



**AUSTRALIAN DENTAL
ASSOCIATION INC.**

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

CONSULTATION PAPER

**Proposed arrangements for handling complaints,
and dealing with performance, health and conduct matters**

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**Authorised by
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AUSTRALIAN DENTAL
ASSOCIATION INC.

SUBMISSION IN RESPONSE TO CONSULTATION PAPER

Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters

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 promote the practice of evidence-based dentistry and encourage access for all Australians to affordable preventive oral care. 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

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

It is noted that some ADA Branches have made submissions in response to this paper. The reason why this has occurred is that to date matters of complaints etc. relating to dentists and other health professionals have been dealt with locally at State and Territory level. As such these matters have been handled by the ADA Branches which are situated in those States and Territories. The Branches have therefore developed expertise and systems in this area that ADA Inc., being the Federal Body has not acquired. Accordingly, Branches have responded providing AHMAC with the benefit of their expertise in this area.

In responding, ADA Inc. will supplement the submissions made by ADA Branches only in areas where it feels competent to comment. 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 it 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.

The ADA is grateful for the extension of time offered to respond to this paper following the teleconference held with the Professions Reference Group.

General Comment:

The ADA has long recognised the importance of having a clear and just complaints' process in place for both the health consumer and practitioner. Because of this, it has developed a Policy: *Complaints Resolution* which outlines the ADA's views on this topic.

A copy of this Policy is attached.

Consultation Paper:

1. Background

The terms of the IGA are noted and the intent and focus stated is accepted.

2. Proposed terminology

Proposal 2.1:

The ADA is happy for the adoption of the "Notification" terminology.

Proposal 2.1.15:

Either option being adopted has some benefit. If the option utilising "Not of good character" is accepted then some clarity is needed as to what amounts to a "defect" in the character of a professional. If the alternative option of "not a fit and proper person" is utilised then the ADA sees that this is a common term used in this area and that ample case law exists defining what is intended by the use of this term.

3. Overview of the proposed system.

The notification management system is acceptable as it clearly defines the three crucial elements to be considered. The ADA agrees that the delineation in the three elements reflects the focus on professional practice, safety of the patient and avoids those areas of potential dissatisfaction that sometimes arise between patient and practitioner that are more in the nature of commercial complaints. The processes must focus on the safety of the patient and not delve into areas that are more commonly commercial disputes. There are others such as legal and consumer institutions that deal with these and they remain the venue for such disputes. The national boards should not be involved in these areas.

The ADA notes that Conciliation processes are created under the proposed scheme. As indicated in the ADA's Policy Statement referred to earlier, the ADA wishes to emphasise that from its experience, speed of resolution of notifications is imperative. Tardiness in dispute resolution often escalates the degree of the complaint and therefore the ADA emphasises the essential need for prompt action to be taken in respect of all notifications. The importance of prompt conciliatory action cannot be overemphasised.

Proposal 3.3.1.

The ADA is concerned with the proposed definition of “unsatisfactory professional conduct.” In Attachment 1 (a), the standard described for such conduct is one that provides alternatives. The Standards are either what might reasonably be expected of the practitioner:

- “by the public” “**or**”
- “by... the practitioner’s professional peers”.

The ADA would contend that provision of an alternative here is dangerous. It is in essence creating two standards against which the professional’s conduct is being assessed. Assessment of conduct by the “public” may be very different to that assessed by “professional peers” and may be, due to knowledge asymmetry, unrealistic. One level may not be satisfied by one test yet could be by the other.

It is important that a clear distinction is made as to exactly what single standard is to apply.

Clarification is needed here and the ADA would contend that the standard ought to be that which is expected by the practitioner’s peers. It is after all that group which can best determine what may be “unsatisfactory professional conduct.”

4. Notifications.

Proposal 4.1.1.

It is noted that this proposal would allow an “organisation” to provide notification to a Board. As the focus of the development of the complaint/notification handling protocols is patient safety, the ADA sees no role for organisations in the notification process.

It is patients who receive health treatment and the ability to make notifications in relation to personal health care delivery ought to be confined to the recipients of the services. Employers or other funders of health care delivery should not be accorded the benefit of the notification process. Commercial interests of such groups may be the motivation for the complaint. Such motivation has no place here. Such entities do not have the requisite standing to assume a role of a notifier in respect of personal patient care and should be precluded from the process.

A place may exist for a foreign professional board or other government agency to advise the relevant national board they have received a notification regarding a practitioner also registered with the national board.

Proposal 4.4:

Mandatory reporting is supported but it has to be couched in terms that make it clear to the reporting registered health provider exactly what obligations exist and the circumstances where reporting is required.

Option 1a is favoured by the ADA, as it confines the obligation for reporting on treating health practitioners. The consequences of a notification of this kind being made are so serious that the ability to notify should not be extended to health practitioners in general, who may only have a reasonable belief as to the registrant's condition.

The use of the term "reasonably believe" in itself creates some vagueness. It involves the treating practitioner having some knowledge of the nature of the registrant's "practice" before that treating practitioner can make a determination as to the impact the condition will have on the registrant's ability to practise. Such treating practitioners may not have this knowledge.

The ADA would recommend that an avenue of enquiry to a board or other qualified practitioner, on a confidential basis, be available for treating health practitioners who have a concern as to the impact a condition may have on a registrant's ability to practise. Such avenue of enquiry would better equip the treating practitioner to make the determination as to whether a "reasonable" belief existed.

Proposal 4.6.1:

Whilst this proposal is a reasonable one, the ADA feels it would be improved if guidelines were created as to precisely when and how this power can be exercised. A literal interpretation of the proposal as it stands provides a board with too general and wide ranging a power and there needs to be constraints, consistent with the notification protocols, put in place.

Proposal 4.7.1 and 4.7.2.

An ability to suspend immediately a practitioner of the ability to practise is a power that must only be exercised in very limited and serious cases. Again the ADA would press for the creation of clear guidelines as to when this most drastic of powers can be used.

Immediate suspension entails an administrative decision being made without the ability of the suspended registrant seemingly having any ability to make representations as to the event or events upon which the right to suspend is based. This would appear to be contrary to natural justice.

The ADA recognises that situations may arise to justify such action but they will be limited. Clear guidelines must underpin the provision of this power. The provision of natural justice including a right of reply to a scenario upon which the ability to suspend immediately must be made available-particularly in situations where the complaint may be anonymous.

While Proposal 4.7.2 provides that a registrant may be able to seek reversal of an immediate suspension decision by way of review (or writ of certiorari in the court system), such a right would not immediately result in a reversal of an inappropriate exercise of the power. The suspension would continue until the later determination

thus preventing the registrant from practising and such action would also result in expenses being incurred. Constraints have to be imposed on this general power that provides clear grounds or guidelines as to when this right to suspend immediately can be exercised.

5. Preliminary assessment of notifications.

Proposal 5.2.1:

The only comment the ADA would make here is that in the 4th dot point there is the proposal that a Board can not consider a notification if a health practitioner is no longer registered. This on its face seems appropriate but perhaps a record of the Board's decision not to investigate should be maintained in the event of later re-registration by the registrant. While the details the notification should be kept they should not prevent re-registration at some later time. The details may also become relevant in the case of a later notification being made following the registrant practising after re-registration.

Proposal 5.4.1:

This is accepted, however in view of the determinations being made by the Committee, the members of the Committee must be qualified to make the determinations. Registrants in the field being the subject of the notification must constitute the Committee.

Proposal 5.6

Option 1 is preferred.

6. Performance matters.

Proposal 6.4.1:

The ADA opposes the concept of a "performance panel" making a determination on a registrant's performance when a proportion of the panel determining the issue is not "from the profession concerned." While recognising that lay participation is a vital part of any review process, what is proposed here provides undue weight of numbers to practitioners/participants who are not of the class of the registrant. Those determining performance issues must be of equal or superior standing to that of the registrant under investigation.

The ADA is also concerned when administrative decisions can be made observing "natural justice but not be bound by the rules of evidence." Rules of evidence must be observed. Hearsay and similar evidence must be excluded-again noting that notifications can be anonymous. To allow such evidence in relation to an anonymous complaint would be grossly inappropriate.

7. Health or impairment matters.

Proposal 7.1.2:

Option 1 is preferred. Option 2 could result in reluctance on the part of a registrant from reporting a problem due to the costs to be incurred in undertaking any health program. Seeking treatment for conditions must be encouraged.

8. Conduct matters.

Proposal 8.1.1:

Use of the word "might" in this proposal is poor. It is too vague.

Proposal 8.3.1:

This proposal provides the ability for the Board to act unilaterally. Strong checks and balances need to be imposed here. For example, the qualification of the investigator should be identified.

Proposal 8.3.3:

This is acceptable but the ADA would recommend that the registrant have a right of reply that may on further enquiry result in a determination that no further investigation is warranted.

Proposal 8.3.4:

Strict limitations need to be imposed on this power.

Investigation by ambush should only be exercised in very limited circumstances and guidelines must be prepared setting out those circumstances.

Proposal 8.5.1:

See the comments made under Proposal 6.4.1.

9. Ensuring accountability, transparency and procedural fairness.

As a general comment the ADA agrees with the sentiments that are expressed in the paper regarding the need for independent safeguards to be created around the investigation processes for a complaint and the determination of the complaints.

Proposal 9.1.1.

The ADA would prefer option 1.

Proposal 9.3.

The ADA would prefer option 2.

Proposal 9.4.

The ADA would prefer option 1.

Proposal 9.8.

The ADA would prefer option 1.

10. Tribunal hearings.

Proposal 10.3.1.

The major option is preferred here over the Alternative option.

11. Offences and regulated conduct.

Proposal 11.5.1.

The major option is preferred over the alternative.

Proposal 11.6.

Options 1 and 3 are preferred but ADA Inc. has no strong preference between them.

The ADA has no strong objection to what is proposed. Simplicity and clarity of responsibilities must be provided. Some flexibility with time frames needs to be given, particularly in the early stages of this new process. Practising certificates or registration certificates should clearly identify the classification of registrant.

General Concerns:

The ADA supports many of the proposals made in the Consultation Paper.

The following general concerns are expressed:

- While recognising the importance that has to attach to the protection of the consumer of health services, the ADA would ask that the rights of the regulated person also be considered in any approaches taken regarding complaints.
- The proposals identify numerous layers in the investigation process. The ADA believes that the processes that are created should be easily able to be understood by both consumer and practitioner alike and that the processes developed remain transparent and “fair” to all parties.
- The numerous layers being created in the processes also cause the ADA concern as to the costs of the scheme. As mentioned at the outset of this submission, prompt resolution of complaints often results in satisfactory

solutions being reached for all parties. It is where prolonged disputation occurs that matters often escalate. Speed in the processes should be focused upon.

- Further, it should always be borne in mind that state, territory and federal justice systems exist and that where economies can be found by the utilisation of these resources, those economies ought to be utilised.

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', with a long horizontal flourish extending to the right.

Neil D Hewson
President
Australian Dental Association Inc.

24 November 2008.

COMPLAINTS RESOLUTION

1 General Principles

The Australian Dental Association [ADA] recognises it has a number of obligations with respect to complaints concerning professional duties.

- 1.1 The interests of the patient must always be paramount.
- 1.2 The ADA should maintain mechanisms which aim to ensure its members practise dentistry at the highest possible standard.
- 1.3 Self-regulation by the dental profession should be preserved and promoted.

2 Responsibility

- 2.1 The ADA recognises its responsibility for matters concerning conduct, performance and standards in the provision of services by its members.
- 2.2 The ADA may provide a mechanism to resolve a dispute where a dentist, who is a member of the ADA, is the subject of a potential or actual formal complaint about that member's conduct, performance or standards in the provision of services.
- 2.3 The ADA may co-operate in a mechanism to resolve a dispute where a dentist, who is not a member of the ADA, is the subject of a potential or actual formal complaint about that dentist's conduct, performance or standards in the provision of services.
- 2.4 The ADA recognises the role of the Dental Boards, State Health Complaints Commissions and other statutory authorities in the resolution of complaints.

3 Conciliation

- 3.1 Conciliation is a process which attempts to resolve differences between dentists and complainants without recourse to adjudication. It may be made available through the ADA or other bodies.
- 3.2 The ADA, through its Branches, may provide an avenue for conciliation in addition to or in conjunction with Dental Boards, state health complaints Commissions and other statutory authorities.
- 3.3 Conciliation should be available to deal with complaints concerning all dentists.
- 3.4 The means for conciliation should be available as a primary response to a formal written complaint.
- 3.5 The conciliatory mechanism should use the services of experienced dental practitioners.
- 3.6 Information provided by a practitioner who is the subject of a complaint during conciliation should remain privileged and be quarantined from future adjudicative or civil proceedings.

4 **Adjudication**

- 4.1 Where conciliation mechanisms have failed to resolve a dispute then the matter may proceed to adjudication utilising either peer review mechanisms or appropriate statutory authorities.
- 4.2 In matters requiring adjudication, preference should be given to peer review mechanisms which allow assessment of the appropriateness and quality of care.
- 4.3 Statutory review applies to all registered dentists and is regulated by Government.

Policy Statement 4.4

Adopted by ADA Federal Council, November 21/22, 2002.
Amended by ADA Federal Council, November 15/16, 2007.

APPENDIX TO POLICY STATEMENT 4.4

PRINCIPLES OF PEER REVIEW

1. Peer Review is a system by which the dental profession assumes a responsibility for reviewing matters concerning the performance of a dentist in carrying out professional duties, upon receipt of a formal complaint.
2. Peer Review is intended to provide assessment of an alleged deficient practice.
3. Appropriate matters for assessment by Peer Review might include (but are not limited to):
 - 3.1 propriety of treatment;
 - 3.2 appropriateness of care;
 - 3.3 quality of services rendered;
 - 3.4 reasonableness of fees;
 - 3.5 questions of overall provider competency.
4. The following guidelines should apply to the operation of Peer Review:
 - 4.1 Assessment of a complaint against a practitioner must be by a committee composed of the practitioner's peers.
 - 4.2 All parties concerned should agree to recognise the authority and finding of a Peer Review Committee.
 - 4.3 A Peer Review Committee should employ established parameters for the assessment of clinical quality and professional performance.
 - 4.4 Clinical assessment may be made only with the consent of both patient and practitioner.
 - 4.5 Where clinical assessment of a patient is undertaken, a Peer Review Committee may engage independent consultants, who should be remunerated.
 - 4.6 A consultant's report shall be in writing, limited to facts, and must only be made to the Peer Review Committee.
 - 4.7 Members of a Peer Review Committee and its consultants must be afforded protection against litigation arising from their participation in the review.
 - 4.8 Where either party initiates legal procedures in connection with a complaint, the review shall cease.