# ADAVB COMMENTS IN RESPONSE TO THE CONSULTATION PAPER ON PROPOSED REGISTRATION ARRANGEMENTS

## 1. Introduction

### 1.1 Overview of the National Scheme

- ADAVB supports the guiding principles underpinning the development of the legislation and the scheme that
  - the safety of the public is paramount,
  - high quality health care must be protected and advanced and
  - that governments should be accountable and processes transparent

## 2. Principles and approach

- ADAVB accepts that terms such as 'responsible board', 'registered health practitioner' and 'regulated profession' are required in order to address 10 major occupational groups under one piece of legislation.

## 3. Regulated professions

- The name 'Dental Care Practitioners' is clumsy and unnecessary. 'Dental Practitioners' should be used instead.
- The names of recognised dental specialties should be regulated also, either in the legislation or in a Code of Practice approved by the new national Dental Practitioners' Board. There are currently 11 recognised dental specialties (see comments under 7.1 below). Only those with the required post-graduate qualifications should be permitted to use specialist titles.

## 4. Initial registration applications

- ADAVB understands that while individual boards will have the power to determine the registration fees for practitioners within their jurisdiction, however we argue that certain principles should be adopted to guide that fee setting process. These include that all practitioners within a field should be charged the same fee – recognising that the administrative work involved for each registrant is the same regardless of their division on the register. We also believe that since a single secretariat is being established for all boards, and presumably economies of scale are being sought through reduction of overlap and duplication, the cost of the new national registration fee should be cheaper than has previously been required for the approximately 88 separate boards and councils. The Ministerial Council and the Agency Management Committee should be charged with ensuring that cost savings are achieved, and that efficiencies are identified to achieve this outcome.

Note: Need to check whether people previously registered may be made subject to a Board's deliberations – as per the Vic HSC report on Noel Campbell

- Given that most dentists are self employed in small practices, Option 4 should be employed, so that the legislation provides the power to require criminal history checks on

applicants at the discretion of the relevant board, while not making checks mandatory for all applicants.

## 5. Qualifications for registration

- Proposal 5.1 recognises that an approved period of supervised practice (i.e. an internship) is one of the means by which a Board might consider an applicant prepared for registration. Internships exist in medicine, pharmacy and psychology, and so ADAVB suggests that internships also be established for dentistry with a view to all dental graduates having an opportunity to obtain additional clinical experience in a range of public dental settings, especially in rural and other underserved areas, so that they develop the special skills required to deal with patients with special needs.

## 6. Registration decisions

### 6.1 Board powers before deciding applications for registration

- Boards should have the power to require a health assessment, including a medical examination or psychological assessment, at any time before or during a person's registration.

### 6.2 Who makes registration decisions

- The notion of registration decisions being made by a committee comprised of members who are registrants from "the profession concerned" (amongst others) needs clarification. In cases where a registration board only deals with a single profession, as in say Optometry, the guideline would be clear. In dentistry, the responsible board or committee will be making registration decisions in relation to dentists, dental therapists, dental hygienists and dental prosthetists. These occupations are not one profession, and indeed there would be some argument as to whether all qualify for the description profession. A professional is normally thought to be fully responsible for their own work, whereas dental therapists and dental hygienists are required to work in a consultative relationship with a dentist – historically described as being "under the supervision and direction of a dentist".
- It would be unacceptable for a dentist's registration to be determined by a committee comprising say a chair who was a dental prosthetist and two other practitioners who were a therapist and a hygienist. It would also contradict the intention behind the principle that a health practitioner's registration should involve and acknowledge the insight of a "registrant from the profession concerned". This will doubtless be equally true for the other named dental occupations.

### 6.3 Professional indemnity insurance requirements

- Where practitioners are registered as non-practicing, they should be exempt from the requirement that they should have PII.
- The guidelines regarding what constitutes acceptable arrangements for PII for registrants may need to allow for differential treatment of different specialties within dentistry, as the surgical procedures performed by Oral and Maxillofacial Surgeons involve considerably higher risk and usually require higher premiums (and possibly levels of cover).
- Hospitals requiring $20m cover should not impose a benchmark which is then applied to office based practice, where the average claim is closer to $10,000 or $15,000. Cover of up to $10m is more than adequate for dental practice.

### 6.4 Board powers to refuse to grant registration

- The Board should have the power to enter into agreements with registered persons that they surrender their registration and never seek to become registered again.
- In such circumstances, a person should not then be able to seek registration at a later date, and claim that they are entitled to do so by virtue of the agreement not being recognised amongst the grounds for denying registration. Clause (j) refers to an applicant being "disqualified from applying", but this may not include the form of agreement noted above.

### 6.5 Refusal process

- The proposed timeframes for notification of board decisions and opportunity for an applicant to seek review of same seem appropriate.

### 6.6 Rights of review of registration decisions

- ADAVB queries whether the provisions described for the establishment of a committee of the Board to perform the registration function, which makes much of their obligation to adhere to the principles of natural justice, are adequately honoured when the review process is restricted to a merits review. If it is important that the committee observes "the principles of natural justice and procedural fairness" then surely any failure to do so should be grounds for review, and therefore the rights of review must allow for points of law to be raised.

## 7. Types of registration granted

### 7.1 General registration

- Recognition of the need to acknowledge specialists by means of endorsement of their registration is particularly welcome – in the public interest. Specialists are an essential part of our healthcare system and it is vitally important that dentists and patients can confidently identify those with genuine specialist qualifications and skills. General practitioner dentists cannot know everything about each specialist field and so rely on dental specialists in the 11 recognised fields (including oral and maxillofacial surgery, periodontology, orthodontics, prosthodontics, endodontics, paediatric dentistry, oral medicine, oral pathology, special needs dentistry, public health dentistry, dento-maxillofacial radiology), to deal with highly complex and difficult cases in those areas.

### 7.2 Specific registration

- Provision for intern or residency programs which provide for post-graduate training as approved by the relevant board is welcome. Such programs may well extend beyond the existing programs in medicine, pharmacy and psychology.
- Specific registration for overseas trained practitioners who are authorised to work in areas of special need remains problematic. The dependency on this workforce and the waiving of safety and quality requirements compared with the strict imposition of such requirements on registered persons who have fully qualified is contradictory.

### 7.3 Non-practising registration

- This provision for practitioners involved in study programs, sabbaticals, or in retirement but doing occasional lectures or seminars, or administrative work such as complaint resolution, is welcome. It needs to be accompanied by relaxation of obligations that apply to practitioners still involved in actively treating patients or supervising others who are treating patients. Such requirements include PI insurance and continuing education obligations.

### 7.4 Student registration

- Of the three options proposed for student registration, ADAVB favours the third, which requires students to be registered at the point of enrolment and for the duration of their course.
- The infectious disease status of dental students is an issue that requires an 'impaired practitioner approach' by the relevant board, and students whose status might pose a risk to patients need to be counselled to change course to an alternative field which will not pose such a risk. It is far preferable for this to happen early in the course than for a student to waste time and money on studying for a qualification and seeking registration in a field they will not be able to work in effectively. This also implies that blood testing should be undertaken prior to entry to a dental degree course.

### 7.5 Corporate registration

- ADAVB agrees that corporate registration is not required or appropriate under this legislation. We note however that the issue of how the public is protected in connection with the delivery of health services by unregistered persons has recently been addressed by the NSW Parliament through the adoption of negative licensing provisions. These have also been recommended to the Victorian Government in the recent Health Services Commissioner Report of her Inquiry into Noel Campbell.
- In our view corporations which own and operate health practices need to be held accountable in some way whenever they do something, or neglect to do something, which ultimately causes or contributes to patient harm. This might be as simple as choosing to order sub-standard or defective materials or equipment, but may go further to involve directing a registered person to do something which causes harm to a patient.
- There also a set of issues where registered health practitioner offer health services beyond their registration, for example when a registered dentists offers naturopathic or homeopathic services (amongst numerous possible other combinations). Negative licensing provisions would impose an obligation to comply with a code of conduct and sanctions for failure to do so, which would provide the currently missing protection for public health and safety. The Noel Campbell Inquiry amply demonstrates why such protections are necessary.
  (Source: Noel Campbell Inquiry Report, July 2008 - Report by the Health Services Commissioner to the Minister for Health, the Hon. Daniel Andrews MP under Section 9(1)(m) of the Health Services (Conciliation and Review) Act 1987)

## 8. Authorities conferred by registration

### 8.1 Title protection

- While the consultation paper recognises the need to make provision for endorsement of general registration for specialists, there is no mention of 'specialist dentists' or any of the 11 different specialist dentist titles. Given the capacity for people who do not possess the requisite qualifications to entitle them to specialist endorsement to use titles

and descriptions that imply that they are 'dental specialists', these titles should also be protected.
- The use of honorary titles can be an area which is abused, and this was also well demonstrated in the Inquiry into Noel Campbell. Noel Campbell was in the habit of styling himself 'Professor Noel Campbell'. The HSC noted in her report on this:
  *"The titles used by Noel Campbell also changed during the Inquiry with Noel Campbell referring to himself as 'Professor' Campbell, a title which this Inquiry has found he was not entitled to use and which was potentially misleading. Some complainants to the Inquiry said they believed he was a medical doctor."*
  (Source: Noel Campbell Inquiry Report, p.2)

### 8.2 Practice protection

- The inclusion of legislative definitions for dentistry and optometry are welcome.

### 8.3 Dentistry practice restrictions

- ADAVB welcomes the inclusion of a definition of dentistry so that unregistered persons do not perform dental procedures.
- We note that this same issue is addressed under the HPRA using a prohibitive approach, viz:

**"98. Restriction on practising dentistry**
(1) A person who is not registered as a dental care provider under this Act must not knowingly do any of the following—
(a) diagnose or manage conditions of the mouth of a person;
(b) perform any invasive or irreversible procedure on the natural teeth or the parts of *a* person's body associated with their natural teeth;
(c) provide artificial teeth or dental appliances to a patient or insert artificial teeth or dental appliances for a patient;
(d) make an intraoral adjustment of artificial teeth or dental appliances for a patient.
Penalty: 120 penalty units."

- ADAVB queries whether similar sanctions will apply under the new legislation so that the public will be adequately protected from irreversible injury.

### 8.4 Optometry practice restrictions

- No comment

### 8.5 Restrictions on spinal manipulation

- No comment

## 9. Renewal of registration

### 9.1 Background

- Given that a wide range of measures has been applied across the country and most dental boards have not administered mandatory CPD requirements ADAVB accepts that this may not be required under the new national arrangements.

### 9.2 Continuing competence requirements

- Our experience of administering CPD programs under a mandatory regime suggests that requiring an average of 40 hours recognised CPD over a two-year cycle is manageable

for general practitioners, but sometimes problematic for specialists who often have to travel overseas to gain access to a wide enough range of courses to meet their obligations. This is undoubtedly a significant cost burden which must be passed on to their patients. We also note that there is no evidence that such measures make a difference to patient safety and quality of care, even though the objective of additional education is to achieve improved practitioner understandings and skills. The impracticality of requiring all registered persons to do hands-on training means that inevitably the bulk of education offered is passive and auditorium style seminar programs.

- Our members in Victorian have also reported that the specification of three hours of infection control and 2 hours of CPR in each cycle may also be unnecessary after the first cycle. Another observation here is that practice accreditation may better address infection control behaviours in the practice than simply requiring people to attend a three hour hotel seminar which may not result in any changed behaviours in the practice.

### 9.3 Annual reporting obligations on registrants

- ADAVB is concerned at the open-ended nature of the suggested provisions regarding annual reporting, especially

  **c. any medical negligence claims**

  **d. if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer, and**

- The requirements under the Health Professions Registration Act 2005 (Victoria) state that where a court has determined a settlement this must be reported to the Board, and we support this as the matter has been assessed formally and determined in favour of the plaintiff. It is not reasonable to seek reporting of all claims made when this would include vexatious and unfounded claims which are ultimately dismissed by a court. The reporting of such unfounded matters to the board ignores this and implies that the practitioner is in some way posing a risk to public health and safety when there is no reasonable basis for this assumption until a court has found against them.
- The other problem with the wording of part (c) is that it uses the word negligence in a way which suggests that all treatment failure arise from the errors or omissions of a practitioner when this is known to be untrue.
- In a recent article on Patient Safety, Robert Wachter, Professor and Chief of the Division of Hospital Medicine, University of California, San Francisco (UCSF) wrote:
  "*Because <u>patients can be injured while receiving perfect care</u>, it is important to separate errors from adverse events. An error is usually defined as "an act or omission that leads to an unanticipated, undesirable outcome or to substantial potential for such an outcome." Adverse events, on the other hand, are injuries due to medical management rather than the patient's underlying illness. Although patients experiencing errors and adverse events may be equally harmed, the distinction is crucial because the fixes may be very different.*" (emphasis added)
  (Source: http://knol.google.com/k/robert-wachter/patient-safety/I8d6CVRe/NRSyrQ#)
- Not only are the remedies likely to be different, but the assignment of blame to a practitioner for an adverse event outcome ignores the broader context in which care is provided, which is acknowledged in open disclosure provisions advocated by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The National Standard on Open Disclosure is described by the ACSQHC as "A National Standard for open communication in Public and Private Hospitals, following an adverse event in health care", and was endorsed by the Health Ministers in July 2003. The Standard states:
  *"In working towards an environment that is as free as possible from adverse events, <u>there is a need to move away from blaming individuals</u> to focussing on establishing systems of organisational responsibility while at the same time maintaining professional*

*accountability. In this context, health care organisations need to foster an environment where people feel supported and are encouraged to identify and report adverse events so that opportunities for systems improvements can be identified and acted on."*

It goes on to note that:
*"There is no agreed universal definition of "adverse event". For the purposes of this Standard, an "adverse event" is defined as "an incident in which unintended harm resulted to a person receiving health care".*
*Adverse events also include harm to patients arising from the environment of care for which the hospital is responsible."*

- As regards notification to a board whenever "any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer", this too has the potential to misapprehend the reasons and purposes of such actions.
- 'Credentialling' is verification of the qualifications, experience and professional standing of practitioners in order to decide whether they are professionally capable and suitable to provide safe, high quality health care services within specific organisational environments.
- 'Defining the Scope of Clinical Practice' is delineating the extent of an individual practitioner's clinical practice within a particular organisation, based on his or her credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support his or her clinical practice.
- Given that a hospital might restrict a dentist's credentials on grounds entirely unrelated to the dentists but actually determined by the lack of facilities within that hospital, or indeed because the dentists chooses not to practice in certain fields, it would be quite inappropriate for such matters to be reported to a board as if there were a public health risk involved or as if there was some question regarding the competence of the dentist which casts a shadow over their registration status.

### 9.4 Monitoring the professional competence of registrants

- The power of registration boards to issue guidelines about professional standards will need to be exercised in the context of minimum safety standards for all healthcare services being set by the Australian Commission on Safety and Quality in Health Care. The Government is at risk of creating overlap and duplication problems between the bodies responsible for protecting public health and safety. Practitioners need to have a simple and clear set of obligations and accountabilities rather than a confusing array of standards and guidelines issued by different Government auspiced organisations, competing for their attention and understanding.

## 10. Endorsements on registration

### 10.1 Specialist endorsement

- See our comments above under points 7.1 and 8.1
- We welcome specific mention of restricted titles such as 'dental specialist' in this section, as these were not included in section 7.1.
- Offence provisions where people use specialist titles without being registered and endorsed to do so are appropriate.

### 10.2 Endorsement as qualified to prescribe scheduled medicines

- As with all aspects of health services, the essential question is whether the practitioner is trained and competent to perform the duties proposed. In the case of some lesser trained practitioners it would be a significant risk to patient safety to authorise them to prescribe medications.

### 10.3 Other endorsements on registration

- As no specific examples are given, ADAVB does not understand the other types of endorsements envisaged by the authors of the consultation paper and so reserves its right to comment on specific proposals for such endorsement as and when they become visible. These too should be subject to extensive consultation arrangements before implementation.

## 11. Other matters

### 11.1 Duration of registration

- The use of rolling registration periods, with renewal dates determined by when practitioners first sought registration sounds sensible, although it will inevitably mean that larger numbers are renewing around the end of each year (upon the anniversary of their graduation). It may also lead to a need for earlier decisions regarding future registration fee adjustment so that these are notified well in advance to all affected parties.

### 11.2 Certification of registration

- The Options of imposing a penalty or not for failure to notify a change of address are noted. In the event a penalty is decided upon, we strongly urge that this be a summary item and that a fixed penalty of say $50 or $100 be imposed rather than treating this as a matter requiring a board hearing, which would generate significant costs for both the Board and the registrant.
- We are aware of a case where a board sought a hearing after a practitioner notified them by phone of a change of address but did not follow up with a written advice. This was unnecessary and overly bureaucratic.
- The register should be publicly available on a website or sites, and should include all addresses at which the person offers dental services at any given time.

### 11.3 Failure to renew

- A grace period of three months should be allowed when a person (usually inadvertently) fails to renew.
- The Board should also be able to treat such a breach as a summary offence, and issue a small fine rather than make it a ‘federal case’.

### 11.4 Reinstatement to the register

- The provision of an option for the board to permit a practitioner’s name to be restored to the register if they re-apply within two years of a lapsed registration is reasonable.

### 11.5 Removal from the register

- The reasons proposed for removing a person’s name from the register are reasonable.

## 12. Transition arrangements

- ADAVB agrees that the transitional provisions proposed are reasonable.
- We also query whether the full disciplinary and impairment history of practitioners will be transferred to the new national agency and whether this will be held off the public version of the register or published for public viewing.
- Our concern here relates to the relevance and currency of historical decisions affecting the registration of practitioners. Many jurisdictions have not published details of disciplinary action on a website, and reporting of such action has been limited to an annual report or similar vehicle with a narrow audience.
- In Victoria we recently made representations on behalf of a practice which had been found in breach of a provision in 1999, which if the same action had occurred today would not be a breach of any Act, Regulation or Code of Practice. The irrelevance of publishing old disciplinary history when the laws and guidelines may have changed many times over is highlighted. The publication of such information is presumably intended to inform the public of some degree of risk associated with a practitioner, and yet in the case referred to, the publication would have been misleading, and indeed cast the practitioners in an unfair light.

Other Comments

'Accreditation' is a term which has been overused by Government Departments and agencies in recent discussion papers and proposal documents. Its use to mean different things at different times inevitably leads to confusion and errors.

1. It is used historically, and in the consideration of new national registration arrangements, to refer to the formal recognition of courses which are considered to satisfactorily prepare candidates for registration to practice.

2. It is used in discussion of safety and quality measures to refer to the certification of a practice as one which meets minimum safety standards for the delivery of healthcare services.

3. It has also been used in connection with Private Health Insurance regulations to refer to the recognition of a practitioner so that a health fund member receiving treatment from that person is eligible to receive a rebate on the cost of that treatment. Indeed, the consultation paper itself describes an endorsement of a practitioner's registration as potentially relating to an "endorsement that qualifies the registrant for accreditation to provide Medicare or PBS funded services, or eligibility for provider rebate status under private health insurance regulations".(p.22)

In this last respect, 'accreditation' is also sometimes confused with 'credentialling', which is a process of recognising a practitioner as suitable to provide nominated health services in a hospital setting.

To avoid this confusion, the agencies involved in the matters referred to above should confer on the establishment of an agreed nomenclature which only uses the word accreditation to mean one thing, and substitutes other suitable terms for the other meanings attached to the term.