24 November 2009

Attention: Chair, Dental Board of Australia

natboards@dhs.vic.gov.au

Dear Dr Lockwood

Please find attached a submission in response to the Dental Board of Australia's Consultation paper on registrations standards and related matters.

We trust that the comments offered are seen as constructive, and we would be pleased to offer additional information or to meet with representatives of the Board if this would be of any assistance.

Yours sincerely,

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National Registration Standards and other matters
ADAVB Submission - November 2009

1. Introduction

The Victorian Branch of the Australian Dental Association (ADAVB) welcomes the opportunity to respond to the draft National Registration Standards as proposed by the Dental Board of Australia (DBA).

The ADAVB represents over 90% of Victorian dentists and has a longstanding commitment to safe and high quality dental care being provided to the entire community. We are pleased therefore to support the general thrust of the draft standards, both as they apply across all health professions, and as proposed specifically for dentistry.

While we agree that the matters on which draft standards have been prepared warrant such attention, we may offer less fulsome support for the content of certain standards. Where this is the case, we will outline our arguments for the Board's consideration.

As a general observation, we note that a number of the standards make reference to accompanying guidelines which are yet to be developed or published. It is difficult to provide a well informed response to these materials when the associated guidelines are not made available at this time. We would therefore urge the Board to establish further consultative processes in connection with the guidelines and their relationship to the standards, and as a corollary, to remain open to review of the standards themselves.

2 Mandatory registration standards (all boards)

2.1 Criminal history

- This standard is supported in principle, certainly as far as proven criminal history is concerned.
- It seems however, that a health practitioner may be required to disclose, and the Board can take into account convictions which, under other laws, are regarded as 'spent'. This seems to apply a higher standard to health practitioners than is required of others in the community.
- The Victorian Parliamentary Scrutiny of Acts and Regulations Committee examined the National Law – Bill C, and referred to Parliament for its consideration the questions of whether or not:
    - "1. clauses 5, 77(3), 79, 109(1)(b), 135 & 231 of the proposed Health Profession Regulation National Law (Victoria), by permitting or requiring the gathering of information about criminal charges resolved in an applicant's favour are an arbitrary interference with those applicants' privacy.

  - clauses 5, 38(1)(b) 55(1)(b) & 74(a) of that Law, by permitting National Boards to have regard to criminal charges resolved in an applicant's favour when making registration decisions, are compatible with the Charter right of those applicants to be presumed innocent until proven guilty." (Alert Digest No. 13 of 2009, Victorian Parliament, p. 14)
- Their concern that health practitioners are potentially being denied rights to privacy and to the presumption of innocence where guilt has not been established are surely fundamental to the integrity of the new regulatory measures.
- It is not clear to us however, what the Board will do with the information. Perhaps it would be helpful to know at what point/s the Board will take the information into consideration, and with what possible outcomes?

2.2 English language skills

- This standard is supported.
- We note that the Australian Dental Council, which has been charged with providing national course accreditation and recognition of overseas candidates for registration functions, will currently only accept the Occupational English Test (OET). As the IELTS is not presently an acceptable assessment, this may require review to bring them into alignment with the requirements of the national Board.

2.3 Professional indemnity insurance

- The proposed $5 million level of cover is also supported. Having worked with professional indemnity providers over decades, we have never seen any dental cases that would require insurance cover greater than this.
- We are advised by our insurers that an indemnity limit of $20M for health care practitioners aligns with the Medical Indemnity Act 2002 - Exceptional Claims Indemnity Scheme (ECIS) benefit. This Act provides that, where health professionals have a professional indemnity cover that qualifies with the threshold of $20M, then the ECIS will respond to claims in excess of that $20M threshold. In other words, by purchasing $20m protection, essentially unlimited protection would be in place.
- From a pure risk perspective, the likelihood of a claim of that magnitude is extremely remote. While there is the potential that it could happen to any dentist (or other health professional), there has never yet been a professional indemnity claim against a dentist in Australia that has exceeded $5m.
- The gap between the $5m cover proposed by the DBA and the $20m cover which qualifies a health professional for ECIS support leaves the consumer somewhat exposed. The minimum level of cover required in Victoria at present is $10m, and we would have no objection to this being maintained. It would make more sense from a consumer protection point of view however if the ECIS were to take effect from that level also.
- Our insurers advise that the difference in pricing between a $5m indemnity limit and $20m (effectively providing unlimited cover) would increase the premium payable by approximately one third, across the profession. The difference between $10m and $20m indemnity would most likely be in the order of 8 .5%.

- We understand that the Medical Indemnity (Prudential Supervision and Products Standards) Act 2009 (MIPS&PS Act) requires insurers to make an offer of retroactive cover available for otherwise uncovered prior incidents. Practitioners therefore already have the option of covering any gaps but are not required to insure for periods for which they already have claims incurred cover. The current wording of the standard may therefore unnecessarily impose duplicate costs and create problems of dual insurance that would result in additional legal costs being incurred and confusion in respect of claims. We therefore recommend that the requirement be modified to **"unlimited retroactivity of cover for otherwise uncovered prior incidents"**, or words to that effect.
- We query the proposed requirement that the mere placing of a condition or restriction on an insured's cover must be reported to the Board. Whilst some circumstances might suggest there is an issue that requires Board attention, most often, it is the fact that a person has been the subject of Board attentions that leads to them having such conditions imposed. This could therefore lead to an oddly circular arrangement in which the Board is being provided with a report on something resulting from its own actions.
- We also argue that there may be an accumulation of relatively minor matters which lead to an insurer imposing conditions or restrictions on cover, and these will not always warrant notification to a registration body. The other concern here is the requirement to notify "any change in the basis of their cover." Policy wordings and other details are changing all the time, so we suggest that perhaps the word "**material**" should be inserted before the word "**changes**", or similar words to that effect.

2.4 Continuing professional development

- The proposed requirements for mandatory CPD are supported.
- We note that guidelines associated with the standard are yet to be developed, and urge that these be kept as simple as possible in the interests of promoting a high compliance level.
- The number of hours and most other conditions are recognised as being broadly similar to present arrangements required by the Dental Practice Board of Victoria (DPBV).
- The extension of the cycle period from two years to three is welcome, as this will allow for illness and other interruptions to a dental care provider's normal capacity to participate in CPD activities.
- The effective reduction (for Victorian practitioners) in the time required to participate in infection control training is also supported as we have found there are not enough fresh infection control topics and themes to keep these programs fresh and appealing to delegates within a two-year cycle. We agree that specifically mandating infection control CPD is justified on the grounds of patient and practitioner safety, but once addressed within the first cycle, it may not require three hours in subsequent cycles to remain up to date. Could we therefore suggest that the Board consider requiring three hours of infection control training in the first three year cycle, but only two hours per cycle thereafter? The three year period set for review of the standard may facilitate such an adjustment.
- While we support 80% of the minimum hours being clinically or scientifically based, our experience suggests that it will be helpful for guidelines to be developed on the definition of these terms in order to make it clearer just what is accepted as clinical or scientific CPD.

- The arrangement made in Victoria at present sees a number of organisation recognised by the Board as approved educational activity providers, and these bodies are authorised to self assess the allocation of CPD credit categories and hours. Such decisions are subject to audit from time to time, but from our perspective this has worked well to avoid the creation of undue bureaucracy. We therefore recommend a similar approach be adopted by the DBA.
- The onus on registered persons to maintain their own logbook of CPD activities with details of the activities and the number of hours spent in each category is the best approach, however this will need to be clearly explained to practitioners. Despite our years of experience of such a scheme, we still have dentists assuming that we know everything they have done and can provide full annual summary statements despite many of the activities they attended being non-ADA events.
- Members have queried whether the new CPD standard means the commencement of a new accountability cycle from July 2010, as this cuts six months out of the current two-year cycle operating in Victoria (due to end in December 2010) and may throw some people's plans awry. Alternatively, the cycle may commence at the end of 2010. Early publication of the proposed 'Guidelines for Registration Standards – Continuing Professional Development' would therefore be welcome to clarify these arrangements.

2.5 Recency of practice

- The concept that practitioners who have not practised within the past five years must meet recency of practice requirements is supported.
- We note that these provisions will tend to have more impact on women than men, and urge sensitivity to family leave circumstances. The framing of the standard in a manner which allows applications to be assessed on their own merits is therefore particularly welcome. While flexibility is a good thing, consistency in approach within and across jurisdictions will also be important to ensure fairness. Guidelines may therefore be helpful in this regard.
- One possible implication of the greater impact on women may be the need to ensure that any educational requirements imposed on women returning to practice after maternity leave are conducted in a flexible way, allowing for child care and associated arrangements.

3 Proposals for board-specific standards

3.1 Scope of practice standard

- The ADAVB is pleased to support Requirements 1-5 without qualification. We especially welcome continued recognition that dentists remain 'clinical team leaders'.
- Requirement 6 however seems too vague as presently phrased. We respectfully suggest that this is an instance where accompanying information material is required to allow us to comment effectively.
- We query how dental therapists, oral health therapists and dental hygienists can "exercise autonomous decisions making" while <u>not</u> being independent practitioners in terms of training?

- What does it mean when the standard refers to dental therapists, oral health therapists and dental hygienists not being independent practitioners "in terms of training"? Does this imply that they are independent once they have completed their training and are registered?
- The definition of 'Independent Practitioner' includes the word 'supervision', and we suggest that this word itself also needs definition. What does it mean when a practitioner is practising with supervision and who will be required to practise in this way?
- The DPBV Code of Practice on the practice of dentistry by dental therapists and dental hygienists required that consultation arrangements be made between the dentist team leader and dental therapists and hygienists who are members of the team.
- If the Board proposes that dental therapists, oral health therapists and dental hygienists be autonomous in operation then it should establish a wholly consistent approach and make it clear that they are now authorised to be independent practitioners. If this is not the case then we suggest that more specific guidelines are required as to how the Board expects the members of the team to interact. What is the relationship the Board expects each of the parties to maintain with the others in the team? If they are independent practitioners, then this will also have consequences for their professional indemnity cover.
- The General Dental Council (GDC) in the United Kingdom has published very helpful guidance to practitioners on the Principles of Dental Team Working (see http://www.gdc-uk.org/Current+registrant/Standards+for+Dental+Professionals/), and we commend this approach to the DBA as one which would be helpful in overcoming confusion and tensions in relations between members of clinical teams.
- Depending on the information to be provided in the guidelines, the ADAVB is concerned at the lack of defined duties within the scope in this standard. In our view, a standard which is so non-specific cannot reasonably be described as a standard. The GDC has also published supplementary guidance on Scope of Practice for dental care providers and we recognise that something of this nature may be intended by the Board when it issues its Guidelines for Registration Standards — Scope of Practice Standard. The draft standard only suggests that these guidelines "<u>may</u> be developed". We therefore urge the Board to commit to do this in order to avoid a dangerously unclear outcome.
- It would be grossly unreasonable for dentists to be held liable or accountable for something they can't effectively control or influence.

4 Proposals for specialist registration

4.1 Approval as a health profession for which specialist recognition operates

- The legislated acknowledgement of dentistry as a profession for which specialist recognition will operate is most welcome and will serve the public well, as it will allow them to clearly identify those practitioners who have special qualifications and skills in a range of complex dental fields.

4.2 Proposed list of specialties

- The proposed list of dental specialties is broadly supported as it is generally consistent with the fields currently recognised across the nation, while adding forensic odontology as a formally recognised field – which we fully support in the light of the very special skills required to assist disaster victim identification teams and criminal investigations.

- One area about which concerns have been raised is periodontics. The proposed definition is felt to exclude implants and so it is suggested that the Board delete the words "*and their substitutes*" and include the words "*and placement and maintenance of osseo-integrated tooth replacements (or substitutes)*".
- The education and training programme of the Royal Australasian College of Dental Surgeons (RACDS) in Oral & Maxillofacial Surgery (OMS) has been comprehensively assessed and fully accredited by the Australian Dental Council (ADC) and Australian Medical Council (AMC). The specialist qualification of the FRACDS (OMS) received full accreditation in 2006.
- The RACDS has fulfilled the mandatory reporting to the ADC and AMC since 2006 and the training pathway of the RACDS with the qualification of FRACDS (OMS) has just undergone a mid-term review in 2009 by the ADC and AMC. The accreditation of the RACDS training pathway and FRACDS (OMS) has resulted in bi-national standardisation and education and training is provided across all six states and the Territories of Australia. And also New Zealand. The Health Insurance Commission, Federal Government of Australia recognises only the FRACDS (OMS) as the required qualification for the practice of OMS in Australia and for the provision of a provider number (Health Insurance Regulations - Schedule 4).
- We note that Oral Surgery is listed as a specialty in the Dental Board of Australia consultation paper. We do not believe that Oral Surgery should be recognised as an independent and separate specialty. The content and duties of oral surgery were incorporated into Oral and Maxillofacial Surgery more than 20 years ago, so that this specialty ceased to exist as an independent specialty in Australia. The definition and practice of Oral Surgery is completely encompassed within the definition and practice of Oral and Maxillofacial Surgery. In Australia there is no training program or curriculum in Oral Surgery, and no trainees. There have been no work-force studies to support the reintroduction of the category.
- A Masters Degree in Oral Surgery has not been taught for many years in Australia or New Zealand, nor is there any evidence to suggest that a Masters Degree in this subject is planned for the future. All aspects of 'oral surgery' as described in the list of proposed specialities of the Dental Board of Australia, that is the diagnosis and surgical management of condition affecting the oral and dento-alveolar tissues, are completely covered within the scope of contemporary OMS training.
- We understand that the recognition of Oral Surgery by the New South Wales (NSW) Dental Board has resulted in significant problems for the other State Boards, whereby overseas trained practitioners become registered in Oral Surgery in NSW. These practitioners have insufficient training and qualifications for registration in their home States as Oral & Maxillofacial Surgeons, however via Mutual Recognition these practitioners attempt to become registered as Oral and Maxillofacial Surgeons, without success. To avoid frustration and disappointment, the DBA arrangements should ensure that realistic expectations are established in the minds of overseas trained practitioners regarding registration to practice as Oral and Maxillofacial Surgeons.
- Overseas trained dentists should be assessed for equivalence of their qualifications to the Australian standard of OMS training. Any qualification without this equivalence lowers the standard and creates unnecessary confusion. A recognised pathway and process for the assessment of foreign trained Oral and Maxillofacial Surgeons has been established by the RACDS and approved by both the ADC and AMC.
- We note that Ministerial Council approval would be required for any additional specialties to be included in the list. We assume that the Board would consult in a similar

manner to the present consultation about the draft standards should such a proposal be forthcoming, and we welcome that arrangement.

4.3 Specialist registration standard

- The requirement that applicants for specialist registration must first have completed two years of general practice is supported. The ADAVB considers that a good grounding in the full range of treatment requirements is an important means by which to ensure that specialists provide their care in a manner which is sensitive to the overall oral and general health of their patients. It will also ensure that in their clinical relationships with referring general practitioners they are sensitive to the care coordination responsibilities of the general practitioner dentist.

4.4 Qualifications for specialist registration

- The expectation that courses will becomes available for oral surgery and forensic odontology in the future is noted, however in the meantime, where practitioners have completed qualifications in these areas at overseas institutions, we believe they should be able to have these recognised by the Australian Dental Council, and that organisation should be able to recommend specialist endorsement for practitioners who meet reasonable qualification standards in these fields.

5 Proposals for endorsements

5.1 Proposed endorsement for conscious sedation

- We fully support the requirement that only a registered dentist may apply for this endorsement and that this practitioner must ensure that he or she is current with all aspects of the guidelines and requirement s of a body approved by the Board and including the Australian and New Zealand College of Anaesthetists.
- Members have queried whether it will be necessary for everyone who currently uses products like Penthrox or nitrous oxide sedation to undertake the Graduate Diploma in conscious sedation. They note that these medications do not affect breathing, and so are not like Midazolam and equivalents. We assume that the foreshadowed DBA 'Guidelines for Conscious Sedation' will make this clearer.

ENDS