



**AUSTRALIAN DENTAL
ASSOCIATION INC.**

**Australian Dental Association Inc. response to
National Registration And Accreditation Scheme
For The Health Professions**

CONSULTATION PAPER

Proposed arrangements for accreditation

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**Authorised by
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AUSTRALIAN DENTAL
ASSOCIATION INC.

SUBMISSION IN RESPONSE TO CONSULTATION PAPER

Proposed arrangements for arrangements for accreditation

About the ADA

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers. The primary objectives of the ADA are to encourage the improvement of the health of the public and to promote the art and science of dentistry. There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

Introduction

The ADA thanks the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee for the opportunity to respond to this Consultation Paper.

This submission will deal with the Paper in the order in which it was presented. It will only respond specifically to issues of interest to the ADA by dealing with each of those Proposals. Should a Proposal from the Paper not be responded to, then the ADA has no comment or input to make in respect of that proposal.

Consultation Paper

1. [Background \(&\)](#)
2. [Current accreditation arrangements](#)

The ADA agrees that the key factors in the development of a national scheme relating to accreditation have been identified in the "Background" to the Paper.

Maintenance of standards of practice in the delivery of health care is essential and standards need to be continually reviewed to ensure that they reflect an appropriate level of care and safety to Australians.

Boards must develop a clear and documented view of the knowledge, skills and judgment required by each of the classes of practitioner they are responsible for registering. Situations such as that which recently occurred in Victoria where the

DPBV issued a draft Code of Practice for dental therapists and hygienists which allowed training institutions to decide what to teach rather than defining those requirements formally must not occur. Boards must dictate the standards, for example in the above case to clearly define the actual scope of practice to be achieved. Accreditation of courses and practitioners must be against those standards so that uniformity is created to maintain the high quality of practitioner to be registered. Clearly defining scopes of practice gives the public information to assist and enable them to determine the exact type of practitioner they need and enables them to have certainty that the practitioner providing treatment is practising within their scope of practice. It is essential that a framework is created that enables the creation of a set of standards that are expected to be achieved in the delivery of health care. Registration of health practitioners should only occur when that registering authority is satisfied that the practitioner has demonstrated a capacity to deliver health care in accordance with those standards.

To achieve this, accreditation processes need to be developed that enable evaluation of education and training courses and institutions as against the standards that have been developed. The same processes have to be put in place to ensure that those practitioners who may be registered in places other than in Australia can have their ability to deliver health services assessed against the Standards. This is important as a certain type of practitioner in one jurisdiction may have a scope of practice that is less extensive and in some cases very different than the equivalent titled practitioner in another Australian, state/territory or overseas jurisdiction.

Considerable care needs to be exercised to ensure that the accreditation processes are carried out in an economic way. Currently in dentistry a significant proportion of the costs of the accreditation process are borne by the participating practitioners who undertake the accreditation role. With this new scheme such voluntary assistance is unlikely to be forthcoming and account will have to be taken to ensure that the resultant cost does not create too onerous a financial obligation on practitioners and the public. Accreditation agencies should be able to determine the fees they charge for such services on a cost recovery or profit basis.

If this is not possible then there needs to be a full Regulatory Impact Statement analysis of the costs of delivering these services before any centrally determined fees are imposed.

[3. Proposed new accreditation requirements.](#)

The ADA generally accepts the sentiments expressed in this section of the paper.

What the ADA is not clear about is that in the paper there is a description of what constitutes the "accreditation function"-see top of page 9 of 21 of the Consultation Paper. There it suggests that one of the functions is the development of the "accreditation standards". It then goes on to refer to the accreditation process involving an assessment of "courses...against those standards."

The ADA has always advocated for a separation in the development of the standards and the accreditation of courses against those standards. The ADA had interpreted the details of the proposed scheme as involving the Boards developing standards independently of accreditation and independently of any ministerial intervention. The paragraph of the paper that follows the description of the Accreditation function

seems to support this but be in conflict with what appeared immediately before this on page 9 of 21.

If the description in the Paper at about page 9.7 and then later at 13.2 (when dealing with the IGA definition of accreditation) intends to refer to the separation of the functions, as described, then the ADA is supportive of this.

The ADA insists that the accreditation role must be carried out by persons skilled in the knowledge of the areas of expertise being accredited. While a place exists for consumer input in this area, the crucial accreditation function must be carried out by persons with expert knowledge in the field. The ADA sees this as a central and key requirement of the accreditation process.

Proposal 3.4.1

The ADA has developed a Policy on Specialisation in dentistry and a copy is attached. There is some differential in the approaches taken by State and Territory Boards in Australia on this issue. The Policy statement may assist in dealing with these local variations.

In general terms the ADA is happy with this proposal. It is certainly in the public's interest for specifically trained specialists to be available to perform the more complex dental procedures required and to be clearly identified.

Proposal 3.4.2

The ADA would suggest a similar approach be taken in respect of the dental profession and that as suggested in medicine, the national board initially take advice from the Australian Dental Council and also from the respective Dental Practice Boards on the issue with a view to developing a consistent approach. Subsequently any review of specialists would be done by the Board not the external accrediting body.

Proposal 3.4.3.

This proposal is ambiguous. If it is saying that a process similar to that applicable to the creation of new professional standards will be followed i.e. created by the national board and then approved by Ministerial Council then this is acceptable.

If the proposal is that the Ministerial Council can initiate and implement changes then this is opposed. The necessity for new specialities or specialty areas of practice is something that the Boards ought to solely be empowered to implement. Issues such as this require specialist knowledge which the ADA feels sits with the national board and not the Ministerial Council.

Determination of speciality areas ought to be carried out in much the same way as health profession standards are to be created as outlined in Section 8 of Bill B.

Proposals 3.4.4 and 3.4.5

The ADA notes the commentary that precedes these proposals and in view of those comments supports these proposals.

Proposal 3.4.6.

Again there is some ambiguity seen here as to exactly what function the Ministerial Council is carrying out. If it is the “approval” only of relevant standards then this is acceptable. For the same reasons as stated under Proposal 3.4.3 the creation of those standards should rest solely with the national board. An issue relating to technology, innovation and technique change is relevant to the issue of accreditation of courses and the ADA does not feel that the Ministerial Council would be sufficiently well positioned to determine this and thus act promptly on accreditation of new courses. The national board which is already involved in standards review would be the better positioned to undertake this task.

Proposal 3.4.7.

This is acceptable and in the case of accreditation of continuing professional development (CPD) courses, it is the ADA’s suggestion that the model used by the Dental Practice Board of Victoria be adopted. This quite simple process merely involves that Board accrediting providers of CPD activities. CPD activities provided by that authorised provider are then sanctioned by the Board. This would avoid a time consuming and expensive process of each individual course undergoing separate accreditation. Consistent with earlier submissions in this area, the ADA believes that it would be better for the board and the accrediting body to be separate from each other.

Proposal 3.5.1 - 3.5.4.

The ADA provides support for these.

Proposal 3.5.5.

The ADA supports this and believes this ability to delegate appropriate functions are appropriate. For example, the delegation of language testing to appropriate trained institutions for foreign trained dental health personnel seeking accreditation seems both effective and efficient.

The ability to delegate must however be confined to such ancillary functions only within the accreditation process and not permit delegation of roles that relate to assessments of ability to practise against the set of standards agreed to, which should remain at the core of the function of the accrediting body.

Proposal 3.5.6 - 3.5.8.

Wide consultation to ensure transparency and credibility is essential. Publication of materials relevant to the standards, activities of the body, fees, charges and financial reports on the agency’s publicly available website is similarly essential. Provision of this data will provide better public accountability for the body’s actions.

However central to the function of accreditation remains the assessment of professional skills against standards created. Such functions are best performed by professionals trained in the areas of practice being assessed. So, whilst community participation and familiarity with the process is highly desirable, for the creation of credibility and acceptance, the actual accreditation functions should rest with the professionals.

Proposals 3.6.1 - 3.6.3.

The ADA has repeatedly said through each stage of the review process that whilst community participation is essential for credibility and transparency, there appears to be an over emphasis of this view in the consultation papers when it comes to the consideration of the make up of various bodies that are to play a role in the accreditation and registration processes.

Dentistry here is a special case as dentists and three classifications of allied dental personnel are to be covered.

The over emphasis on non practitioner representation is evident in the proposed make up of the accreditation committee. From a proposed eight person committee only two are to be from the relevant profession. As the crucial role being conducted is the assessment of a course or in the case of an overseas trained professional that professional, such an assessment would best be conducted by persons with the equivalent or greater skills than those of the course or the person being accredited. Persons making decisions on the accreditation of practitioners and courses must be adequately qualified to do so by ensuring that they are: aware of the qualities that have to be held by proposed registrants seeking accreditation and are capable of identifying that those proposed registrants have the skills required to perform the tasks associated with their registration category.

On the assumption that the Australian Dental Council [ADC] will be the initial accrediting body for the dental profession and it is required to change its structure, the ADA would suggest a make up of the ADC be as follows:

- Five dentists
- One each of dental hygienists, dental therapists and dental prosthetists;
- One member with education and training expertise;
- One consumer representative and
- A Chairman who in the case of dentistry be a dentist.

Should the ADC not be later appointed to permanently carry on this role then the ADA would recommend that any new Committee have the same structure.

In the case of accreditation of specific courses this body would be able to appoint sub committees to then report back to the Committee on the course being evaluated. So for instance for accreditation of a "dentist" training course the make up would be of dentists and a consumer. For courses pertaining to the lesser skilled allied dental personnel, the make up would be a dentist, the relevant allied dental practitioner and consumer.¹

The ADA has viewed the ADC submission on these particular proposals and notes that in this respect its submission is generally consistent with the ADA submission.

¹ See reference to this issue in the ADA's submission on *Proposed Registration Requirements* to the Committee. This is dealt with under discussion regarding Proposals 6.2.1 and 6.2.2.

Proposal 3.8.1:

ADA believes this requirement is essential for the proper functioning of this body. To attract the calibre of person required will necessitate appropriate indemnity protection. Just as is the custom in commercial settings such cover should be provided to participants here so as to provide the participants with the freedom to execute their duties without fear of financial reprisal or adverse ramifications.

Proposal 3.10.1.

As indicated in an earlier submission in this process the ADA strongly supports the utilisation of the *Standards for Professional Accreditation Processes* paper. It also agrees to the creation of compatibility with international standards.

In reference to the point in (d), the ADA would reiterate that while independence is essential the point raised under proposal 3.6.1 must be heeded.

Proposal 3.10.2.

While agreeing with this, some clear cut rules or requirements must be put in place which will identify for the institution requiring accreditation what constitutes "any significant curricular changes or resourcing issues" that are required to be reported. Unless this is done there is too much scope for an institution to relax its curricula once accreditation has been granted.

A heavy onus must be placed on the institution to ensure ongoing compliance; as without that students undertaking such an approved course risk forfeiture of time spent undertaking such a course. Anecdotally, situations have been encountered where this risk to students has caused accreditation approval to be maintained (which on strict interpretation should have been revoked) on certain conditions being applied retrospectively. Such action is unacceptable and institutions must be forced to maintain compliance or provide prompt notice of a departure so modifying action can be taken to ensure maintenance of quality course deserving of accreditation.

Proposal 5.1:

Where possible the extent of consultation must be such as to achieve joint agreements being reached between the accreditation bodies. The opportunity must not be taken by either country to compromise their standards for the purpose of obtaining agreement. It has to be remembered that the whole objective of the national program is to improve the quality and safety of health care being delivered. This will not occur if compromise is permitted in order to achieve agreement.

With Trans Tasman mutual accreditation in place, the standards of both countries' accreditation must be uniform. There is no point one country compromising its standards and allowing in what would be inferior practitioners (in the other jurisdiction) as to do so would, with mutual recognition in place, create an obligation on the other country to recognise a practitioner that would, but for mutual recognition requirements, not be accredited.

Accreditation authorities in both countries must recognise the existence of a world market in health services and must respect each other's position on the standards required to be achieved so as to avoid any compromise in health care delivery.

Proposal 6.1:

The ADA supports these transitional arrangements.

The ADA again wishes to thank the Subcommittee for the opportunity to reply to the Consultation Paper.

A handwritten signature in black ink, appearing to read "Neil D Hewson". The signature is written in a cursive style with a long horizontal stroke at the end.

Neil D Hewson
President
Australian Dental Association Inc.

17 December 2008.

SPECIALISATION IN DENTISTRY

1 Introduction

1.1 The recognition of specialities and specialist practitioners serves to identify to the public and to the dental and allied professions individual practitioners who have special competence in a specified area of dental practice.

1.2 **Definitions**

1.2.1 **SPECIALISATION** is the exclusive practice of a recognised speciality of dentistry by an appropriately qualified practitioner.

Notwithstanding the delineation of a speciality, the area defined may be practised by registered dentists provided they possess the necessary skills, experience and expertise.

1.2.2 A **SPECIALIST PRACTITIONER** or **SPECIALIST** is one who practises a recognised speciality, possesses a higher qualification relevant to this area of dentistry, and has fulfilled any other statutory requirements within the State or Territory of practising and has been so registered.

In the absence of appropriate credentials, limitation of practice does not confer specialist status; nor does possession of a higher qualification and limitation of practice to an area of dentistry not formally recognised as a speciality.

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

2 Principles

2.1 Specialisation serves to stimulate organisation, education and research in a particular area of dentistry.

2.2 The establishment of a dental speciality must address a clear health need and public demand.

2.3 The acquisition of specialist status and the use of the designated title of the speciality should be strictly regulated.

2.4 Only fully qualified and registered dentists will be eligible for training as specialists.

2.5 A specialist's primary purpose must be to render a service to patients and the community which requires knowledge and skill beyond those which could normally be expected in the relevant area of dental practice.

2.6 Specialisation should not in any way curtail the right of the general dental practitioner to practise any discipline of the profession.

2.7 Only dental specialists, as recognised by Boards, may use specialist titles or refer to themselves as specialists. The public must not be misled about a practitioner's specialist status.

3 Policy

Recognition of Dental Specialties

- 3.1 To be recognised as a dental speciality, any proposed speciality should meet the following criteria. It should:
- Have a clear need and demand of a substantial portion of the population.
 - Be important to the health of individual patients.
 - Be an area of dentistry in which general practitioners may have need to refer patients for provision of expert services in a particular area of dentistry.
 - Require special knowledge and skills, superior to undergraduate dental education and training, in order to perform procedures of an advanced, difficult, or unusual nature.
 - Be definable in order to prescribe the scope of the speciality.
 - Be one in which approved educational institutions conduct accredited formal courses to qualify practitioners appropriately.
 - Have an established specialist organisation.
 - Be recognised by the Australian Dental Association Inc. (ADA).

Requirements for Specialisation

- 3.2 A person seeking recognition as a specialist in a chosen area shall have:
- Successfully completed an acceptable undergraduate course in dentistry.
 - Attained the legal status to practise dentistry.
 - Completed a mandatory period in the general practice of dentistry in private practice, hospital or other institutional practice, a public health service or the Armed Services.
 - Completed a course of graduate education leading to an acceptable higher qualification relevant to the area of specialisation.

Education Requirements

- 3.3 The minimum period of postgraduate education, including training/experience for any speciality, should preferably be three years full time, but longer clinical training may be deemed to be appropriate for some specialities.
- 3.4 Only those courses of specialist education which have been accredited by the Australian Dental Council or courses deemed equivalent by Boards should be recognised as acceptable qualifications for specialisation.
- 3.5 Completion of research, no matter how advanced or valuable, should not be considered as sufficient grounds for registration in any speciality.

Registration

- 3.6 Specialist status shall be subject to registration conferred through statutory powers vested in State or Territory Dental Boards.
- 3.7 Dental Acts should prescribe:
- areas of dental specialisation;
 - requirements for registration as a dental specialist; and
 - that only recognised dental specialists may use specialist titles.

Currently Recognised Specialties

3.8 The specialties recognised by the ADA shall be designated and defined as follows:

3.8.1 **Dento-maxillofacial Radiology**

That part of dental practice which deals with diagnostic imaging procedures applicable to the hard and soft tissues of the oral and maxillofacial region and to other structures which are relevant for the proper assessment of oral conditions.

A Specialist in dento-maxillofacial radiology shall have the title of Dento-maxillofacial Radiologist.

3.8.2 **Endodontics**

That part of dental practice which deals with the morphology, physiology, and pathology of the human tooth and, in particular, the dental pulp, root and peri-radicular tissues. It includes the biology of the normal pulp, crown, root and peri-radicular tissues and the aetiology, prevention, diagnosis and treatment of diseases and injuries that affect these tissues.

A Specialist in endodontics shall have the title of Endodontist.

3.8.3 **Oral and Maxillofacial Surgery**

That part of dental practice which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.

A Specialist in oral and maxillofacial surgery shall have the title of Oral and Maxillofacial Surgeon.

3.8.4 **Oral Surgery**

That part of dental practice which deals with the diagnosis, surgical and adjunctive treatment of diseases and injuries limited to the dento-alveolar complex.

A Specialist in oral surgery shall have the title of Oral Surgeon.

3.8.5 **Oral Medicine**

That part of dental practice which deals with the clinical diagnosis, assessment and principally non-surgical, pharmacological management of anatomical variants, pathological conditions, diseases and pain of the dental, oral and adjacent anatomical structures and the dental/oral manifestations and complications of systemic diseases, pathology and conditions and their treatment.

A Specialist in oral medicine shall have the title of Oral Physician.

3.8.6 **Oral Pathology**

That part of dental practice which deals with diseases of the teeth, jaws, oral soft tissues and associated structures, studies their causes, pathogenesis and effects, and by use of clinical, radiographic, microscopic and other laboratory procedures establishes differential diagnoses and provides forensic evaluations.

A Specialist in oral pathology shall have the title of Oral Pathologist.

3.8.7 **Orthodontics**

That part of dental practice which deals with the study and supervision of the growth and development of the dentition and its related anatomical structures, including preventive and corrective procedures of dentofacial irregularities requiring the re-positioning of teeth, jaws, and/or soft tissues by functional or mechanical means.

A Specialist in orthodontics shall have the title of Orthodontist.

3.8.8 Paediatric Dentistry (Paedodontics)

That part of dental practice which deals with the prevention and the treatment of dental diseases and abnormalities in children and their associated developmental and behavioural problems.

A Specialist in paediatric dentistry shall have the title of Paediatric Dentist or Paedodontist.

3.8.9 Periodontics

That part of dental practice which deals with the prevention, recognition, diagnosis and treatment of the diseases and disorders of the investing and supporting tissues of natural teeth or their substitutes.

A Specialist in Periodontics shall have the title of Periodontist.

3.8.10 Prosthodontics

That part of dental practice which deals with the restoration and maintenance of oral health, function and appearance by coronal alteration or reconstruction of natural teeth, or the replacement of missing teeth and contiguous oral and maxillofacial tissues with substitutes.

A specialist in prosthodontics shall have the title of Prosthodontist.

3.8.11 Public Health Dentistry

That part of dental practice which deals with the community as the patient rather than the individual, being concerned with oral health education of the public, applied dental research and administration of dental care programmes including prevention and control of oral diseases on a community basis.

A Specialist in Public Health Dentistry shall have the title of Public Health Dentist.

3.8.12 Special Needs Dentistry

That part of dental practice which deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans.

A Specialist in Special Needs Dentistry shall have the title of Special Needs Dentist.

Obligations of Specialists

3.9 In treating a referred patient, a specialist shall:

- keep the referring practitioner informed of progress;
- attempt to seek consent of the referring practitioner before making a further referral;
- not perform services which are outside his/her specialty without the consent of the referring practitioner; and
- after completion of treatment, direct the patient back to the referring practitioner.

3.10 A specialist shall guide and educate dentists to higher levels of competence.

Policy Statement 2.4

Adopted by ADA Federal Council, November 15/16, 2001.
Amended by ADA Federal Council, November 11/12, 2004.
Amended by ADA Federal Council, November 13/14, 2008.