



**AUSTRALIAN DENTAL  
ASSOCIATION INC.**

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

**Consultation Paper on  
Proposed Registration Arrangements.**

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

## **Consultation Paper on Proposed Registration Arrangements.**

The Australian Dental Association (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 prevention based 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](http://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.

In responding, the ADA will deal with the matters raised in the paper in the order in which they were presented. It will then respond specifically to issues of interest to it by dealing with each of the Proposals set out in the paper. 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. Introduction.

The ADA notes the statement made in the Paper that *“the safety of the public is paramount, that high quality health care must be protected and advanced and that governments should be accountable and processes transparent.”*

The ADA is happy to note the recognition given to this objective as it too believes that any reform to the process of registration must have this as its central aim.

#### 2. Principles and Approach

##### ***Proposal 2.1:***

The ADA agrees that this reform process provides a significant opportunity to create an efficient effective scheme for registration and accreditation of practitioners and that what is created indeed “builds on the best aspects of the State and Territory Schemes”.

### 3. Regulated professions.

The ADA notes the use of the title "Dental Care Practitioners Board of Australia". Consistent with the ADA's earlier suggestions (which seem to have been adopted in Bill A before the Queensland Parliament) the ADA's preference is for use of the title "Dental Board of Australia".

The ADA suggests it would be advantageous to add to the 'Dentists' category within the Divisions of the Register, the various dental specialities. See later under "Types of Registration" in Section 7.

### 4. Initial Registration.

#### ***Proposal 4.1.1 and 4.2.1:***

The ADA agrees with the concept that for individual professions a registration fee be fixed for that profession but says that the fee ought to solely and accurately reflect the cost of administration of the regulatory process for that profession.

Such registration fee should not exceed that currently paid for registration under existing schemes.

#### ***Proposal 4.2.1:***

Specifically in respect of paragraph (e), the ADA refers to comments made later in relation to the issue of "Recency of Practice." In the case of applications made for registration by previously disqualified practitioners, there must be a requirement that any such applicant provide details as to "recency" (or more likely lack of this) of practice and that there be a cross reference to existing Australia wide registration information for verification.

#### ***Proposal 4.3.1:***

The ADA feels that Option 2 for initial registration and Option 4 for re-registration is acceptable.

### 5. Qualifications for registration.

#### ***Proposal 5.1:***

The ADA feels that is acceptable in general terms. The ADA agrees that the determination of qualifications should be left to the National Board and specifically to its Course Accreditation Committee's recommendations.

#### ***Proposal 5.2:***

The ADA does not support this. To allow a Board to register persons who have "training and experience... substantially equivalent to an approved course of study and supervised practice" is fraught with danger. Levels of training and supervised practice will be difficult to determine. Theory taught through courses of study is essential for the proper appreciation of health care delivery. A combination of an approved course of study, training, supervised practice and assessment must be the minimum essentials for evaluation.

The terms of the "NOTE" are accepted.

## 6. Registration Decisions

### ***Proposal 6.1.1:***

The ADA is in general agreement with this Proposal. It is proposed that the legislation provide for a responsible Board, at its discretion, to exercise the following powers before deciding an application for registration:

- a) investigate the applicant
- b) require the applicant to attend before the board to answer questions about their application
- c) require the applicant to provide further information or any documents considered necessary by the board to decide the application
- d) require the applicant to undergo a written, oral or practical examination to assess the applicant's competence to practise, and
- e) require the applicant to undergo a health assessment (eg a medical examination or psychological assessment) to assess the applicant's capacity to practise.

### ***Proposal 6.1.2:***

The ADA is in general agreement with this. Fitness to practise is a crucial determination of the Board and the Board should have power to order examinations to enable it to access this for registrants.

### ***Proposal 6.2.1 and 6.2.2:***

The ADA recognises that a considerable workload is being imposed upon the Boards in relation to registration. Delegation of this very important function should not be provided without considerable care - as this function is central to whole scheme. Persons making decisions on the registration of practitioners 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 registration and are capable of identifying that those proposed registrants have the skills required to perform the tasks associated with their registration category.

The constraints imposed by this proposal, as to the precise identity and qualifications of the members of the Committee, are inappropriate in the case of dentistry.

Similar considerations to those raised by the ADA in its Submission to Health Workforce Principal Committee on National Registration and Accreditation Scheme – Dental Board of 9 September 2008 are required when considering the make up of any Committee to which delegation of a registration authority is being given.

The ADA asks that the comments there be noted in this context. In that paper the ADA addressed the unique situation that confronts the proposed Dental Board - in that the Dental Board will need to deal with registration applications from 4 separate groups of intended registrants (dentists, dental therapists, dental hygienists and dental prosthetists); all of whom have different skills befitting their special (in some cases, restricted) areas of practice.

The ADA contends that it would be inappropriate for a proposed application for a dentist registration to be determined by a lesser trained professional such as a member of one of the other dental groups.

The degree of delegation provided in the registration process must reflect which of the dental groups is being considered. For example, the limited number of applications that may come from some dental groups may not necessitate any delegation; as all decisions could be made centrally. The number of dentist applications may necessitate delegation more locally.

With the cost of the processes to be undertaken in the registration and accreditation roles being required to be funded by the professionals themselves, economic constraint must be exercised so as to avoid duplication of services over too many delegated committees. A sound economic case must be presented before delegation to a Committee is considered.

***Proposals 6.3.1 and 6.3.2***

The ADA agrees that non practicing registrants should be exempted from the need to acquire PI cover. It agrees that all other practitioners should have "adequate" cover as befits their area of practice. Appropriate levels of cover need to be determined by the Board for the various categories of registrant.

One area that should be given consideration when determining appropriate "cover" is "run off" cover for those practitioners that cease to practice and/or retire. The very nature of "claims made" covers (which is the typical style of cover available in the PI market) can leave a gap in protection if cover is not maintained to accommodate claims made. Having run-off and/or "retirees cover" is important to ensure that there are not gaps in the protection of a health professional even though they have ceased to practice. Some have suggested that 5 years "run-off" is sufficient. We would disagree with such a limitation as we do not believe it to be adequate.

***Proposal 6.4.1:***

The ADA is supportive of the intent stated in this proposal. Some clarification is needed to paragraph (e). The ADA says that the fact proceedings have been brought against an intended registrant or that such proceedings have not been finalised should not preclude registration. The mere existence of proceedings should not be a permanent impediment to registration. Preclusion from registration in this area should only follow findings by a tribunal or court.

In so far as paragraph (g) is concerned, reference is made to the issue of "recency of practice" later in this submission.

***Proposal 6.4.2:***

The ADA has some serious concerns with this proposal. While sympathetic to the general intent of the proposal, it is concerned that registration of a practitioner could be suspended if a Board has "reasonable grounds" only of the fraudulent nature of an application for registration. The ramifications of suspension of a practitioner are so serious that to do so must be based on more than just "reasonable grounds." Facts in support of a potentially fraudulent application must require a higher standard than this.

Proving fraud is a very serious matter. The ramifications potentially lead to criminal sanctions. The standard of proof must be higher "than on the balance of probabilities". Being criminal in nature, the fact must require the criminal onus of proof, namely, "beyond reasonable doubt".

***Proposal 6.5.1, Proposal 6.5.2:***

The ADA agrees.

***Proposal 6.6.1:***

The ADA agrees.

[7. Types of Registration.](#)

***Proposal 7.1:***

As stated in the introduction to the Consultation paper, public interest and safety is to be of paramount importance.

Any clarification of the roles of the various categories of registrant is welcome. The caveat to this is that in creating categories of registrant, the public must always be able to clearly identify the particular category of registrant with which they wish to deal. At the outset of this registration review process the ADA pointed out the similarity and potential for confusion in the use of terms "prosthodontist" and "prosthodontist" and suggested the latter category be identified as "denturist." The ADA maintains that suggestion.

Recognition of specialists is supported. Such categorisation will enable the public to be clear as to the category of practitioner with which they deal.

There is some concern as to the use of the proposed "Specific" category of registration. Special purpose registration has its place but care will have to be taken that these categories do not confuse the public and also that practitioners with "specific" registration do not practise outside their area of specificity.

***Proposal 7.3.1 and 7.3.2:***

The ADA agrees.

***Proposal 7.4.1:***

Of the options proposed, the third one is preferred due to its consistency across all health professions. For your information please find attached an ADA Policy Statement 5.3.1 that deals specifically with infectious disease status of dental students. The ADA commends this Policy to the Subcommittee.

***Proposal 7.5:***

The ADA agrees with this proposal. Protection from the practice of a health profession by unqualified persons (be they non registered persons per se or registered practitioners practising outside their authority) must fall within the ambit of the Board, so that appropriate action can be taken against such persons. Negative licensing provisions are under consideration in some state jurisdictions to deal with this and must be examined with a view to adoption here.

It would be desirable that if corporations are to be involved in health delivery, through ownership of practices, then they be held accountable for their practices. Powers ought to be provided under corporations' law in this regard. The ability to sanction corporations which are delinquent in their management and delivery of

health care should be capable of being penalised and more importantly being able to be directed to improve levels of health care delivery to levels commensurate with those imposed upon registered practitioners.

#### 8. Authorities conferred by registration.

As mentioned in 7.1, recognition of dental specialists is welcomed. It is not however dealt with under this topic of title protection.

Reference is made to the attached ADA Policy Statement 4.9: *"Dental Acts and Boards."*

##### **Proposal 8.1.1:**

The ADA accepts this.

The use of the term "oral health therapist" as set out in the Table is opposed. As stated earlier public interest and safety is paramount. Utilisation of the title "oral health therapist" will create confusion in the minds of the public as it is indistinguishable from the term "dental therapist".

##### **Proposal 8.3.1:**

The adoption of a definition of the practice of dentistry is agreed.

A definition makes it clear as to what is permitted to be performed and makes it clear that those persons who are not registered as dental treatment providers are precluded from performing such tasks within the definition.

#### 9. Renewal of Registration and continuing competence.

##### **Proposal 9.2.1, 9.2.2, 9.3.1 and 9.4.2:**

The ADA generally agrees with the sentiments expressed. The ADA refers you to the attached ADA Policy Statements 2.9: *"Recency of Practice"* and 4.9: *"Dental Acts and Boards"* specifically paragraphs 1.2.3, 1.2.4, 3.2.2 and 3.2.6.

To a large extent the publication of "minimum standards" is something that is being dealt with by the Australian Commission for Safety and Quality in Healthcare. The ADA would have no objection to the Ministerial Council having oversight of the process developed. The ADA suggests the process of standard setting be implemented by one authority so as to avoid confusion.

##### **Proposal 9.4.1**

The Monitoring of practitioners whose fitness to practice is under question is accepted.

One matter that the ADA would like to canvas here is that in cases of monitoring such practitioners, it is imperative that the fact a monitoring process is being undertaken and the nature of the possible disability remain confidential. There have been cases (some of suggested alcohol abuse and others regarding possible infection status) where this has not occurred to the long term detriment of the practitioner.

If in the monitoring process some level of rehabilitation is occurring or some temporary limitation imposed on the practitioner's ability to practise also remain confidential between practitioner and Board.

***Proposal 9.4.3:***

While generally agreeing with the proposal, the ADA suggests that the mere receipt of a medical negligence claim (as identified in paragraph (b)) is not something that should be necessarily reported to a registering authority. Receipt of a claim is not evidence of neglect and should not be treated as such unless and until a finding is made in an appropriate court of law. It is then and only then that there should be an obligation to report a claim. Even then, a finding of negligence should not equate with unfitness to practice. Before any action is taken in respect of the finding, the full facts and findings need to be evaluated by the reporting authority to determine if fitness to practise is placed in question.

In many civil actions of negligence, settlements of claims are negotiated. Often settlements require that the terms of the settlement not be disclosed. If disclosed, contempt of court occurs. There can be many and varied reasons for such settlements. E.g. from the making of a nuisance payment to rid the practitioner of a frivolous claim, to the payment of a compromised sum to avoid a court hearing and the potential for an adverse finding and a larger verdict. These protections must remain.

[10. Endorsement of registration.](#)

***Proposal 10.1.1:***

The ADA has made comment on the recognition of "specialists" earlier in this paper. In determining the "qualifications that the responsible board considers should apply for the purpose of endorsement of registration in each recognised specialty", the ADA says such determinations must only follow detailed analysis and advice from practitioners most able to comment on the questions to be considered. Practitioners exercising this power must in themselves have adequate qualifications to enable reasoned decisions to be made.

***Proposal 10.1.3:***

The ADA agrees with this and suggests that the authorisation be to use the appropriate specialist title not the title "dental specialist".

***Proposal 10.3.1:***

Caution is required in the exercise of the powers in this area. The ADA again emphasises that public safety is paramount in this process. If there are to be refinements to the qualifications of certain practitioners to deliver a particular service that they were not otherwise qualified to provide, then that determination can only be made after full and complete analysis by persons who already have that ability and authorisation to practise in that area.

A determination as to whether a particular class of practitioner can expand their area of practice cannot be determined by persons within that class of practitioner. It has to be a determination by a more senior practitioner that already has those skills and is authorised to practise in that area.

A situation could not arise whereby a dentist or group of dentists could evaluate whether “dentists”, as a class of practitioner, could be permitted to have their area of practice expanded to allow them to perform cardiac procedures. It would be cardiologists or similarly qualified practitioners that already possess the skills and authority to perform such services that have to determine if the applicants possess the appropriate skills to perform such tasks.

## 11. Other matters

### ***Proposals 11.1.1-11.5.1***

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.

## 12. Transitional arrangements.

### ***Proposal 12.1:***

What is proposed here is acceptable. It provides for continuity of existing registration requirements. Proposal 12.1 (f) is acceptable necessitating a fresh application for registration be required on an expeditious basis.

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

A handwritten signature in black ink, appearing to read "John E. Matthews". The signature is fluid and cursive, with a prominent initial "J" and a long, sweeping underline.

John E Matthews  
President  
Australian Dental Association.

## HEALTH CARE WORKERS [INCL. STUDENTS] INFECTED WITH BLOOD-BORNE VIRUSES

### 1 Introduction

- 1.1 Historically dentists, dental students and allied dental personnel have been at risk of succumbing to a disease acquired in the course of their duties. Community concern about the risk of acquiring a blood-borne virus in a health care setting has generated a review of infection control policies and procedures, and has identified the need for national guidelines for health care workers [HCWs] who may be infected with HIV, hepatitis B [HBV], hepatitis C [HCV], or other blood-borne viruses.
- 1.2 Reports that there are other hepatitis viruses, e.g. hepatitis G [HGV], associated with persistent viraemia and needle-stick injury, suggest that blanket rules are likely to create numerous administrative and practical dilemmas. Individual case assessment by expert panels established by State/Territory health authorities is therefore recommended.
- 1.3 Transmission of blood-borne viruses from HCW to patient in the health care setting is extremely rare. However, all reasonable measures must be taken to ensure that patients in the health system are protected from the risk of acquiring life threatening infections as a consequence of their treatment, and that HCWs have a safe working environment.
- 1.4 Implementation of Standard Precautions and adoption of nationally recommended procedures for sterilisation and disinfection will minimise the risk of transmission of blood-borne viruses in the health care setting. Additional precautions may be required where there are complicating circumstances, such as HIV-positive patients with infectious pulmonary tuberculosis.

### 2 Definition of Terms

- 2.1 In the context of these guidelines, HCWs are defined as "persons, including students and trainees, involved in contact with patients or with blood or body substances from patients".
- 2.2 The term, "blood-borne virus", as used in these guidelines, includes HIV, HBV and HCV. It may also include new or emerging viruses which are considered to be transmissible by blood or other body fluids.
- 2.3 Invasive procedures include any surgical entry into tissue, body cavities or organs, or repair of traumatic injury. "Exposure prone procedure" is a term usually characterised by "the potential for direct contact between the skin [usually finger or thumb] of the HCW and sharp surgical instruments, needles, or sharp tissues [spicules of bone or teeth] in body cavities or in poorly visualised or confined body sites [including the mouth]". In the broader sense, and for the purpose of these guidelines, an exposure prone procedure is considered to be any situation where there is a potentially high risk of transmission of blood-borne disease from HCW to patient, and vice versa, during dental procedures.

### 3 Policy

- 3.1 The ADA acknowledges that HCWs have a duty of care to patients and are, therefore, responsible for the protection of patients against infection.
- 3.2 It is an ethical obligation of all HCWs performing exposure prone procedures to know their infection status for testable blood-borne viruses.
- 3.3 Any HCW infected with a blood-borne virus should immediately cease to perform exposure prone procedures. It is noted that, in the case of students, this may preclude the student from ongoing training and completion of studies. However, it should be noted that in general dentistry, modifications can be made to practice so that risks are kept to a minimum. A combination of practice modification and utilisation of risk reduction procedures [such as retraction with an instrument during local anaesthetic administration, double gloving, blunt suturing, avoidance of surgical procedures where possible, correct use of luxators, and other measures] can ensure most practitioners with a blood-borne virus can continue to work under supervisory arrangements which adequately protect the public and meet the requirements of the relevant regulatory authority.
- 3.4 The practitioner should be managed by a panel similar to that outlined in the "Infection Control Guidelines for the prevention of transmission of infectious diseases in the health care setting" [2004] published by the Department of Health and Ageing. As a minimum, this should consist of the practitioner's treating specialist physician, a member of the Dental Board and a practitioner from the same branch of dentistry as the infected practitioner. This management should be confidential and each case assessed on an individual basis. The Panel's advice to the Dental Board would take note of factors including the practitioners skills, compliance with risk reduction procedures, mental and physical state, and current viral load.
- 3.5 Punitive measures may result in practitioner non-compliance and so are counter-productive in ensuring the best patient/practitioner outcome.
- 3.6 Employers should ensure that adequate processes are in place in the work environment to ensure that confidentiality is maintained and that appropriate counselling and treatment are available to infected HCWs.

#### **Policy Statement 5.3.1**

Adopted by ADA Federal Council, November 15/16, 2001.  
Amended by ADA Federal Council, November 10/11, 2005.

## DENTAL ACTS AND BOARDS<sup>1</sup>

### 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.

<sup>1</sup> 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.



## 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.