the regulation of dental service delivery?



The Australian Capital Territory only very recently (as at 21 December 2006) confirmed Health Professionals (ACT Dental Board Standards Statements) Approval 2007 (No 1) - Notifiable instrument NI2007-9 made under the Health Professionals Regulation 2004, Section 134 (Standard's Statement), which includes both clearly defined auxiliary duties and supervisory arrangements.

Likewise, the Dental Board of Queensland updated its Code of Practice regarding dental auxiliaries in July 2006, and both a defined list of duties and supervision requirements continue to be included.

Possible trade practices issues

Where an auxiliary chooses to practice independently (i.e. not as an employee), we believe the written agreement between that auxiliary and a dentist (who is another independent or incorporated entity) may potentially expose the dentist to restraint of trade liability. Has the Board satisfied itself with expert legal advice that dentists could not be found in breach of Trade Practice law in these circumstances?

Depending on the way the agreement is framed, it might be construed to constitute third line forcing, or price fixing, and so breach the Trade Practices Act. This is another reason why the ADAVB would recommend to members that they not sign an agreement with an independent auxiliary.

Informed consent

Members have often reported that dental therapists working in the public sector have not identified themselves as such, and their patients have assumed that they were dentists. The Code is silent on the whole matter of auxiliary personnel informing patients of their registered title, and in circumstances where independent practice rights are being granted, we believe this should be addressed so that patients' consent to treatment by this newly independent operative is informed and patients fully understand the difference between being treated by dentists and auxiliaries (see also comments on scope of practice on page 11 below).

With this in mind, ADAVB poses the following questions:

- Would a patient of a hygienist have a say in which dentist the hygienist has an agreement with, or conversely, which hygienist/s the dentist has agreements with?
- What if a dentist refuses to be identified as a consultant for a particular hygienist, but the patient wants to continue seeing both that dentist and independently, that hygienist?



Patient privacy

ADAVB questions whether the patient's privacy will be fully protected - for instance, where the hygienist wishes to discuss that patient's clinical details with a dentist with whom the hygienist has an agreement, but the patient has no relationship with the dentist, and indeed has never met them. Surely this situation would cause compliance problems under Privacy and Health Records Acts?



Scope of practice

The revised Auxiliaries Code suggests that it “describes the scope of practice of dental auxiliaries registered in Victoria”, whereas in fact it has deleted almost all reference to the scope of practice for these two classes of dental operative, and now vaguely refers to them performing “only those facets of dentistry for which they have been formally educated, in courses approved by the Board, and in which they are competent” in the very wide areas of periodontics, orthodontics, restorative and preventive care.

Given the lack of any direction to dentists as to what the Board considers these auxiliaries can now do, and the proposal that no dentist must actually be present on the premises when an auxiliary is providing treatment, we suggest that the Board is effectively allowing auxiliaries to do whatever they wish, and question why a dentist must be held in any way accountable for the problems that will inevitably arise.

Furthermore it is unreasonable to expect dentists to obtain and study the curriculum of every dental hygiene and therapy course their staff may have done in order to determine whether they may be trained to provide treatment or not.

If both dental therapists and dental hygienists are able to do whatever parts of dentistry they feel competent to do in “preventive, periodontal, restorative and orthodontic dental services”, we question why there are still two titles.

Also, the poorly defined scope of practice will mean the public will have no basis for understanding what they can and can't do. Therefore patients will not be able to judge if their provider should be delivering their treatment and this will prevent them from giving genuine informed consent.

The existence of hybrid auxiliaries that have completed an oral health degree which is acceptable as a basis for registration as both a hygienist and a therapist does not seem to have been acknowledged in this code.



Section 9 of the draft code (as in the current Code) says that it will take into account CPD courses completed in determining levels of competence i.e. scope of practice. That seems to be at odds with note 11 in the accompanying Information Sheet, which notes there is a “distinction between courses that are formally approved by the Board for the expansion of a registered person’s skills and those educational activities that are undertaken for Continuing Professional Development (CPD) credit.”

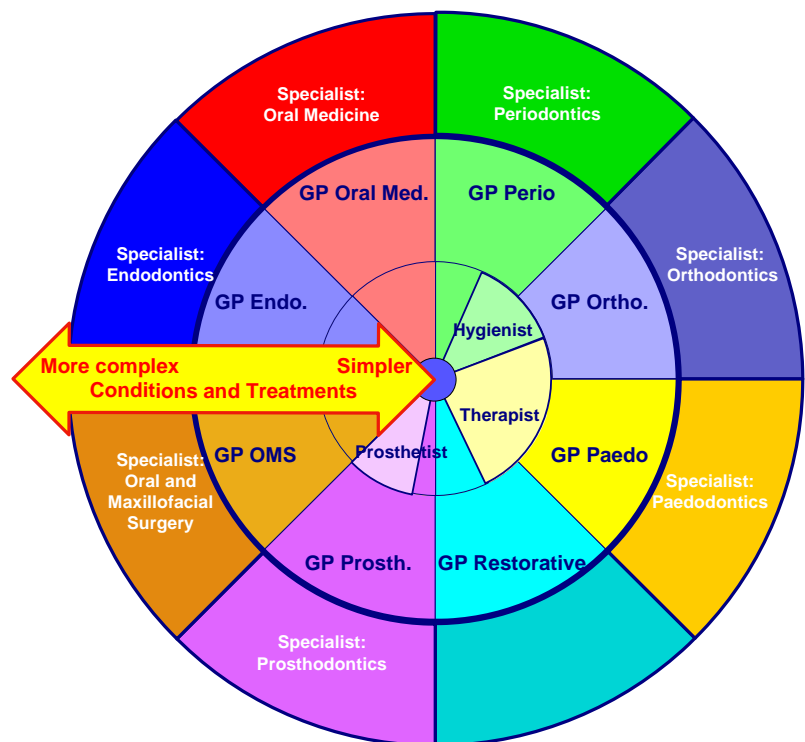
Model of care

The ADAVB would welcome the Board’s explanation of the model of care which is assumed to underpin the work of members of the dental team.

In our view, patient welfare is best served by a model which places the general practitioner dentist in the role of care coordinator. The schematic chart below presents a simplified view of the way in which treatments in the various fields of dentistry are delivered by the different types of dental care providers.

The chart indicates that simpler problems and treatments are near the centre of the wheel, while dental conditions and diseases, and their interactions with other health conditions, become more complex the further towards the outer rim one travels. The patient perspective in the inner blue circle reflects their limited understanding of oral diseases and conditions, and their contribution to treatment through self-managed care.

General practitioner dentists are trained to provide treatment across all modalities and areas, while specialist dentists provide highly complex treatment in only one nominated field. Likewise, dental auxiliaries such as dental hygienists, dental therapists and dental prosthetists only deliver basic treatment within selected areas, to which their training and skill are limited.





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The ADAVB considers that patients undergoing dental treatment will often have needs in multiple areas, and therefore general practitioner dentists should normally complete their dental treatment. However a dentist is also the care coordinator of the patient's overall dental treatment, referring to dental and medical specialists and/or auxiliaries as appropriate for selected aspects of patient care. This role is similar to that performed by the general medical practitioner in relation to general health.

Arguments for 'workforce substitution' do not recognise the sound patient welfare basis of this model when they suggest that a lesser trained auxiliary could safely substitute for a general practitioner dentist. Most older and public patients tend to have more complex conditions and therefore require a dentist to provide their treatment.

The approach adopted in the framing of the revised Code seems to have been devised from a resource-poor public sector perspective rather than the skills and qualities that dentists bring to the general community. That model places an auxiliary, usually a dental therapist, in the role of primary care provider, regardless of their lack of knowledge and skill in numerous areas of dentistry. If the Government wishes to impose an arrangement like this on public patients then it should be forthright in stating what it is doing and why. These same arrangements should not be applied to the private sector just because the public sector has resource problems. The community needs to be aware that two standards of care are being proposed and be given the opportunity to respond to that concept.

The treatment pathway used under the Code will not support establishment of ongoing partnerships between health care providers and their patients, and indeed is designed to promote piecework by public agencies focused on simply treating the next patient on the waiting list and thereby providing evidence of throughput to justify their funding. (See diagram on page 14 below).

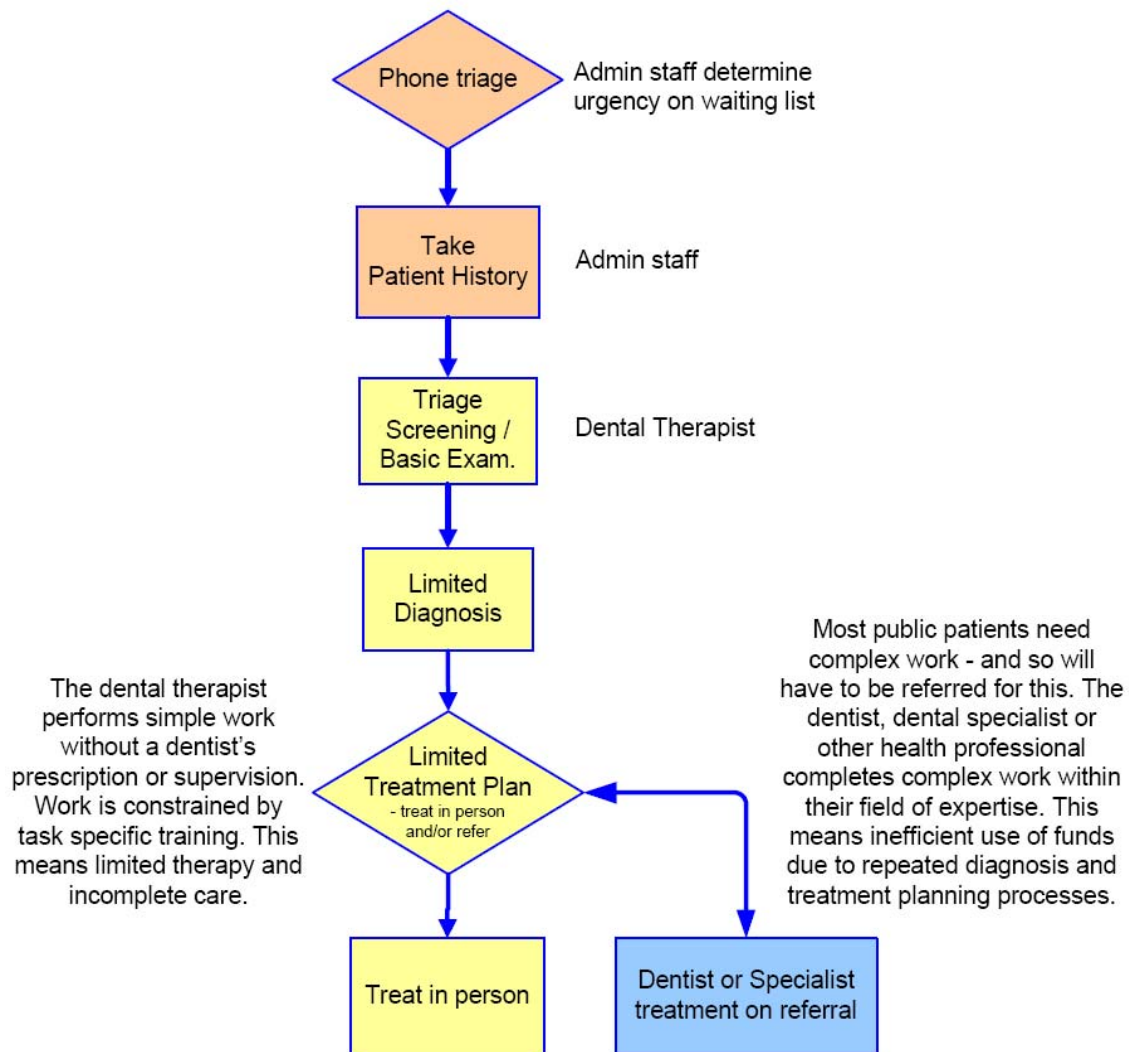
In our view the shortcomings of this approach result in the Board's objective of protecting public health and safety being compromised. A preferable model is the one which follows (on page 15), as it promotes continuing care and a partnership which involves the patient in self-managed care between attendances for professional care:

END.



Possible public dental treatment process

The dental therapist is primary care provider and refers if necessary

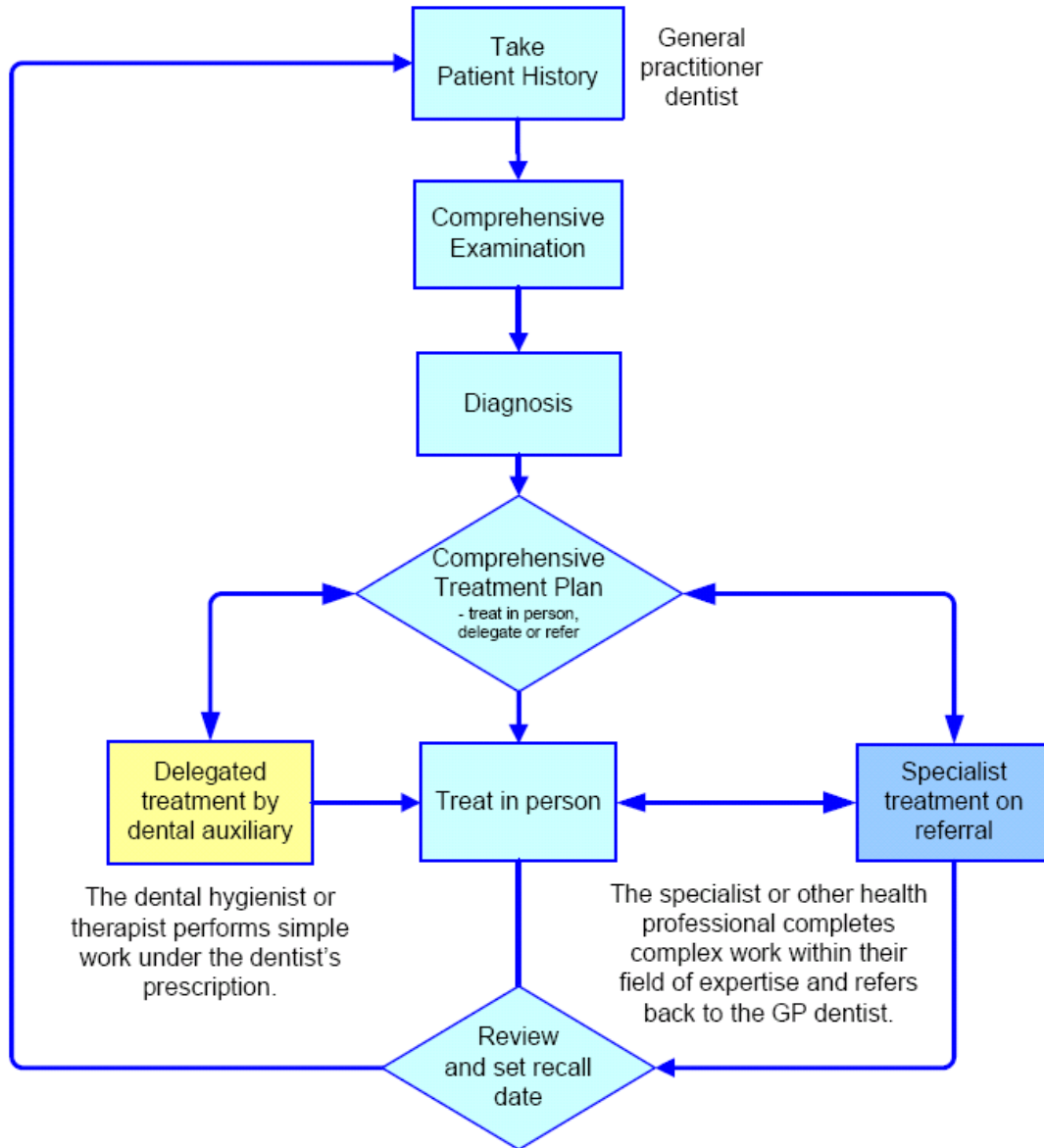


**No review or overall plan.
No ongoing work. Patient leaves and goes on to the waiting list again if they ask for this.
Treatment limited by annual funding caps.**



Dental Treatment Process

The dentist is primary care provider and care coordinator



The Dentist completes most treatment on an ongoing basis. The dentist is responsible for overall care management and oversees any treatment delegated to an auxiliary or referred to a specialist.

8 March 2007

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Dear Garry

Practice of Dentistry by Dental Auxiliaries – Draft Code of Practice No. C002 [2007]
Our Ref: MN:newc:2004785

1. We refer to our recent discussions and thank you for providing us with the opportunity to advise upon a draft Code of Practice that has been developed by the Dental Practice Board of Victoria (“DPBV”). The draft Code is titled “Practice of Dentistry by Dental Auxiliaries” (“the draft Code”).
2. In preparing this advice we have reviewed:
 - 2.1 The Dental Practice Act 1999 (“the Act”);
 - 2.2 The Dental Practice Regulations 2000;
 - 2.3 DPBV Policy no. P003;
 - 2.4 DPBV Code of Practice C003;
 - 2.5 DPBV Policy no. P007;
 - 2.6 Code of Practice No. C002 – Practice of Dentistry by Dental Hygienists and Dental Therapists (“the current Code”);
 - 2.7 The draft Code; and
 - 2.8 Draft information sheet prepared by DPBV titled “Practice of Dentistry by Dental Auxiliaries Information”.
3. We do not propose to comment upon the “scope of practice” issues and we confirm that you are happy for us to focus on the broader legal aspects of the draft Code.
4. It is our preliminary view that the draft Code has serious deficiencies. We are concerned by the absence of the current requirement that a dental auxiliary be in an employment relationship with a dentist. We consider the concept of the “Agreement” ill-conceived and un-workable. If the draft Code is promulgated we hold the view that it may:

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- 4.1 cause confusion amongst dental care providers about respective roles in the patient care scheme;
 - 4.2 cause tension between dentists and dental auxiliaries about respective rights and obligations under the proposed Agreements;
 - 4.3 result in a challenge to the legality of the Agreements under consumer protection legislation;
 - 4.4 result in a challenge to the enforceability of the Agreements generally;
 - 4.5 cause an increase in patient complaints, an increase in insurance claims and hence, an increase in the insurance premiums payable by dental auxiliaries; and
 - 4.6 cause a lowering of the standard of patient care.
5. In order to understand the above summation, it is necessary to:
- 5.1 consider the role of the DPBV;
 - 5.2 consider the effectiveness of the current Code;
 - 5.3 analyse the draft Code;
 - 5.4 consider the proposed status of the dental auxiliary as an independent practitioner; and
 - 5.5 consider the proposed Agreement.
6. We will now deal with each of these areas.

The Role of the DPBV

7. Section 69(1)(e) of the Act provides the DPBV with power to promulgate Codes about the practice of dentistry. Section 69(3)(b) of the Act provides that when exercising that power the DPBV must have regard to the following objectives:
- 7.1 to minimise the community's exposure to health risks in dental care.
 - 7.2 to promote the community's access to dental care.
8. It is arguable that the draft Code does not meet those objectives and indeed, is contrary to those objectives.
9. Policy No. P003 provides that one of the DPBV's major roles is to demarcate appropriate and acceptable standards of practice of dental care providers to provide standards against which their conduct can be evaluated. These standards will be set out in Codes of practice. P003 then goes on to define a Code of Practice as:

“The Board will establish Codes of Practice to regulate the standards of practice of dental care providers. These Codes of practice may relate to any matter that directly affects clinical practice”.

10. It is arguable that the draft Code does not demarcate appropriate and acceptable standards of practice for dental auxiliaries against which their conduct can be evaluated.

The Current Code

11. The key features of the current Code can be summarised as follows:
- 11.1 A dental auxiliary may not engage in independent practice.
 - 11.2 There must be a team approach in the delivery of dental services to the public.
 - 11.3 The “team leader” is the registered practising dentist (“the dentist”). The dentist has “overall responsibility for patient care”.
 - 11.4 The dentist can administer and control his or her overall responsibility to the patient due to the fact that the dental auxiliary is an employee of the dentist (or an employee of the dental partnership that employees the team leader dentist or the employee of an entity that employees the team leader dentist). The existence of the employment relationship allows the dentist to properly administer and control processes and communication.
 - 11.5 It is “fundamental” to the current Code that “within the defined range of skills, dental therapists and dental hygienists must practice only those skills for which they have been formally educated (in courses approved by the Board) and in which they are registered and competent”.
 - 11.6 The dental auxiliary works with the dentist in a “consultative and referral relationship” to provide any or all of the following: preventive, periodontal, restorative and orthodontic dental services.
 - 11.7 The “consultative and referral relationship” between the dentist and the dental auxiliary is reduced to writing (“the current Agreement”). The current Agreement must specify:
 - 11.7.1 roles and responsibilities of the dental auxiliary;
 - 11.7.2 roles and responsibilities of the dentist;
 - 11.7.3 competency achieved by the dental auxiliary (that is, the tasks that the auxiliary can perform for which he or she has been formally educated in courses approved by the Board); and
 - 11.7.4 working relationships between the team leader dentist and dental auxiliary, including procedure and protocols for the operation of the dental team and quality assurance system.

12. It is arguable that the current Code meets the objectives of section 69(1)(e) of the Act in that it promotes the community's access to dental care and minimises the community's exposure to health risks in dental care.
13. In this regard, a member of the public can feel confident that the team leader dentist has the overall responsibility for his or her care and has in place procedures and protocols within his or her own practice to ensure a high standard of care. Most importantly, the team leader dentist has the ability to enforce those procedures and protocols by virtue of the employment relationship with the dental auxiliary.
14. So in short, it is the employment relationship which provides the team leader dentist with a high level of control to the benefit of the patient. A high level of control is required in order to minimise the community's exposure to health risks in dental care. The existing relationship of employer / employee also provides legal certainty. In this regard the law recognises that in most circumstances an employer is responsible for the acts and / or omissions of the employee. This legal responsibility ensures that the employer dentist has procedures and protocols in place to minimise the risk of harm to the patient.

The Draft Code

15. The draft Code reflects a significant shift in the relationship between the patient, the dental auxiliary and the dentist. It is our understanding that auxiliary personnel were originally introduced to provide simple care for simple conditions under the supervision, direction and control of dentists. The notion was that dentists could be freed to do more complex work and the auxiliaries could provide care at a more economical rate.
16. It is arguable that the significant shift proposed under the draft Code does not meet the objective of minimising the community's exposure to health risks in dental care and to promote the community's access to dental care.
17. The key features of the draft Code include:
 - 17.1 A dental auxiliary may engage in independent practice.
 - 17.2 The registered dentist is a notional "team leader" but may no longer have "overall responsibility for patient care". In this regard the draft Code permits a dental auxiliary to consult direct with a patient without necessarily consulting and / or referring to a dentist if the dental auxiliary forms the view that the dentistry falls within his or her "scope of practice".
 - 17.3 The dentist must "provide clinical support to the dental hygienist or dental therapist. The level and specific nature of this support will depend on what is required for the safety and wellbeing of the patient, the treatment being provided, the type of practice and the education and experience of team members".
 - 17.4 The "treating relationship between a patient and a dental hygienist or dental therapist" must be covered by a documented agreement for the provision of

clinical support by a dentist should such support become necessary. The agreement must specify the mechanism for consultation. It is the dental auxiliaries' professional responsibility to ensure that such a document exists.

The Dental Auxiliary as an Independent Practitioner

18. The draft Code permits a dental auxiliary to practice independently. Whilst the Code envisages consultation and referral to a registered practising dentist, the Code also acknowledges that it may not be necessary to obtain clinical support from a dentist (see paragraph 19 of the draft Code). Therein lays the fundamental flaw of this draft Code. How can the draft Code talk of "a team approach in the delivery of dental services" when the Code permits a dental auxiliary to enter into a legal and professional relationship with a patient to provide dental care without necessarily involving a registered practising dentist.
19. The Code is permitting a dental auxiliary to become "a gate keeper" of patient care. Whilst it is desirable that most dental auxiliaries have a high level of education, knowledge, care and skill, it is a simple fact that a dental auxiliary is not trained to the level of a registered practising dentist. The question of whether a patient requires the clinical input of a dentist should not rest with the dental auxiliary. It is simply not in the public interest to place this clinical responsibility on the shoulders of a dental auxiliary alone.
20. In our view the existing requirement that a dental auxiliary be employed by a dentist is the key to maintaining control over the standard of care provided to the patient.

The Proposed Agreement

21. The proposed "Agreement" referred to in paragraphs 19 to 21 of the draft Code raises up a number of legal problems.
22. The existing Code provides that the dentist and dental auxiliary must enter into a written agreement that outlines the professional relationships and activities that affect clinical care. That agreement must specify the roles and responsibilities of the dentist and the dental auxiliary. It must also set out the working relationships between the dentist team leader and the dental auxiliary including procedure and protocols for the operation of the dental team and quality assurance system. Under the current Code the dental auxiliary is an employee of the dentist / dental practice. An employer has the legal right to ensure that such a protocol is followed by the dental auxiliary. Therefore, there is a legal framework that supports such an agreement between the dentist and auxiliary.
23. However, under the draft Code there is no longer the requirement for an employment relationship. So, what is the nature of the Agreement under the draft Code? How will the DPBV ensure that the Agreements are drafted in a manner to make them consistent and enforceable? What will be the respective rights and obligations of the dental care providers under the Agreement? Will either party have a right to terminate the Agreement and under what circumstances? Does the dentist have a right to inspect the premises of the auxiliary?

24. This is just a short sample of the questions that a lawyer would ask a dental practitioner or dental auxiliary seeking advice about entering into an Agreement. There is little doubt the proposed Agreements under the draft Code will provide a source of work for lawyers and we doubt that was an intended outcome of the draft Code.
25. We also raise the possibility that the proposed Agreement will offend consumer protection legislation. The difficulties raised by the Agreement in this area is best dealt with by example:

A dental auxiliary operates an independent practice (entitled to do so under the draft Code). A new patient consults the dental auxiliary. The patient questions the training and capability of the dental auxiliary and asks what happens if she needs to have dental work performed outside of the auxiliary's scope of practice. The dental auxiliary produces a copy of an Agreement he/she has with a local dentist. The patient wants to know if there will be any "doubling up" of fees if she ultimately needs to be re-assessed by a dentist. The patient says that if referral to a dentist is necessary, the patient wants to engage a dentist of his/her choice. The patient queries whether the Agreement in fact offends consumer protection legislation given that a decision has apparently already been made as to who will be her "team leader dentist". The dental auxiliary contacts the DPBV for guidance. What would the DPVB say to the dental auxiliary?

26. Under the draft Code the dentist is to be a notional "clinical team leader". This needs to be reflected in the proposed Agreement. How can the dentist remain a "clinical team leader" when the draft Code enables the dental auxiliary to practice without consulting a registered dentist? In the case where a dental auxiliary does not consult or refer a patient, the "overall responsibility for patient care" must rest with the dental auxiliary, not the dentist. In this regard it is a legal nonsense to impose a responsibility on a registered dentist who has no contact with the patient. Dentists would need to ensure that the Agreements do not impose a responsibility on them that they cannot exercise. Obtaining legal advice would be advisable given the implications that flow if there is an adverse outcome to the patient.

Insurance

27. In our view proposing a draft Code that permits the registered dentist to be taken out of the clinical loop is contrary to the objectives set out in Section 69(1) (e) of the Act. If a dental auxiliary becomes an independent practitioner then the legal exposure of the dental auxiliary increases and this will no doubt lead to an increase in the cost of professional indemnity insurance for the dental auxiliary.
28. It is our understanding that the insurance premium for a dental auxiliary is currently about 1/3 of the cost of a premium for a dental practitioner. Dental auxiliaries should expect an increase in insurance premiums if the draft Code is promulgated. In this regard the ADAVB may want to consider obtaining the advice of a professional indemnity insurer on this point.

Recommendation

29. It is arguable that the patient care regime proposed under the draft Code is not in the best interests of the patient. The registered dentist may no longer be the “clinical team leader” and may no longer have “overall responsibility for patient care”.
30. We recommend that the ADAVB consider making a submission to the DPBV that it maintain the current requirement that a dental auxiliary must only practice:
 - 30.1 in the employ of a registered practising dentist or dentist who shall be the team leader(s); or
 - 30.2 in the employ of a registered practising dentist or dentist who employ a registered practising dentist who shall be the team leader; or
 - 30.3 in an entity that employs a registered practising dentist or dentists who shall be the team leader(s).

If you have any queries about this advice please do not hesitate to contact us on the number below.

Yours sincerely

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INFORMATION SUMMARY 2006/07

ABOUT THE ADAVB

The ADAVB is the peak professional association of Victorian dentists and its aims are to

- improve the dental health of all Victorians;
- promote the art and science of dentistry; and
- promote the highest standards of professional dental care
- enhance the professional lives of members

MEMBERSHIP

- About 2480 dentists in private and public practice, as well as 4th & 5th year students and overseas trained candidates
- 95% of registered private practitioners
- 10 suburban and 7 country groups

MEMBER SERVICES & FUNCTIONS

- Continuing Professional Development Program
- Dental health education programs (eg. Dental Health Week)
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent Graduate support
- Dental Assistant Training seminars
- Member Service Plans (eg Professional Insurances; preferred suppliers)
- Industrial relations advice and representation
- Defence and legal support
- Advice on Practice Management
- Quality Assurance (including Doctors Health Support Service)
- Benevolent Fund
- Library and resource collection
- Political representation
- Representation to Government bodies
- Superannuation (Professional Provident Fund)
- Sports and social functions
- Publications – Newsletter, Journal, Award details, Manuals etc.
- Home Page (find us at <http://www.adavb.com.au>)

DISPUTE RESOLUTION SERVICES

The Branch provides information to the public on dental matters, and offers a conciliation service to assist patients to resolve disputes with members. Information on treatments, facilities, dental issues and careers is available.



PRESIDENT

Dr Greg Morris
BDS, LDS

Greg is a general practitioner in Hawthorn. He has served on numerous ADA committees including Dental Health Education, Graduate Education and Infection Control

CHIEF EXECUTIVE OFFICER

Mr Garry Pearson
MEdSt, HDT (SAC)
AFAIM, MAICD

Garry commenced with the ADAVB in 1991 after senior executive roles in the Victorian Education Ministry



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