National Standards in Dentistry Project

ADAVB response to Discussion Paper

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Prepared for: **Dental Boards of Australian States and Territories, the Australian Dental Council and the Dental Council of New Zealand**

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PREAMBLE

The ADAVB recognises that the National Dental Board has not yet been established, no specific brief on the development of professional standards has been devised by the State and Commonwealth Governments, and Health Ministers have not defined the scope of standards that their Governments will require to be addressed. Notwithstanding this, the preparation of early advice to the new Dental Board of Australia and beyond that body to the Ministerial Council and the Ministers themselves, is a worthy activity.

We note that Figure 1 in the Discussion Paper identifies three sets of national standards which will need to be addressed:

- Registration standards
- Accreditation standards
- Professional Standards

It may therefore be helpful to the new Dental Board of Australia for the draft standards prepared as a result of this process to be presented under these headings.

The General Dental Council's 'Standards for Dental Professionals' publication and the five supplementary guidance documents, which expand on the following Principles of Practice in Dentistry in the Standards, offer a useful **benchmark**:

1 Putting patients' interests first and acting to protect them.
2 Respecting patients' dignity and choices.
3 Protecting the confidentiality of patients' information.
4 Co-operating with other members of the dental team and other healthcare colleagues in the interests of patients.
5 Maintaining your professional knowledge and competence.
6 Being trustworthy.

Source: GDC, Standards for Dental Professionals, May 2005, page 4

Appendix 1 contains a summary of the key points covered in the five guidance notes which supplement these professional standards. Appendix 2 offers an outline of the key areas in which the Dental Council of New Zealand has set professional standards.

What matters should be covered by the dental standards and what priority should be attached to them?

The Discussion Paper proposes these topics as the subject of national dental standards:

"a. scopes of practice (for dentists, dental prosthetists, dental hygienists, dental therapists, oral health therapists, dental technicians, and including a description of the dental team, an overview of the roles of the professions and how they work together)2
b. qualifications for registration
c. record keeping
d. infection control
e. professional boundaries
f. anaesthesia and conscious sedation
g. continuing professional development
h. code of ethics
i. attributes of the profession. (It is proposed to document the attributes of the profession by asking for instance: what sort of person is the practising professional? What sort of person is the newly emerging graduate? What sort of person are universities trying to turn out? What sort of abilities (e.g. clinical competence, communication skills etc) do practitioners need?

What kind of practitioner does the community need? Where possible it is intended to base the development of the standards on models that have worked in comparable countries such as New Zealand, the UK and Canada).”

Some of these relate to registration standards while others are about professional standards. We assume that item ‘i’, relating to desired attributes, is meant to relate to course accreditation standards.

While items a – g are all supported, there is potential for a wide difference of views about the approach to be taken to these. With regard to item ‘a’, the absence of any specificity in the scopes of practice for dental therapists and dental hygienists in the recent versions of the Dental Practice Board of Victoria Code of Practice governing their work, compares unfavourably with the clarity of the General Dental Council’s approach.

Professional and clinical boundaries

Item ‘e’ professional boundaries, has until now been limited to defining appropriate relationships between registered persons and others. While this standard may actually belong in the group applicable to all registered health professionals, it might justify remaining in the dental standards if it also included ***clinical boundaries.*** We suggest that this additional issue would also benefit from guidance, as there have been some questionable activities offered and delivered by dental practices, including (but not limited to):

- **Use of splints** for headaches, bedwetting, impaired libido, and back conditions (Chirodontics)
- **Homeopathic** treatment
- **Herbal remedies** in the practice or sold for home use
- **Naturopathic** treatment
- Relaxation **Massage**
- **Therapeutic massage**
- **Prayer** and/or faith healing
- **Prescribing** scheduled substances for non-dental conditions
- **Dispensing** scheduled substances for dental and/or non-dental conditions
- **Selling** non scheduled therapeutic substances
- **Diagnosis** of non-dental conditions e.g. heart disease, diabetes and cancer
- **Botox injections** outside the mouth
- local anaesthetic injections preparatory to a person receiving lip tattooing or piercing in a nearby beauty salon or tattoo parlour

In the first example, the use of an occlusal splint implies that the treatment is a dental treatment. However, if the purpose of the treatment is to treat an illness or

condition that is non-dental, we argue that complaints about such treatment are most likely to relate to its failure to satisfactorily address the non-dental illness or condition. This means that the treatment would not fit comfortably within the definition of dentistry proposed for the new registration system. The evidence base for claims of therapeutic benefit from such treatments is not established at an acceptable level and the public should therefore be protected from being mislead. As with sleep disorders, dentists may be able to assist a physician and / or other members of a treatment team in the treatment of headaches, but a dentist is not qualified to diagnose headaches that may arise from vision, neurological (e.g. tumours) and other non-dental causes.

The negative licensing regime established by the NSW Parliament is commended to the Ministers as a mechanism by which to protect the public where the treatments and services offered fall outside the scope of regulated practice. This may be necessary for registered practitioners offering treatments or services outside their regulated field as much as for non-registered persons.

The NSW Government promulgated the NSW Code of Practice for Unregistered Health Practitioners, effective from 1 August 2008. The Code is incorporated into the Public Health (General) Regulations 2002 under the Public Health Act 1991. We understand that an alleged breach of the Code would be dealt with in a Magistrates Court, with a maximum possible fine of 20 penalty units. Adoption of such an approach was recommended by the Victorian Health Services Commissioner in the Noel Campbell Inquiry Report of July 2008 (see http://www.health.vic.gov.au/hsc/noel_campbell_inquiry.htm). In his response to that report the Victorian Minister for Health proposed:

> *"that Victoria lead work on options for future regulatory arrangements for unregistered health professionals, in the context of the National Registration and Accreditation Scheme. This work is currently underway and involves consideration of current arrangements in New South Wales."*
> Source: Health Services Commissioner Inquiry into the activities of Mr Noel Campbell, - Minister for Health statement in response to recommendations of the Inquiry, August 2008

Ethical decision making

ADAVB does not support a code of ethics being included in a regulatory instrument. This is because, in our view, it goes beyond the brief determined under the legislation, and runs the risk of removing any 'ownership' of ethical principles by the professional groups being regulated. Ethical behaviour is not amenable to regulation. Compliance with rules is.

It has long been recognised, that "*the ethics of a profession are not imposed by legislation but self-inflicted and voluntarily accepted for the purpose of establishing and maintaining an honourable pattern of behaviour recognised by*

both its members and the community it serves". (Seear, J. Law and Ethics in Dentistry, 1975, p.103)

It is acknowledged that serious professional misconduct will usually also be unethical, but the definition of such misconduct should not presume to be a complete definition of unethical behaviour.

Nor should the national standards create any impression that the Dental Board of Australia will become a forum for civil remedies. Dr Margaret Seward, past-President of the UK General Dental Council, in her chapter about that organisation in, Dental Law and Ethics (Lambden, P. Radcliffe Publishing, 2002, pp.1-2) notes:

> *"... there remain certain common misunderstandings about professional regulations in general terms. It cannot and should not be used as a substitute for the well-established systems of civil redress. The actions normally taken by regulatory bodies are, to put it simply, to protect a member of the public, a patient, from a professional, a dentist, hygienist or therapist, who may either cause him/her harm or undertake treatment which falls short of the expected standards which would have been provided by their peers. The self-regulatory process is certainly not designed to award compensation to the affected parties and again, it is certainly not a substitute for a matter of concern, for example, fraud, which clearly needs to be investigated by the police or criminal courts who then decide on the appropriate punishment or penalty."*

Immanuel Kant, whose philosophical theories have informed elements of our current social structure, saw the law functioning as a system of **externally imposed** constraints on behaviour, whereas ethics functions as **self-imposed** constraints. When it came to ethics, he described people as "self-legislators".

Ethics have been defined as "the moral principles or virtues that govern the character and conduct of an individual or group". When regulators start to deal with moral judgments they engage with vastly complex multi-factorial decisions, sometimes underpinned by religious and spiritual beliefs. The virtues are normally thought to include such qualities as: politeness, fidelity, prudence, temperance, courage, justice (honesty), generosity (kindness), compassion, mercy, gratitude, humility, simplicity, tolerance, purity, gentleness, good faith, humour and love. A virtue is a force that has or can have an effect. These individual virtues do not actually exist in isolation from each other or the context in which a judgment is made about them.

Any Code of Ethics, such as the Code which has long been promoted by the Australian Dental Association, can only be a guide to personal judgment. The principles and values that are enshrined in the Code need to be absorbed and lived by the professional in order to have the desired force and effect. When

faced with an ethical dilemma, no-one resorts to reading the guidelines in order to make their decision. They make the choice between all possible responses according to an inner compass – the product of a lifetime of experiences and learnings about right and wrong; about what works and what constitutes a mistake.

Dr Simon Longstaff, Executive Director of the St James Ethics Centre, says: "*Paradoxically, the less that people are required to exercise their own good judgment, the more they become wedded to depending upon written rules. Guidelines have become a substitute for the trust that has evaporated. But then it becomes too expensive to reduce everything to a legal regulation. I don't think you can function as an effective society when nobody trusts anybody*." (Quoted in an article in The Australian, 'Pillars crumble under the weight of mistrust', September 2008)

A number of behaviours might be considered 'unethical' without being illegal in dentistry today. These include:

- Criticising a colleague's work
- Using a dental presentation to promote one's practice
- Failing to make a contribution to the needs of the indigent
- Failing to share clinical knowledge with one's colleagues
- Failing to take steps to conduct a more sustainable practice e.g. installing amalgam separation technology, and using biodegradable consumables wherever possible.

This suggests that the new Dental Board of Australia should beware of using an approach which seems to be the last word on ethical obligations. The need for personal ownership of ethical decisions and the wide range of ethical issues which fall outside the scope of matters that a regulatory body could reasonably seek to control, suggest a more open-ended approach is desirable. This is reminiscent of the observation that "Ethics is an allegiance to the unenforceable".

In setting professional standards, the State, as embodied in the form of a registration board, does not represent the profession, nor can it seek to be responsible for defining all ethical conduct in dental practice.

The *Dental Ethics Manual*, published by FDI in 2007, notes:

> *"... ethics should not be confused with law. One difference between the two is that laws can differ significantly from one country to another while ethics is generally applicable across national boundaries. In addition, ethics quite often prescribes higher standards of behaviour than does the law, and occasionally situations may arise where the two conflict. In such circumstances dentists must use their own best judgement whether to comply with the law or follow ethical principles. Where unjust laws conflict*

> *with ethical principles, dentists should work individually and collectively to change the laws.*
> (FDI World Dental Federation, Dental Ethics Manual, 2007, p.20)

If, as a result of this process, the Dental Board of Australia is offered a national standard related to ethical behaviour, we suggest that a guide to ethical decision-making by registered persons, similar to that published by the American College of Dentists (**http://www.acd.org/ethicshandbook.htm**) would be constructive. This approach would help practitioners to accept personal responsibility for their decisions rather than deciding for them. (Refer attached extracts from this Handbook in Appendix 3.)

'Best practice' or 'minimum safety' standards

ADAVB argues that the regulatory guidance promulgated by dental boards should be set at a level that protects public health and safety but doesn't impose unreasonable cost burdens on practitioners which are passed on to patients. Such regulatory guidelines should not be set at the level of 'best practice', but rather at the level of minimum safety standards. The cost of best practice in all circumstances may be too great for the community to bear.

Professional attributes

In the list of proposed areas in which standards are to be developed, we note that item 'i' seeks to define professional attributes. The purpose of this standard is not entirely clear. Some of the sample questions offered in that point may imply discriminatory practice and caution will be required to ensure that this is not the case.

In the examples given in the Discussion Paper we note that there are a number of types or classifications of questions that this standard would seek to address. Those related to suitability to practice dentistry have historically been addressed in university course selection processes. Perhaps this relates to an accreditation standard but it is difficult to see how the identification of the desired attributes will be used and by whom.

What issues should have a cross-profession standard developed and what priority should be attached to them?

The Discussion Paper identifies a number of matters which might be considered applicable to all health professions and suggests that these, listed below, will <u>not</u> be covered by the project. This is confusing given that one of the two key questions on which responses have been sought is "*What issues should have a cross-profession standard developed and what priority should be attached to*

them?" We assume that while feedback is sought on these topics for which cross professional standards should be developed, the project does not intend to commence drafting of these standards:

a. eligibility for initial registration – including evaluating good character, requirements for good standing certification from other bodies an applicant is registered with, English language proficiency, proof of identity etc.
b. health practitioners infected with blood borne viruses
c. advertising
d. recency of practice/returning to practice
e. obtaining informed consent.

The definitions of some of the terms used in these topics will be of interest, however they do seem to be a reasonable list to begin with. Examples of definitional issues include:

- What is meant by 'good standing' in this context?
- How does one test 'good character'? Given the problems encountered by Dr Mohamed Haneef when the Immigration Department considered his character to be in question, and the subsequent damage done to Australia's international reputation, great caution will need to be exercised here. As remarked above in connection with professional attributes, caution will be required to avoid charges of discrimination.
- Will health practitioners infected with blood borne viruses include students? And if so, at what point in a student's enrolment will this issue be drawn to attention?
- How long a period of absence from practice will be considered a trigger for invoking recency of practice measures?

ENDS

APPENDIX 1 – SUMMARY OF GDC GUIDANCE TO ACCOMPANY 'Standards for Dental Professionals'

Principles of Patient Consent

1 Informed consent - the patient has enough information to make a decision.
2 Voluntary decision-making - the patient has made the decision.
3 Ability - the patient has the ability to make an informed decision.

Principles of patient confidentiality

1 Duty of confidentiality
2 Releasing information with the patient's consent
3 Preventing information being released accidentally
4 Releasing information in the public interest

Principles of Dental Team Working

1 'Co-operate with other members of the dental team and other healthcare colleagues in the interests of patients'
2 Co-operate with other team members and colleagues, and respect their role in caring for patients.
3 Treat all team members and other colleagues fairly and in line with the law. Do not discriminate against them.
4 Communicate effectively and share your knowledge and skills with other team members and colleagues as necessary in the interests of patients. In all dealings with other team members and colleagues, make the interests of patients your first priority.

Principles of Complaints Handling

'Put patients' interests first and act to protect them.'
Give patients who make a complaint about the care or treatment they have received a helpful response at the appropriate time. Respect the patient's right to complain. Make sure that there is an effective complaints procedure where you work and follow it at all times. Co-operate with any formal inquiry into the treatment of a patient.

Principles of Raising Concerns

'Put patients' interests first and act to protect them.'
If you believe that patients might be at risk because of your health, behaviour or professional performance, or that of a colleague, or because of any aspect of the clinical environment, you should take action.

Principles of Management Responsibility

'Put patients' interests first and act to protect them'. Put patients' interests before your own or those of any colleague, organisation or business.

Scope of Practice

This guidance clearly lists the things that each member of the team is able to do and also describes those matters reserved for only certain classes of dental professional.

APPENDIX 2 – DCNZ PROFESSIONAL STANDARDS

The Dental Council of New Zealand's Professional Standards page at http://www.dcnz.org.nz/dcStandards, lists the following as relevant:

- **Overview**
- **Competence and Recertification**
- **Competence Review**
- **Recertification for Dentists or Dental Specialists**
- **Recertification for Dental Hygienists, Dental Auxiliaries and Orthdontic Auxiliaries**
- **Recertification for Dental Therapists**
- **Recertification for Dental Technicians and Clinical Dental Technicians**
- **Education and accreditation of training programmes**
- **Codes of Practice and Council Statements**
  Relating to clinical, cultural and ethical standards, such as
  - **Informed Consent**
  - **Infection Control**
  - **Emergencies in Dental Practice** (Click **here** for a list of approved training providers)
  - **Record Keeping**
  - **Sedation for Dental Procedures**
  - **Sexual Boundaries in the Dentist/Patient Relationship**
  - **Transmissible Major Viral Infections (TMVI)**
  - **The professional relationships associated with the practice of Dental Technology and Clinical Dental Technology**
  - **Patient Registration and Health Questionnaire form**

- **Policy Guidelines**
  Relating to matters of administration and interpretation of the HPCA Act
- **Complaints about Oral Health Practitioners**
- **Dentists Disciplinary Tribunal Decisions and Orders**

APPENDIX 3 - Extracts from Ethics Handbook for Dentists

American College of Dentistry
http://www.acd.org/ethicshandbook.htm

Ethical Decision Making

The process of ethical decision making by dentists may be simple or quite complex, ranging from "The Golden Rule" to decisions that contemplate the ethical principles or considerations at stake. Ethical decision making involves both judging and choosing. Emotional state, incompetence, physical and mental disorders, and other conditions may adversely affect a dentist's decision-making capacity. Decision principles, elements, and models are summarized to broaden the dentist's understanding of the processes involved and to accommodate individual needs or preferences.

Decision Principles see **7:51**

Autonomy, nonmaleficence, beneficence, and justice are four generally accepted ethical principles. These principles require that all actions, including decisions by dentists, demonstrate:

1. Regard for self-determination (respect for autonomy);
2. The avoidance of doing harm (nonmaleficence);
3. The promotion of well-being (beneficence);
4. Fairness in the distribution of goods and the reduction and avoidance of harms (justice).

Decision Elements see **1:38-40**

Assessing the Medical and Social Context

Good ethics begin with good facts.

Clarifying the Ethical Problem

What type of conflict is present—moral weakness, moral uncertainty, or moral dilemma? What moral principles are imbedded in the conflict? What is the nature of the choices involved? Who will make the decision?

Determining the Stakeholders

Who is involved in the ethical concern? Decisions often involve many parties.

Identifying Options and Alternatives

Some moral choices inevitably involve compromise of some moral principle; others may not. Ethical decision making requires imagination and creativity to discern options not envisioned when a conflict presents itself.

Examining the Process of Decision Making

Decision processes involve collaboration, partnership, or interaction with the patient as opposed to a paternalistic model where the dentist unilaterally makes the decisions.

Balancing Conflicting Principles and Obligations

Thoughtful scrutiny helps dentists, patients, and others balance their responsibilities in the face of conflicting principles and obligations.

Decision Model I see **7:66-68**

Step 1—*Determine the Alternatives*

Determine that there is clarity and agreement on all relevant facts.

Step 2—*Determine the Ethical Considerations*

Consider the ethical implications of each alternative. Identify the ethical principles involved and determine the role of beneficence, nonmaleficence, autonomy, and justice. Determine the balance of good over harm.

Step 3—*Determine the Considered Judgments of Others*

Consider what your colleagues have concluded in similar situations. Consider codes of dental ethics, other codes, and views of other organizations.

Step 4—*Rank the Alternatives*

Try to determine which alternative best satisfies the ethical requirements of the case. Select the course of action that best resolves the conflicts.

Decision Model II see **1:42-49**

Step 1—After identifying an ethical question facing you, gather the dental, medical, social, and all other clinically relevant facts of the case.

Step 2—Identify all relevant values that play a role in the case and determine which, if any, conflict.

Step 3—List the options open to you. That is, answer the question, "What *could* you do?"

Step 4—Choose the best solution from an ethical point of view, justify it, and respond to possible criticisms. That is, answer the question, "What *should* you do, and why?"

Decision Model III see **3:78-80**

Step 1—*Identifying the Alternatives*

What courses of action are available? What are their likely outcomes? To what other choices are they likely to lead? How likely are such outcomes and such future choices?

Step 2—*Determining What Is Professionally at Stake*

What ought and ought not to be done professionally?

Step 3—*Determining What Else Is Ethically at Stake*

What other ethical considerations apply to the action being considered?

Step 4—*Determining What Ought to be Done*

Rank the successful alternatives. The best alternative is done; equal alternatives require choice.

The ACD Test
For Ethical Decisions

Assess

Is it true?
Is it accurate?
Is it fair?
Is it quality?
Is it legal?

Communicate

Have you listened?
Have you informed the patient?

Have you explained outcomes?
Have you presented alternatives?

Decide

Is now the best time?
Is it within your ability?
Is it in the best interests of the patient?
Is it what you would want for **yourself**?

The ACD Test for Ethical Decisions prompts questions that should be considered when deliberating an ethical dilemma.

Core Values

Core values represent a guide for ethical behavior. The core values that follow are from the American College of Dentists, and are the foundation from which its principles are derived. These values collectively reflect the character, charter, and mission of the College (in alphabetical order):

Autonomy—Patients have the right to determine what should be done with their own bodies. Because patients are moral entities they are capable of autonomous decision-making. Respect for patient autonomy affirms this dynamic in the doctor-patient relationship and forms the foundation for informed consent, for protecting patient confidentiality, and for upholding veracity. The patient's right to self-determination is not, however, absolute. The dentist must also weigh benefits and harms and inform the patient of contemporary standards of oral health care.

Beneficence—Beneficence, often cited as a fundamental principle of ethics, is the obligation to benefit others or to seek their good. While balancing harms and benefits, the dentist seeks to minimize harms and maximize benefits for the patient. The dentist refrains from harming the patient by referring to those with specialized expertise when the dentist's own skills are insufficient.

Compassion—Compassion requires caring and the ability to identify with the patient's overall well-being. Relieving pain and suffering is a common attribute of dental practice. Acts of kindness and a sympathetic ear for the patient are all qualities of a caring, compassionate dentist.

Competence—The competent dentist is able to diagnose and treat the patient's oral health needs and to refer when it is in the patient's best interest. Maintaining competence requires continual self-assessment about the outcome of patient care and involves a commitment to lifelong learning. Competence is the just expectation of the patient.

Integrity—Integrity requires the dentist to behave with honor and decency. The dentist who practices with a sense of integrity affirms the core values and recognizes when words, actions or intentions are in conflict with one's values and conscience. Professional integrity commits the dentist to upholding the profession's Codes of Ethics and to safeguarding, influencing and promoting the highest professional standards.

Justice—Justice is often associated with fairness or giving to each his or her own due. Issues of fairness are pervasive in dental practice and range from elemental procedural issues such as who shall receive treatment first, to complex questions of who shall receive treatment at all. The just dentist must be aware of these complexities when balancing the distribution of benefits and burdens in practice

Professionalism—Self-governance is a hallmark of a profession and dentistry will thrive as long as its members are committed to actively support and promote the profession and its service to the public. The commitment to promoting oral health initiatives and protecting the public requires that the profession works together for the collective best interest of society.

Tolerance—Dentists are challenged to practice within an increasingly complex cultural and ethnically diverse community. Conventional attitudes regarding pain, appropriate function, and esthetics may be confounded by these differences. Tolerance to diversity requires dentists to recognize that these differences exist and challenges dentists to understand how these differences may affect patient choices and treatment.

Veracity—Veracity, often known as honesty or truth telling, is the bedrock of a trusting doctor-patient relationship. The dentist relies on the honesty of the patient to gather the facts necessary to form a proper diagnosis. The patient relies on the dentist to be truthful so that truly informed decision-making can occur. Honesty in dealing with the public, colleagues and self are equally important.