



**AUSTRALIAN DENTAL
ASSOCIATION INC.**

**Submission to Health Workforce Principal
Committee on National Registration and
Accreditation Scheme – Dental Board.**

9 September 2008

**Authorised by
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Federal President**

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Submission to Health Workforce Principal Committee on National Registration and Accreditation Scheme – Dental Board.

The Australian Dental Association (ADA) thanks the Health Workforce Principal Committee for the opportunity to respond to the Committee's second invitation to make a submission relating to a number of matters identified in the Inter Governmental Agreement.

The ADA is the national body representing over 10,000 registered dentists engaged in clinical practice. This represents over 90% of all dentists in Australia, the vast majority of whom are self-employed. The primary objective of the ADA is to encourage the improvement of the health of the public and to promote the art and science of dentistry. Each State and Territory has its own association Branch, with individual dentists belonging to both their home state Branch and the national body. Further information on the activities of the ADA and State and Territory Branches can be found on the ADA website at www.ada.org.au.

Your letter of invitation of 13 August 2008 seeks comments on three issues, to which the ADA responds as follows:

1. Size and Composition of the National Board

Consistent with the ADA's submission in response to the Committee's first invitation, the ADA encloses a copy of its Policy Statement relating to Dental Acts and Boards of 30 May 2007. Specifically, reference is made to Paragraph 3.1.1 which refers to the ADA's recommendations regarding composition of Dental Boards.

This Policy Statement was prepared by the ADA with the primary view of ensuring that the conduct and actions of the Board described in the Policy was in the interests of the Community. Its constitution or make-up was developed to provide dental expertise, utilising all sectors of the dental profession and to provide both professional and community focus to its actions.

The ADA sees the clear need for significant "dentist" participation in the Board. The dentist is the most highly qualified of the professions to be represented on the Board and is the team leader in the delivery of all dental services.

As one of the key functions of the National Dental Board will be the creation of standards for the various sectors of the profession and the preparation of advice on dental matters to the Ministerial Council, it is essential that the most highly trained professional be properly represented. The dentist is trained in all spheres of dentistry as distinct from only parts of dental practice, as is the case for other professions. The dentist is therefore best placed to provide professional input on these issues.

It should be borne in mind that the make up of the dental profession workforce is that there are approximately 11,000 dentists; 1,200 dental therapists; 1,000 dental hygienists; 1,000 dental prosthetists and 500 combined dental hygienists/therapists.

The number of dentists that will be subject to the determinations of the Board is very much greater than the numbers involved from each of the other dental care provider groups. For the credibility of the Board and to achieve regulated constituency, there should be proportionate representation on the Board reflecting the numbers of practitioners in each profession. Any new regulatory system will only be as strong as the confidence of the regulated parties in the structures required to administer it. If the 11,000 dentists in Australia see only one or two dentists on the new national board responsible for regulating them and matters relating to dental practice, they will understandably view it as having little capacity to grasp the complexity of their work and to respond appropriately to emerging clinical and technical issues affecting the delivery of dental care to the community.

a. Chair of the Board

As a general observation, representation on the Dental Board should be such as to ensure that decisions made by the Board are evidence based and provide for delivery of dental service that will guarantee maintenance of the patients' safety and wellbeing.

With no disrespect to the other sectors of the dental professional groups, dentists are trained to the highest level of the dental health groups and possess the greatest scope and depth of dental skill and knowledge.

The ADA contends that the Chair of the Board ought to therefore be a dentist by virtue of this level of training and skill as compared to the others within the dental group. The other dental professions all hold expert skills but those skills are confined to their area of expertise. The dentist is on the other hand trained in all facets of dental practice and is the team leader in the delivery of dental care.

b. Constitution of the Balance of the Board.

It is noted that the IGA provides that at least 50% of the remaining members of the Board must be from the relevant profession with no more than 2/3 of the Board, including the Chair, being members of the relevant profession.

Consistent with the general intention of the IGA, the ADA would suggest that representation on the Dental Board be a dentist as Chair, four other dentists (including at least one dental specialist) and one each of the dental therapists, dental hygienists and dental prosthetists. This would mean that eight members of the profession would constitute the make-up of the Board from the relevant profession.

The reason for representation of four dentists in addition to the Chair is that it is the ADA's view that major decisions on how dental care is to be delivered should responsibly be made by a panel comprising a majority of the highest trained professional who has the requisite skills and knowledge to make evidence based decisions on any issue pertaining to the delivery of dental care.

The ADA believes that unlike the other registration boards that will each deal effectively with only one profession, the Dental Board will be representing four separate professions: dentists, dental therapists, dental hygienists and dental prosthetists. Such a unique situation justifies an exception being made in respect of these proportional requirements for the National Dental Board as set out in the Inter Governmental Agreement (IGA).

The exception suggested by the ADA in relation to the Dental Board is removal of the requirement that no more than 2/3 of the Board include the relevant profession. The reasons for this are good governance and economy. If these recommended eight members of the profession are to constitute only 2/3 of the Board, it would mean that the total number of Board Members would be twelve. Four non-professional members would be required. The ADA does not see this need for four (the remaining 1/3) non-professional members of the Board. The ADA recognises the value of a non-professional presence on the Board but fails to see what additional value would be provided by having four, as distinct from say only two, non-professional members. As costs of the operation of the Board are going to be reflected in registration fees to be paid, this economy of representation seems appropriate and would not compromise on the quality of the actions of the Board.

c. Two Community Members

The ADA would agree with this suggestion within the IGA. Consistent with ADA Policy, the ADA would suggest that the two community members should be one consumer representative and one lawyer.

2. Views on the Use of Existing Bodies for Accreditation Functions for the Dental Profession

The ADA agrees that consistent with the transitional measure enabling the Ministerial Council to assign accreditation functions to existing accreditation bodies, the accreditation role in dentistry be provided to the Australian Dental Council (ADC).

Consistent with all submissions made by the ADA, it remains supportive of the role of the ADC. It ensures that dental training institutions that are accredited provide premium quality dental education programs. Further graduates that qualify as practitioners do so with the commensurate level of skill required to maintain the safety and quality of (dental) services available to Australians.

Similarly, it considers that the ADC's role in both the assessment and examination of overseas trained dentists (OTDs) and the assessment and examination of specialists is carried out in an expert fashion. It should be noted that in dentistry there are no specialist colleges that control the creation of specialists. The ADC accredits courses for specialists and the training institution determines the award of specialist qualification.

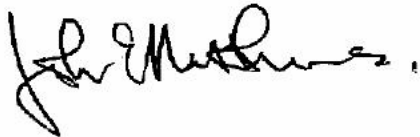
The ADA has in earlier submissions raised issues relating to the existing non-statutory framework for the ADC. Review of the IGA would however suggest that the ADC would have to fall within the statutory framework created pursuant to the IGA and provided the ADC is given the ability to

carry out its functions in the fashion that it has to date, the ADA would be supportive of provision of a statutory framework for the ADC.

3. Other Appropriate Existing Body for Accreditation Functions

In view of the response provided in Paragraph 2, the ADA has no further comment to make here.

The ADA thanks the Committee for the opportunity to respond.

A handwritten signature in black ink, appearing to read "John E. Matthews". The signature is written in a cursive style with a prominent initial "J".

Dr John E Matthews
President
Australian Dental Association Inc.

9 September 2008.

Encl.

DENTAL ACTS AND BOARDS¹

1 Introduction

1.1 Background

Dentistry was first regulated by legislation in Britain in 1878 and two years later in New Zealand. In Australia, the first Dental Act received Royal Assent in the colony of Victoria on 16 December 1887. Since then the practice of dentistry has been regulated by the States and Territories to provide protection and safety to the public.

In 1992 the Commonwealth Government and every State and Territory Government passed Mutual Recognition Acts, which guaranteed a practitioner registered in one jurisdiction could automatically register in any other. This led to the formation of the Australian Dental Council (ADC) which was charged by the Boards to accredit courses of education and training leading to registration of dental practitioners and also to examine overseas trained dentists.

In April 2007 the Council of Heads of Australian Governments (COAG) announced the structure that from 1 July 2008 would administer the national process of registration for nine professional groups that at the time were registered in every jurisdiction. COAG's decision included the establishment of nine separate National Registration Boards, one for each professional group.

1.2 Definitions

1.2.1 BOARD is a Federal, State or Territory dental registration board.

1.2.2 DENTAL ACT is any Federal, State or Territory Act that has a primary purpose to regulate the practice of dentistry.

1.2.3 FITNESS TO PRACTISE includes:

- the applicant's mental and physical health;
- the applicant's command of the English language;
- the applicant's criminal history;
- any deregistration, suspension, condition or limitation imposed under a similar law; and
- the applicant's recency of practice.

1.2.4 RECENCY OF PRACTICE means that a practitioner has maintained an adequate connection with the profession since qualifying.

Recency of practice requirements may include:

- the nature, extent and period of practice;
- the nature and extent of any continuing professional development undertaken;
- the nature and extent of any research, study or teaching relating to dentistry; and
- the nature and extent of any administrative work relating to dentistry.

¹ This Policy Statement is linked to other Policy Statements: 2.1 *Dental Workforce*, 2.2 *Dentists*, 2.3 *Allied Dental Personnel*, 2.4 *Specialisation in Dentistry*, 2.8 *Overseas Trained Dentists*, 2.9 *Recency of Practice*, 4.7 *Regulatory Authorities*, 4.10 *Accrediting Authorities*, 5.3.1 *Healthcare Workers (incl. Students) Infected with Blood-Borne Viruses*, 5.3.2 *Management of Impaired Practitioners* & 5.13 *Advertising in Dentistry*

- 1.2.5 RENEWAL OF REGISTRATION is the process of re-registering a person already registered.

2 Principles

2.1 Purpose of Regulation

To ensure the health and safety of the community, it is essential to regulate dental practice as it includes irreversible, invasive and exposure prone procedures and potentially fatal risks.

2.2 Dental Act Objects

The Objects of a Dental Act should be to:

- 2.2.1 Protect the public by ensuring that health care is delivered by health care providers in a professional, safe and competent way; and
- 2.2.2 Uphold the standards of practice within the health professions; and
- 2.2.3 Maintain public confidence in the health professions; and
- 2.2.4 Provide a uniform system to deal with complaints, investigations and disciplinary proceedings relating to health care providers, and to the management of impaired practitioners; and
- 2.2.5 Provide a system to deal with complaints about practitioners that is complementary to the States and Territories health complaints commissions.

2.3 Boards

Boards must reflect contemporary community expectations of standards of dental care, as well as those of oral care providers and other relevant scientific and standard setting bodies. In order for Boards to function effectively, Board members must understand the role of Boards, and must have or acquire a broad knowledge of health, governance, communication and legal issues.

3 Policy

3.1 Boards

3.1.1 Composition of Boards

Any Board must be expert with regard to the practice of the whole of dentistry. Therefore the composition of the Board must be based on expertise and allow for representation of oral health practitioners other than dentists.

Boards should be composed of the following:

- Dentists, who should –
constitute a majority of the Board;
include a representative of the Deans of Dental Schools of Australia, and
be practising in a clinical setting, without a condition on their registration;
- one of each of the registered allied dental care providers;
- one consumer representative; and
- one lawyer.

Appointment of dental care provider Board members, especially dentists, should include some who are elected by their peers.

3.1.2 ***President and Vice President of the Boards***

The President and Vice-President of the Boards must be dentists.

3.1.3 ***Role of Boards***

The role of Boards should be to:

- protect public health and safety by -
setting minimum standards of dental practice through promulgation of Codes of Practice, Policies and Guidelines,
counselling and/or disciplining oral care providers, and
maintaining a Register, part of which is open to the public;
- register dental care providers.

3.1.4 ***Governance of Boards***

Good governance of Boards should include the following:

- measures to ensure that appointees are competent to be Board members;
- use of outside expertise;
- decisions based on evidence; and
- consultation with stakeholders before promulgation of Codes, Policies and Guidelines.

3.1.5 ***Communication with Registrants***

- It is essential that Boards keep their registrants fully informed on matters pertaining to the regulation of dental practice within the Board's jurisdiction.
- Communication with all registrants should include:
Annual Reports,
provision of a complete set of statutory requirements to registrants, i.e. the Act, Regulations, Codes of Practice and Guidelines,
any update of statutory requirements,
education of registrants via seminars, information sheets etc. to assist their compliance with the statutory requirements,
availability of Dental Register.

3.1.6 ***Communication with the Public***

- It is essential that Boards inform the public on relevant matters pertaining to the regulation of dental practice within the Board's jurisdiction.
- Communication with the public should include:
availability of that part of the Dental Register which is open to the public,
Annual Reports,
current statutory requirements

but, should not include:
any claims lodged or settlements determined,
any conditions on registration that are not current,
the naming of impaired providers who are not currently practising,
any previous penalties levied against a dental care provider.

3.2 **Registration**

3.2.1 ***Types of Registration***

There must be provision for separate registers of:

- dentists including dental specialists; and
- operative allied dental personnel -
dental hygienists

dental therapists, and
dental prosthetists (denturists).

3.2.2 **Criteria for Registration**

All registrations must be based on the holding of appropriate qualifications, fitness to practise and recency of practice.

3.2.3 **Accreditation of Qualifications**

Accreditation of qualifications should be done by an accrediting authority although such a body may be part of or should report to a board.

3.2.4 **Examination of Holders of Unaccredited Qualifications**

Boards must have the power to decide if the holders of unaccredited qualifications have an equivalent qualification to an accredited Australian qualification and have the power to examine such persons. However Boards should delegate this assessment and examination function to an accrediting authority.

3.2.5 **Fees**

Registration fees must be calculated on a cost recovery and apply equally to all practitioners.

3.2.6 **Renewal of Registration**

Registration must be renewed every year and practitioners must continue to meet fitness to practise and recency of practice requirements.

3.3 **Restriction of Practice and Definition of Dentistry**

3.3.1 **Restriction of Practice**

The Dental Act must make it illegal for persons who are not dentists to practise dentistry. Exceptions should be made for:

- students and other dental registrants for their scope of practice;
- medical practitioners (for dental emergencies);
- anyone to provide first aid in emergencies; and
- removal of primary teeth without local or general anaesthetic by parents or other persons.

The removal of primary teeth by parents or other persons without local or general anaesthetic should also be excluded from the restriction.

The scope of practice and supervision requirements for operative allied dental personnel should be defined in Regulation along with prescribed qualifications.

3.3.2 **Definition of Dentistry**

The practice of dentistry should be defined in Dental Acts as:

- diagnosis or management of conditions of the mouth of a person;
- performance of any invasive and/or irreversible procedure on the natural teeth or parts of a person's body associated with their natural teeth;
- provision of artificial teeth or dental appliances or insertion of artificial teeth for a person; or
- making an intraoral adjustment of artificial teeth or dental appliances for a person.

3.4 Obligations on Registrants and Other Persons and Entities

3.4.1 *Restriction of Titles*

- The titles for dentists that should be protected and reserved are "dentist", "dental surgeon" and "dental practitioner".
- The recognised titles for each dental speciality should be protected and reserved for persons registered as specialists.
- The titles for operative allied dental personnel that should be protected and reserved are "dental hygienist" and "dental therapist", and "dental prosthetist" or "denturist".
- Students enrolled in dental education programs should be identified as such. Examples are "student dentist", "orthodontic registrar", "oral and maxillofacial surgery trainee".
- The use by any dentist of the honorary title "doctor" should be continued.

3.4.2 *Falsely Holding Out*

There must be provisions in Dental Acts prohibiting persons who are not registered as any category of registrant from holding themselves out as registrants and also to ensure registrants only use titles for which they have been registered. It should also be an offence to hold out falsely another person to be a registrant if they are not. Persons also should not be allowed to use the word "specialist" or "speciality" or "specialty" in circumstances that indicate or could reasonably be understood to indicate, that the person provides professional services in an area of dentistry that is not presently recognised as a speciality.

3.4.3 *Advertising*

Provisions giving the Board power to act against false, misleading and deceptive advertising should be included in a Dental Act.

3.4.4 *Payment for Referrals*

Payments for referrals and receiving payments for referrals must be prohibited.

3.4.5 *Professional Standards*

Dental Acts should give Boards the power to make Codes of Practice and other professional standards.

3.4.6 *Penalties*

The penalties applicable to persons successfully prosecuted for breaches of the obligations above should be substantial to deter illegal practice and to protect the public.

3.5 Complaints

3.5.1 *Who May Make Complaints*

A complaint against a registrant may be made by any person including but not limited to a patient, a patient's representative or another registrant.

3.5.2 *Who May Receive Complaints*

The Board or a commission may receive a complaint but whichever receives the complaint must report it to the other authority if it concerns the treatment of a patient.

3.5.3 ***Role of State Health Complaints Commissions [commissions]***

Commissions are to undertake the assessment and conciliation of complaints. If any jurisdiction does not have a commission then a committee appointed by the Board should undertake this role.

3.5.4 ***Assessment of Complaints***

Where a complaint is kept by the Board or is referred by a commission, the Board must be empowered to assess the complaint before deciding to investigate it or not.

3.6 **Investigations**

3.6.1 ***Conduct of Investigations***

Boards must decide whether to investigate a complaint or a matter about a registrant unless directed to investigate by the Minister. Boards and investigators appointed by them must have adequate powers to conduct investigations.

3.6.2 ***Notice of Investigation***

As soon as practicable after deciding to investigate a complaint or practitioner, Boards must give the practitioner concerned notice of the investigation.

3.6.3 ***Investigators***

Any investigator appointed by the Board will be provided with written authority to conduct the investigation and will provide proof of such appointment when required.

3.6.4 ***Reports of Investigation***

The investigator on completion of the investigation will give the Board a preliminary report of investigation. The Board as soon as practicable after receiving a preliminary report will prepare its report of investigation and may adopt the preliminary report with or without changes.

3.6.5 ***Actions Open on Completion of Report of Investigation***

Boards must decide to do one of the following:

- If a Board believes the matter is one deserving suspension or deregistration as a penalty it must refer the matter to hearing by a Tribunal;
- If the matter follows action to suspend immediately the practitioner and the investigation indicates further disciplinary action is necessary, a Board must refer the matter to a Tribunal;
- Otherwise the Board may
 - refer the matter for disciplinary action by a committee of the Board, which may conduct a hearing or action by correspondence or enter into an undertaking with the practitioner, with the practitioner's agreement, about the practitioner's conduct or practice;
 - refer the matter to a commission with the commission's agreement;
 - deal with the matter under the Part of the Dental Act dealing with impairment;
 - take no further action.

3.7 **Immediate Suspension and Imposition of Conditions**

3.7.1 ***Protective Purpose***

Boards must have the power to effectively respond to imminent threats posed by registrants to the wellbeing of vulnerable persons. Boards must have the power to suspend or impose conditions on the registration of the practitioner.

3.7.2 ***Minimum Necessary***

Boards must take appropriate action to protect the vulnerable persons.

3.7.3 ***Natural Justice***

Boards must allow a practitioner reasonable time to respond to a complaint or action before taking action themselves.

3.7.4 ***Board must Investigate or Refer for Hearing***

Once a Board has decided to take action it must decide to either investigate the matter or refer it directly to a Tribunal.

3.7.5 ***Right of Appeal***

A practitioner subject to action by a Board may appeal the Board's decision to a Tribunal. In the case of suspension, the Tribunal shall deal with the appeal expeditiously.

3.8 **Informal Disciplinary Processes**

Informal disciplinary processes are those conducted by a Board or its committee and must have the following characteristics:

3.8.1 The penalties open to a Board or its committees shall be restricted to caution, reprimand and undertakings.

3.8.2 The practitioner shall not be entitled to legal representation at any hearing.

3.8.3 There shall not be public access to informal processes.

3.8.4 The practitioner must have the right to request a formal hearing by a Tribunal.

3.8.5 The recording of penalties on the public register must be at the Board's discretion.

3.9 **Formal Disciplinary Processes**

3.9.1 A Tribunal should be a Judge of the Federal Court advised by a dentist and a practitioner of the same profession and category as the practitioner subject to the action.

3.9.2 The practitioner before a Tribunal shall be entitled to legal representation.

3.9.3 All formal proceedings should be open to the public unless decided otherwise by the Tribunal.

3.9.4 The Tribunal may impose penalties including deregistration, suspension, conditions and fines which must be paid to the Board.

- 3.9.5 Any adverse disciplinary decision of the Tribunal must be recorded on the public register.
- 3.9.6 Any conditions imposed by the Tribunal upon the practitioner should be for not more than three years. Thereafter the conditions can be reviewed by the Board.
- 3.9.7 In any review by a Board pursuant to 3.9.6, the Board shall be at liberty to impose further restrictions on the practitioner as may be consistent with the Tribunal's earlier findings.

3.10 **Monitoring Compliance with Disciplinary Decisions**

3.10.1 ***Power to Monitor Compliance***

Boards must have adequate powers to monitor and enforce compliance with orders of a Tribunal, conditions and undertakings.

3.10.2 ***Appointment of Inspectors***

Boards shall appoint inspectors with similar powers to investigators for the purpose of monitoring compliance with orders, conditions and undertakings. It is possible that a person may be appointed as both an inspector and an investigator.

3.11 **Appeals**

3.11.1 ***Appeals Authorities***

Appeals against decisions of a Board shall be made to the Federal Court. If the matter involves a complaint by a patient, the appeal shall be made to a Tribunal.

Appeals from Tribunals shall be by way of customary process for appeals from the Federal Court.

3.11.2 ***Who May Request Appeal***

A practitioner subject to a decision of a Board or a Tribunal may appeal that decision or a Board may appeal a decision of a Tribunal.

3.11.3 ***Appeals to be Dealt with by Re-hearing***

Any appeal is to be dealt with by re-hearing.

3.12 **Impairment**

Boards must have the power to deal with impaired practitioners in a process separate from the usual disciplinary processes. Continued practice by practitioners recovering from impairment is not inconsistent with maintenance of professional standards and safety of the public.

Policy Statement 4.9

Adopted by ADA Federal Council, May 30, 2007.