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

CONSULTATION PAPER

Proposed Arrangements for Specialists within the National Registration and Accreditation Scheme (NRAS) for the Health Professions

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SUBMISSION IN RESPONSE TO CONSULTATION PAPER

Proposed Arrangements for Specialists within the National Registration and Accreditation Scheme (NRAS) for the Health Professions

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. One of the primary objectives of the ADA is 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 on arrangements for specialists.

Whilst the Australian Dental Association has been supportive of the creation of a National Registration and Accreditation scheme for the Health professions, it remains concerned regarding the following:

a) From the various consultation papers it is apparent that to facilitate the creation of National Registration and Accreditation a significant level of bureaucracy is being created. The ADA impresses upon the Practitioner Regulation sub-committee the need for efficiency and economy in creation of the bureaucracy surrounding the scheme. The greater the level of bureaucracy, the greater will be the level of red tape and compliance required by professionals under the scheme. Increase in administrative time spent by practitioners will impact adversely upon time available for actual health delivery. The ADA urges the Committee to ensure that an efficient bureaucracy is created so as to not impinge upon practitioner health service provision time.

b) Hand in hand with the creation of a large bureaucracy will be increased costs. It is clear from the papers published to date that it is the intent of the scheme that it will be self-funded. Increases in the cost of the bureaucracy will result in increased registration costs which will in turn adversely impact upon the cost of health services. Every effort must be made to ensure that costs of registration remain economic and that with

the benefits of scale that can be utilised, registration costs will diminish for the benefit of all Australians.

c) From the outset, the ADA has been concerned as to the existence of an underlying thread of a possible workforce reform agenda. Improvement to the safety and quality of delivery of health services was the initial objective for the creation of a national scheme and this focus must be maintained with no provision for compromise. Problems that are confronting health delivery in Australia must not be addressed by the provision of compromised care. Australia can be proud of the safety and quality of health care delivered and this must be maintained.

ADA Position

Specialisation in dentistry and recognition of "specialists" is supported by the ADA and this had been stated in an earlier response to national registration proposals.

An ADA Policy Statement (2.4) on "Specialisation in Dentistry" in enclosed. As indicated in the introduction to that Policy, "the recognition of specialties 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".

Criticisms of current specialist registration arrangements have been based on a belief that professional groups place barriers on entry to these occupations, and that these restrictive practices serve to make specialist services expensive or less accessible for the public. The ADA would like to affirm that this is not the case in dentistry, as no limits are imposed on numbers by any of the professional bodies involved. Given this, dentistry should not be treated as a mirror of some health professions where these restrictions may exist.

Submission Structure

In responding to the further Consultation Paper, the response will deal firstly with some comments made under the Summary that appears at page 2 and 3 of the paper and will then deal with some of the commentary made in Attachment A and Appendix 1 of the paper.

Further Consultation Paper Summary

<u>Specialist Endorsement</u>

The comments made in Paragraph (a) are supported by the ADA. This support is on the proviso that the status quo that exists in relation to recognition of specialisation in dentistry continues.

The ADA has interpreted this paragraph as suggesting that it will be the National Dental Board that will be making a recommendation to the Ministerial Council for approval of the specialist training course and that as with the development of professional standards, such approval of the specialist training cannot unilaterally be provided by the Ministerial Council but can only be provided on the "recommendation by the relevant Board".

It is assumed that the National Dental Board will in all probability delegate responsibility for the accreditation of a specialist training course to a relevant authority. In the initial period of the new scheme, it would be the ADA's recommendation, that the relevant body to assess the courses would be the Australian Dental Council. The individual members of that Council conducting this

process should themselves have adequate qualifications to enable appropriate decisions to be made.

The ADA maintains that as it is the National Dental Board (or its delegate) that will have the relevant expertise to determine the accreditation standard for the specialist training, approval of the training must only be provided based on the recommendations of the National Board and not at the instigation or decision of the Ministerial Council.

The comments made in Paragraphs (b) and (c) are accepted by the ADA. The ADA has interpreted Paragraph (c) as again suggesting that in relation to the types of specialist endorsements that will be available, the Ministerial Council may seek some guidance from a national board, but can only respond to a national board's proposals for specialist endorsement, and that the Ministerial Council cannot on its own authority instigate the creation of any specialist endorsement.

Where the ADA does have some concern is in relation to Paragraph (e). The ADA would reject any proposal that would allow specialist endorsement to be obtained by any practitioner prior to that practitioner having first obtained general registration. Australian standards for the obtaining of specialist endorsement must therefore incorporate a preliminary qualification that the practitioner seeking specialist endorsement be firstly a registered practitioner. A standard must then uniformly be applied to all applicants for specialist endorsement. Such national specialist accreditation standards would, in the ADA's view, be created by the National Dental Board and then later approved by the Ministerial Council.

Continuing Competence Requirements

The statement made a Paragraph (f) is acceptable.

In relation to (g), the ADA has previously expressed opposition to requiring obligatory continuing professional development. Continuing competence requirements for specialist endorsement should entail both standards within the general classification and specialist discipline.

The concept described in Paragraph (h) is acceptable.

Registration of Specialists (including Area of Needs Specialists)

The ADA is opposed to the creation of a category of "area of need" specialists. If an applicant is not eligible for primary registration for a health profession, then that applicant ought not be allowed to practice within Australia. As safety and quality has been the objective of this process, to allow compromise in areas of need is inappropriate. "Areas of need" have to be addressed by the provision of fully qualified and registered practitioners meeting that area of special need - not a second tier of practitioner.

Notwithstanding recognised shortages and areas of need, delivery of compromised care in those areas of need is unacceptable. This is an issue of workforce maldistribution and has nothing to do with recognising extra training and expertise and should be dealt with by introduction of initiatives such as rural scholarships and not by the registration process.

Scope of Practice

The proposal set out in Paragraph (j) is acceptable to the ADA. It is not clear whether the Board has the option to consult with other boards. If the statement is to be read to mean that it is optional for the Board to consult with the other boards, then that option ought be removed and it ought be made compulsory.

Attachment A

In respect of the Registration Arrangements Consultation Paper the ADA has the following comments in relation to the proposals noted (where no comment is made for a proposal then the ADA generally accepts the comments made).

i. Proposal 10.1.1

As can be gleaned from the ADA's policy on dental specialisation, the following principles should underpin the regulation of specialist dental practice:

- Specialisation should serve to stimulate organisation, education and research in a particular area of dentistry.
- The establishment of a dental speciality must address a clear health need and public demand.
- The acquisition of specialist status and the use of the designated title of the speciality should be strictly regulated.
- Only fully qualified and registered dentists will be eligible for training as specialists.
- 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.
- Specialisation should not in any way curtail the right of the general dental practitioner to practise any discipline of the profession.
- 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.

In respect of point (a) the ADA repeats comments made earlier that provided the National Dental Board is the body instigating any change to the current situation governing specialist practice and not the Ministerial Council creating change, then this is acceptable to the ADA. It is after all those who understand the clinical complexities and relationships in the profession concerned that can best determine the need for any change.

The ADA would make the following general comments in respect of point (d). The category of offence ought be extended to all means by which practitioners may indicate to the public that they have a special area of practice. To allow such behaviour would confuse the public in failing to differentiate between practitioners who have a particular area of interest and those that are actual dental specialists in that area.

Every effort must be made to ensure that all dental specialties currently recognized by State and Territory dental registration boards continue to be recognised under the new scheme. The loss of any one of these specialties could seriously disrupt access to appropriate care for patients. If necessary, some grandfathering of categories may be needed.

ii. Proposal 12.1

In respect of paragraph (f), if an investigation or disciplinary process is not finalised, then the practitioner subject to the investigation or disciplinary process should not be precluded from registration. The ADA would concede that the registration can be annotated to the effect that there is an outstanding investigation or disciplinary process to be finalised and that ongoing registration would be conditional upon the findings of that process, but in all other respects such an applicant must be entitled to be registered until some definitive fact or circumstance has been established to preclude registration.

iii. Proposal 3.4.3

The creation of new specialties or specialty areas of practice should only occur on the recommendation and advice of the National Board, whose recommendation and advice will be considered by the Ministerial Council. The ADA agrees that where applicable, consultation between the various national health boards <u>must</u> occur prior to creation of such new titles, especially where potential for confusion may arise across health professions. Reference is made to comments made earlier regarding the desired criteria that should be used to determine any new specialty created.

iv. Proposal 9.2.1 and 9.2.2

The ADA is agreeable to the addition proposed here. The ADA would however ask the Committee to review the ADA's previous submissions in relation to the issue of current continuing competence and continuing professional development requirements. As indicated in the ADA's accompanying Policy Statement 2.9 on Recency of Practice, the ADA endorses the principles expounded within this document.

v. Proposal 10.1.3

This should be amended to read as follows:

"those endorsed as dental specialists by the Dental Board of Australia be authorised to use the title "dental specialist" <u>and the title of the speciality for which they are registered.</u>"

vi. Proposal 7.1

As indicated above, the ADA opposes the granting of provisional registration or registration in respect of some specialist area of need without such applicant having firstly obtained a general registration. This is consistent with the objectives of maintaining safety and quality in the delivery of care. Accordingly, concepts such as provisional registration and limited registration are opposed. Either a practitioner is able to be registered or not and if not registered should be precluded from all forms of practice. There must not be an ability for someone to practice a health profession who has not obtained general registration. Creation of a qualified registration should not be permitted as it constitutes provision of compromised care, impacting upon the level of safety and quality that currently is available. Current shortcomings in the health workforce must not warrant delivery of care by practitioners with a level of skill below that of registered health practitioners. Reference is again made to the ADA's Policy Statement 2.4.

Thank you for the opportunity to respond to the Paper.

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President
Australian Dental Association Inc.

13 February 2009

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.

AUSTRALIAN DENTAL ASSOCIATION INC.

POLICY STATEMENT

RECENCY OF PRACTICE

1 Introduction

1.1 The Australian Dental Association Inc [ADA] is an active provider and supporter of continuing professional development, not only for its members but also for allied dental personnel. It has a strong interest in maintaining professional standards and thus recency of practice is an important issue.

1.2 Under National Competition Policy, it must be clearly established that any legislation or behaviour that lessens competition must be undeniably necessary in the public interest. Otherwise, that requirement would breach NCP principles and be in breach of the Trade Practices Act.

2 Definitions

2.1 **BOARD** is a State or Territory Dental Registration Board.

2.2 **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.

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

3 Principles

3.1 **Role of Boards**

It is important that professional standards be maintained. Boards have a role in this as they are responsible for the safety of the public.

3.2 **Requirements must be Evidence-Based**

There should be unequivocal evidence that any measure being introduced as a

requirement for recency of practice must be effective in protecting the public.

3.3 Obstacles to Renewal Should not be Greater than for Registration

Dental registration legislation generally requires that applicants for registration must be suitably qualified and fit to practise. The recency of practice requirements for renewal of registration should not be more onerous than the fitness to practise requirements for registration.

3.4 Requirements must Address Real Risks

Dentistry is provided by practitioners with a broad range of expertise. Most dentistry is performed by general practitioner dentists who may refer or delegate treatment to dental specialists or allied dental personnel. Where there is little or no risk to patient safety, there should be no restrictions on the usual scope and privileges of practice. Where there is a real risk to patient safety, restrictions may be appropriate.

3.5 Simple to Administer

Registration authorities should avoid requirements that necessitate complex and potentially expensive administration to monitor recency of practice and to follow up breaches.

3.6 Respect Non-Practising and Retired Dentists

Boards should adopt a respectful and supportive approach to registrants who, for various reasons, are not practising dentistry. A dental registrant enjoys a respected position in society and an important object of dental registration legislation is to maintain confidence in the profession.

3.7 Practice of Dentistry

The practice of dentistry for the purpose of this discussion of recency of practice should be clinical dentistry, clinical specialist practice, administration in the field of dentistry, study, teaching and research in the field of dentistry.

3.8 Time Frame for Action

For the purposes of registration, the minimum time that a practitioner can work and be considered to be safely practising dentistry needs to be established.

4 Policy

4.1 Requirements Must Address Real Risks

The following are low risk activities, and so not relevant to recency of practice:

- a dental specialist occasionally performing services outside the normal scope of the specialty which they have not performed for some time [it should also be noted that the scopes of dental specialties overlap and it would be impossible to describe the limitations of a specialty];

- a dentist attempting treatment not previously attempted [Keeping up to date makes it a necessity that all dentists will, many times in their practising lives, attempt things for the first time. However, a dentist must be adequately informed of new techniques, together with the risks and outcomes expected.].

The following are higher risk activities, and so relevant to recency of practice:

- a practitioner who has ceased practice for some time [approximately five years for the purposes of unconditional registration] and lost touch with contemporary dentistry [Boards must ensure that they focus on the real risk of loss of skills and knowledge that attend protracted absences from practice];
- professional isolation [i.e. practitioners without access to a peer group, continuing professional development and referral pathways].

4.2 Simple to Administer

The ADA advocates a simple system where the relevant Board:

- establishes an appropriate standard for recency of practice,
- requires an annual declaration of compliance from applicants for renewal, and
- undertakes a number of audits of registrants records each year, including as part of any Board investigation of a complaint.

The ADA supports a Board employing any of the following strategies for a registrant who does not meet recency of practice requirements:

- assessment [the form of any assessment should be at the discretion of the Board and may include oral, written and/or practical components];
- retraining or re-entry courses;
- supervised practice;
- registration in a non-practising category.

4.3 Respect Non-Practising and Retired Dentists

Non-practising registrants should have a special category of registration and be entitled to use protected titles, provided the words “non-practising” or “retired” are included. These registrants should not practise dentistry at all while registered in this category.

This arrangement should not permit a non-practising registrant who has exceeded the time limits for recency of practice to regain registration through practice in research, administration or teaching only, without assessment by the Board.

4.4 Time Frames for Action

There is no unequivocal evidence for time frames. Therefore, Boards should only set guidelines for time frames. Each individual case should be assessed on its merits. Only applicants for registration where there is clearly a risk to public safety should be subject to examination or conditions on registration.

These guidelines may include that a practitioner should have practised within the last five years and should have practiced for at least 250 hours per year for any period of continuous practice.

These timelines should apply equally to practitioners involved in the areas of research, education and administration who are practising dentistry and remain in close contact with other members of the profession and pose minimal risk to the public.

Policy Statement 2.9
Adopted by ADA Federal Council, April 20/21, 2006
Amended by ADA Federal Council, April 12/13, 2007.