



## Public consultation on draft registration standards

May 2014

### Responses to consultation questions

Please provide your comments in a **word document** (not PDF) by email to [dentalboardconsultation@ahpra.gov.au](mailto:dentalboardconsultation@ahpra.gov.au) by close of business on **14 July 2014**.

#### Stakeholder Details

*If you wish to include background information about your organisation please provide this as a separate word document (not PDF).*

<b>Organisation name</b>
Australian Dental Association, Victorian Branch Inc. (ADAVB Inc.)  Please see Attachment A for more information about the ADAVB
<b>Contact information</b> <i>(please include contact person's name and email address)</i>
Mr Garry Pearson, Chief Executive Officer, ADAVB Inc.  Australian Dental Association Victorian Branch Inc. Level 3, 10 Yarra Street, South Yarra VIC 3141 Ph. 03 8825 4600 Fax 03 8825 4644 <a href="mailto:garry.pearson@adavb.org">garry.pearson@adavb.org</a>

#### Your responses to consultation questions

<b>Registration standard: Professional indemnity insurance arrangements (PII)</b> <i>Please provide your responses to any or all questions in the blank boxes below</i>
<b>1. From your perspective how is the current PII registration standard working?</b> The ADAVB is generally supportive of the key requirements included in the current Dental Professional Indemnity Insurance Registration Standard.  However, the ADAVB has some concerns: <ul style="list-style-type: none"><li>• <b>Practitioners who are in an employee relationship:</b> particularly those working for non-registered persons or dental corporations. If a dental corporation or business views profit as a central motivator we are concerned that the best interests of the patient may conflict with the rules laid out by the employer. There is little instruction in the draft PI Insurance Registration Standard to manage a scenario where the clinical autonomy of the dentist is affected by their relationship with their employer. One possible solution is to require dental corporations and</li></ul>

## Registration standard: Professional indemnity insurance arrangements (PII)

Please provide your responses to any or all questions in the blank boxes below

businesses to be registered entities with the DBA, as per the approach used by the General Dental Council in the UK.

- **When a complaint is made against an owner of a dental practice who is not a registered person, or a dental corporation:** it is the practitioner who holds responsibility rather than the owner of the business or the corporation, despite the owner being the source of benchmarks or targets that the practitioner must meet. The business is not held accountable within the DBA regulatory system and prosecution would only be possible through the courts. This could act as a disincentive against pursuing complaints against a business.

2. Are there any state or territory specific issues or impacts that have arisen from applying the existing PII standard?

No

3. Is the content and structure of the draft revised PII registration standard helpful, clear, relevant and more workable than the current standard?

- The standard is clear but some important information has been omitted. See comments under (1) and (4).
- Under the heading 'Evidence', practitioners who hold PII in their own name are required to retain documentary evidence of this for five years. This requirement is new to the PII Standard and we question why the period of five years has been chosen. How is the five year period calculated, is it from present time? We also note that this period is inconsistent with the requirements in the Board's own Guidelines on Dental Records in Section 2.7, which state that: "Dental Practitioners should be aware of local privacy laws that govern the retention of records, which require retention from 7-10 years". Evidence of PII coverage should be maintained for the same period of time as dental records.

4. Is there any content that needs to be changed or deleted in the draft revised PII registration standard?

- While we accept that practitioners working in public dental agencies can be covered by a Government funded insurer, we argue that for all private sector work the practitioner is held personally accountable by AHPRA and the DBA and so **their PI insurance should be issued in their name or in a manner where they are named as a beneficiary of the policy**, we therefore raise the following points for consideration:
- **Under the heading 'What must I do?' point 5:** Practitioners must disclose to the Board any conditions or restrictions that are placed on their policy or any change in the basis of their cover. The cover an employed practitioner has may not be "their cover" and if it covers multiple practitioners, they all need to be named in order for them to be able to comply. A situation in which one practitioner covered by an employer's policy requires additional conditions or an excess poses complex issues.  
We therefore propose that each practitioner be named on the PII policy so that any restrictions or conditions can be specifically associated with the individual practitioner and this can be accurately reported to the DBA.
- From time to time, practitioners are declined cover by their insurer. The person declined cover is obliged to disclose this to any other insurer from whom they seek cover, however the present wording of the Registration Standard may be interpreted to suggest no such obligation exists to disclose declinature to the Board. We suggest this would desirably be clarified in the updated Standard.
- **Under the heading "Evidence":** The practitioner should keep a copy of the insurance policy, regardless of whether or not they are the primary beneficiary. This means that employers,

<b>Registration standard: Professional indemnity insurance arrangements (PII)</b>	
<i>Please provide your responses to any or all questions in the blank boxes below</i>	
	including those in the public sector, should provide the practitioner with a copy of the insurance policy upon commencement and whenever the policy is amended.
	<ul style="list-style-type: none"> <li>The Board requires those who are covered by a third party insurance arrangement to produce documentary evidence of their PII coverage upon request. We suggest that the Board further specifies that the third party be required to provide evidence of this coverage.</li> </ul>
<b>5. Is there anything missing that needs to be added to the draft revised PII registration standard?</b>	
	See comments above.
<b>6. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?</b>	
	Five years is an appropriate length of time.
<b>7. Do you have any other comments on the draft revised PII registration standard?</b>	
	Whilst we acknowledge the following matters are administrative in nature and do not strictly concern the PII Standard we would like to take this opportunity to provide feedback on the related issue of notification data.
	<b>Notification data:</b>
	<ul style="list-style-type: none"> <li>The ADAVB has previously commented on the need to access AHPRA detailed notification data in its submission on the review of the Dental Board of Australia's Data and Research Policy in April 2013.</li> <li>The ADAVB believes it would be extremely beneficial for notification data to be published by practitioner type instead of 'dental practitioners' as a whole category. This would allow the identification of which groups are responsible for the majority of notifications, for example, whether a denture complaint relates to treatment provided by a dentist or a prosthetist. It would also provide detail about what issues are generally the causes of notifications. This differentiation is already provided in the Victorian Office of the Health Services Commissioner's Half Yearly and Annual reports, and provision of AHPRA data in this format would allow better understanding of risk and therefore better targeting of prevention and response measures.</li> <li>This data would be helpful to the association and our professional indemnity insurance partners (currently Guild Insurance Ltd) in conducting root cause analyses and in developing targeted education to reduce incidents. Detailed notification data would also be beneficial for informing reviews of professional indemnity insurance policies and accompanying advice.</li> <li>The ADAVB sees risk management and efforts to reduce the number of notifiable events as vitally important in ensuring that the public is exposed to less risk of harm, and consequently PI insurance premiums do not rise substantially and increase the cost of dental services.</li> </ul>

<b>Registration standard: Continuing professional development</b>	
<b>Guidelines: Continuing professional development (CPD)</b>	
<i>Please provide your responses to any or all questions in the blank boxes below</i>	
<b>1. From your perspective how is the current CPD registration standard working?</b>	
<b>2. Are there any state or territory-specific issues or impacts arising from applying the existing CPD standard that you would like to raise with the Board?</b>	

**Registration standard: Continuing professional development**

**Guidelines: Continuing professional development (CPD)**

*Please provide your responses to any or all questions in the blank boxes below*

3. Is the content and structure of the draft revised CPD registration standard helpful, clear, relevant and more workable than the current standard?

The draft CPD registration Standard lacks clarity and specificity with respect to the nature of the CPD that should be undertaken. We ask the Board to consider what areas of CPD training are essential to ensure the health and safety of both patients and practitioners. For example, the draft CPD Registration Standard does not mention any requirement for a current CPR certification, nor is the need to regularly update infection control knowledge discussed. These are two areas in which we believe dental practitioners should be educated regularly.

**Under the heading ‘What must I do?’**

We suggest that the language be clarified as follows:

a minimum of 60 hours of CPD activities over three years, which applies whether you are working full time or part time or are registered in more than one division of the dental register

- A minimum of forty-eight of these hours (80%) must be spent on clinically or scientifically based activities, and
- a maximum of twelve of these hours (20%) can be spent on any suitable CPD activity and does not necessarily need to be of a clinical or scientific nature (NB some courses concern business or commercial matters and would not be suitable for non-scientific credit)."

**Under the heading ‘Evidence’:**

- the Standard states that ‘records of your CPD activity must be maintained for five years’. The beginning and end of this five year period is unclear, is it five years after the activity was undertaken, or five years after the completion of that three-year CPD cycle?
- ‘The Board may ask for additional supporting information, such as certificates of attendance’ we suggest that, in the Guidelines, the Board specifies what type of documentation is required to demonstrate participation in passive self-learning CPD activities such as listening to a CD, reading a journal article, watching a DVD or accessing online content.

**Under the heading ‘Definitions’**

The definition of ‘Practice’ is very broad, and may include practitioners who work in non-clinical relationships with clients and patients. Under what circumstances does the Standard apply to these people?

4. Do you think that:  
(a) a percentage of the total CPD hours should be allocated to non-scientific activities?  
OR  
(b) all CPD activities should be scientific or clinically based?  
(Please provide your reasons)

We agree that the current minimum threshold of 80% of total CPD hours should be devoted to clinical or scientific training, but suggest clarifying that the remaining 20% of CPD hours can be spent on any relevant activity, as follows: “The remaining 12 hours (20%) can be devoted to any suitable CPD activity and does not necessarily need to be of a clinical or scientific nature (NB some courses concern business or commercial matters and would not be suitable for non-scientific credit).”

5. Recognising that a transition process would be required, do you agree with the Board’s proposed change that the three year CPD cycle should be aligned with registration period (i.e. each three year CPD cycle run from 1 December – 30 November)?

Yes, we agree that it is logical to align the CPD cycle with the registration period, provided that period is aligned with a 30 November renewal deadline.

Were this to be changed to a financial year renewal and a 30 June deadline, we would be concerned about the potential economic impacts.

**Registration standard: Continuing professional development**

**Guidelines: Continuing professional development (CPD)**

*Please provide your responses to any or all questions in the blank boxes below*

6. Is there any content that needs to be changed or deleted in the draft revised CPD registration standard?

**Under the heading ‘What must I do?’:**

- We suggest clarifying that 20% of the minimum total CPD hours can be spent on any relevant activity, as follows: “The remaining 12 hours (20%) can be devoted to any CPD activity and does not necessarily need to be of a clinical or scientific nature.”

7. Is there anything missing that needs to be added to the draft revised CPD registration standard?

**Under the heading ‘What must I do?’, we suggest that the following additional statements be considered:**

- In any given cycle, CPD undertaken above the minimum requirement of 60 hours may be of a clinical or non-clinical nature.
- If you undertake more than 60 hours of CPD in a given cycle this cannot be transferred into the next cycle.

8. Is there any content that needs to be changed or deleted in the draft revised CPD **guidelines**?

**Under the heading “How do I keep a record of my CPD activities” we suggest:**

That the Guidelines specify what type of documentation is required to demonstrate participation in passive self-learning CPD activities such as listening to a CD, reading a journal article, watching a DVD or accessing online content.

**Under the heading: “What are the requirements if I am returning to practice after an absence?”**

The Guidelines require 40 hours of CPD in the first year if a dentist has been absent from the profession for more than two years. The Guidelines also require 40 CPD hours in the first year for those who have not practiced within Australia for more than two years. We view this requirement as particularly onerous. This arrangement will act as a disincentive for professionals returning to work and those who would like to work part-time (most likely females returning after a period of maternity leave). We recommend that this requirement be removed or revised down. We suggest that a more reasonable requirement would be to mandate that practitioners returning to the workforce after a period of absence complete 20 hours of CPD in the first year.

The introductory comments in this Draft Consultation Standard state that a review of the literature, commissioned by the National Boards, found that “the available evidence however does not provide definitive answers to issues such as the most effective amount and types of CPD”. We therefore suggest that no evidence exists to support the decision to mandate that a practitioner undertake a minimum of 40 hours CPD in the first year after returning from an absence. Furthermore, this mandate appears to contradict the Board’s previously articulated reasons for not requiring a minimum number of CPD hours per year for all practitioners, including a wish to achieve maximum flexibility to allow the practitioner to choose the most appropriate CPD, for example some conferences and CPD programs are only offered biennially.

9. Is there anything missing that needs to be added to the draft revised CPD **guidelines**?

**Under the heading “How do I choose appropriate CPD activities”**

- We suggest the DBA recommend practitioners prepare an individual learning plan before the start of each CPD cycle, through which they identify areas in which they need to maintain current knowledge or improve skills, and describe how they intend to do this.

**Under the heading “How do I keep a record of my CPD activities” we suggest:**

- That the Guidelines specify what type of documentation is required to demonstrate participation in passive self-learning CPD activities such as listening to a CD, reading a journal article, watching a DVD or accessing online content.

10. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?

**Registration standard: Continuing professional development**

**Guidelines: Continuing professional development (CPD)**

*Please provide your responses to any or all questions in the blank boxes below*

Three years is an appropriate review period as we believe that the current Standard and Guidelines and the new drafts proposed by the Board require further revision through consultation with stakeholders. This review period also aligns well with the length of the CPD cycle.

11. Do you have any other comments on the draft revised CPD registration standard?

12. Do you have any other comments on the draft revised CPD **guidelines**?

**Under the heading 'Definitions'**

The definition of 'Practice' is very broad, and may include practitioners who work in non-clinical relationships with clients and patients. Under what circumstances does the Standard apply to these people?

**Practitioners are confused about what the DBA requires in order to comply with clinical record keeping regulations:**

There is currently confusion among dentists regarding what the DBA expects in the area of clinical dental records keeping. Therefore clinical records education should be encouraged and supported by the DBA to help provide clarity.

We would like to highlight that, of all the panel hearings reported in the 2011-12 AHPRA annual report (21 cases), every dental case listed occurred in Victoria, and there were apparently no dental panel hearings in other (non-NSW) States. Most of these cases cited inadequate record keeping as an issue. The data indicate that educating dentists on what the DBA expects in the area of dental records keeping is needed.

Further analysis of this anomalous data is warranted. Access to national data on notification patterns would allow an analysis of whether the issue is a cultural one within a particular profession, or whether it is solely related to differences in State/Territory processes, such as varying approaches by AHPRA investigators.

The DBA is one of only five of the 14 national registration boards that have developed specific guidelines for keeping health records. Whilst the majority of the 14 national boards have specified maintaining adequate health records as a requirement under their codes of conduct, the existence of detailed health records guidelines for five of the 14 professions (including dental) suggests that these five are subject to additional requirements despite the promise of a nationally consistent set of regulatory measures designed to protect public health and safety.

**There is a lack of formal control over the educational quality of CPD programs and their providers:**

The current Guidelines for choosing CPD providers are broad and we are concerned about the lack of formal control. We maintain that 'peer review' is the most appropriate mechanism through which

**Registration standard: Continuing professional development**

**Guidelines: Continuing professional development (CPD)**

*Please provide your responses to any or all questions in the blank boxes below*

to ensure the educational quality of CPD programs. There is a need to ensure that both practitioners and CPD providers are approved and audited for the following reasons:

- Without the requirement of meeting specific criteria, any organisation can provide CPD programs and the value of education cannot be quality assured.
- Commercial companies may overrun the market with non-scientifically independent CPD and a sales oriented approach, reducing credibility and the need for well researched CPD content. This could result in the quality of education being compromised.

**RECOMMENDATIONS**

- That the DBA acts as an overseer to the compliance of CPD course providers to the Board's Guidelines for course providers, or appoints an appropriate body (such as the Australian Dental Council) to do so.
- That providers conduct internal quality reviews in every triennium cycle.
- That the DBA (or other appointed organisation) undertakes a CPD provider approval or 'recognition' process that assesses CPD programs against quality criteria such as those specified by the FDI World Dental Federation. This process would be funded by fees paid to the recognising agency by CPD providers.
- That peer review is built into the course provider approval process.
- That CPD providers be approved for a five year period and audited regularly to ensure compliance.
- That CPD providers be required to ensure that qualifications and/or experience of professionals providing CPD be relevant to the particular topic and subject matter for all types of CPD activities, from reading articles to hands on workshops, and that the DBA (or other appointed agency) audits this activity.

**Registration standard: Recency of practice (ROP)**

*Please provide your responses to any or all questions in the blank boxes below*

1. From your perspective how is the current ROP registration standard working?

2. Are there any state or territory-specific issues or impacts arising from applying the existing ROP standard that you would like to raise with the Board?

3. Is the content and structure of the draft revised ROP registration standard helpful, clear, relevant and more workable than the current standard?

Very broad definitions of Practice and Recency of Practice are provided in this Standard. This may lead to further confusion about whether or not this Standard applies to a practitioner, and also confusion about what qualifies as 'recency of practice'.

4. Is there any content that needs to be changed or deleted in the draft revised ROP registration standard?

See (3), above.

5. Is there anything missing that needs to be added to the draft revised ROP registration standard?

<b>Registration standard: Recency of practice (ROP)</b>	
<i>Please provide your responses to any or all questions in the blank boxes below</i>	
6. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not??	
7. Do you have any other comments on the draft revised ROP registration standard?	

<b>Registration standard: Endorsement for conscious sedation (CS)</b>	
<i>Please provide your responses to any or all questions in the blank cells below</i>	
1. From your perspective how is the current CS registration standard working?	
	The ADAVB is aware of the increasing practise of office-based conscious sedation (CS), and we are concerned that the CS registration standard, both in its current and revised forms, may have a significant impact on this area of practise. The current CS registration standard is working but overly onerous in the definition as to who can be the third person assisting during the procedure.
2. Are there any state or territory-specific issues or impacts arising from applying the existing CS standard that you would like to raise with the Board?	
	<ul style="list-style-type: none"> <li>• <b>Victorian health services legislation is currently under review (the Health Services Act and Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013).</b> This review demonstrates that there is a need to provide clearer definitions of, and guidance concerning IV anaesthesia use and the differences between conscious sedation and general anaesthetic.</li> <li>• <b>We therefore suggest that the DBA publish an additional set of guidelines that more specifically discusses the methods and circumstances under which conscious sedation should be administered.</b> Providing clear instruction in this area could reassure the State regulatory bodies that conscious sedation in dentistry is clearly and effectively regulated.</li> </ul>
3. Is the content and structure of the draft revised CS registration standard helpful, clear, relevant and more workable than the current standard?	
	Yes
4. Is there any content that needs to be changed or deleted in the draft revised CS registration standard?	
	<p>Under the revised CS Standard, if a registered nurse assists, this nurse must be trained in ICU or anaesthesia. This requirement could be changed to simply read 'a registered nurse with appropriate documented training within the surgery field'.</p> <p>We suggest that the requirement for capnography be included as it further elevates the safety margin. Although pulse oximetry alerts the practitioner when a patient's blood oxygenation has fallen below an acceptable level, this event occurs several minutes after the cessation of breathing. Capnography tells you immediately when a patient stops breathing and so you can intervene well before blood oxygen levels drop.</p>
5. Is there anything missing that needs to be added to the draft revised CS registration standard?	

**Registration standard: Endorsement for conscious sedation (CS)**

*Please provide your responses to any or all questions in the blank cells below*

**Additional guidelines are needed to clearly describe the methods and circumstances under which conscious sedation in dentistry should be administered.** We therefore suggest that the Conscious Sedation Standard include reference to documents describing the minimum standards a dental practice must maintain in order to safely administer conscious sedation and allow for swift treatment in the case of medical emergency as well as information concerning therapeutics and prescribing.

6. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?

Given that the State regulatory environments may change significantly in the near future we feel that a review period of at least every three years is appropriate. This will allow the opportunity to more efficiently coordinate regulatory mechanisms concerning conscious sedation in dentistry.

7. Do you have any other comments on the draft revised CS registration standard?

**Unreasonable restrictions on dental sedation could be imposed by a revised ANZCA PS09 Guideline:**

We note that the ANZCA 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures', PS9, is under revision. Changes proposed in this document may result in mandating that another doctor or dentist trained in sedation be present during the procedure. If adopted, the new requirement would effectively end operator sedationist practice, i.e. the dental sedationist would only be able to provide the sedation, and would be prohibited from conducting dental surgery unless another dentist or medical practitioner was present.

**There is an increasing need to provide guidance on the practice of office-based General Anaesthetic:**

Internationally, the provision of general anaesthetic (GA) by anaesthetists in office-based settings, such as dental practices, is becoming accepted as standard practice for low risk patients. Provided that appropriate quality and safety standards are met, the higher risks posed by GA can be successfully managed. We have recently observed local indications that this model may be adopted in Australia.

Given that GA is associated with a higher level of risk of complications than conscious sedation, ADAVB believes that it is important to clearly define the different levels of anaesthesia and separately regulate those considered to be of higher risk. We suggest that the DBA and the Medical Board may like to consider the most appropriate way to regulate the provision of GA in the dental practice and provide a broader and more detailed Guideline on anaesthesia for dental procedures.

This Guideline could include reference to the minimum requirements to maintain safety and quality for provision of office-based GA. The American Dental Association's Guidelines for the Use of Sedation and General Anesthesia by Dentists 2012 provides guidance to assist dentists in the delivery of safe and effective sedation and anesthesia. The American Society of Anesthesiologists provides further guidance in their 2009 publication entitled "Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Office Anesthesia Environment".

In Victoria, access to GA for dental procedures in private hospitals and Day Procedure Centres (DPCs) is becoming increasingly limited. Health fund rebates paid to hospitals and DPCs for dental care provided under GA are so low that many are now closing their lists to dentists and their patients. This is denying patients access to the most appropriate care.

Patients, such as children and those with physical disabilities, rely on access to GA to receive dental care. We note for instance that the ASA 2009 Guidelines for Office-based GA recommend additional considerations and training before conducting the procedure on children who are less than 12 yrs

**Registration standard: Endorsement for conscious sedation (CS)**

*Please provide your responses to any or all questions in the blank cells below*

old. Consequently, children and special needs patients may still need to be treated in purpose built facilities, as they may not be considered low risk.

For low risk patients however, standard procedures such as wisdom teeth extraction could readily be provided in the dental practice by a General Dentist, if GA can be administered by an anaesthetist. This could substantially reduce the cost of dental surgery for uninsured patients and improve their access to care. It is therefore important to keep in mind the need for continuing access to care when considering how to regulate the provision of these services.

**Registration standard: Specialist**

*Please provide your responses to any or all questions in the blank cells below*

1. From your perspective how is the current specialist registration standard working?

2. Are there any state or territory-specific issues or impacts arising from applying the existing specialist standard that you would like to raise with the Board?

3. Do you support the proposed changes to the existing standard as outlined in Option 2? (Why or why not?)

**The ADAVB supports Option 2 for the Specialist Registration standard. However, we ask that our additional comments be considered:**

- **We believe that specialist dentists applying for registration renewal should not have to maintain a full dual registration as both a specialist and a general dentist to practice some elements of general dentistry.** Reasons for this include the risk of reducing the efficiency of patient care, the cost of dual registration and the unreasonable expectation for dentists to complete the requirements for both registration processes.
- **We therefore propose that the specialist scope of practice provides for a specialist to practice both within their specialty and include related procedures for which they are educated, trained and competent, provided that these procedures are simple, adjunctive and connected to the specialist care procedure.**
- While the Board states to the contrary, the definitions of the specialties outline their scope. Scope of specialist practice is constantly changing. For instance, periodontists did not originally place implants.
- **One cannot compartmentalise clinical practice.** Most dental specialists may, on occasion or frequently, practise dental procedures which can be considered to fall outside their specialty scope of practice. Common examples where prosthodontists may work outside of the definition of their specialty (as described in the Draft Registration Standard) are:
  - Implant placement;
  - Extraction of teeth to facilitate placement of a prosthesis. This is commonly done with periodontally compromised teeth and/or some older patients;
  - Supra and sub-gingival cleaning of teeth prior to tooth preparation;
  - Gingivectomy and crown lengthening, as necessary. Particularly site preparation and recontouring where treatment by a periodontist may be unwarranted;
  - Biopsy;
  - Minor orthodontic procedures to upright or reposition teeth prior to prosthodontics procedures;
- **Restricting specialists to the narrow interpretation of their specialist scope of practice risks compromising patient care.** We must not create a situation where patients are unnecessarily referred back to a general dentist to perform simple procedures which the specialist is competent to perform. Patients must receive competent, timely and cost effective care and specialists must be able to use their professional judgment to ensure this.
- If, during a specialist procedure, an unexpected event or emergency occurs that requires immediate treatment in the area of general dentistry the specialist must be able to legally provide the treatment that they are competent to provide in order to deliver safe, economical and timely care to the patient.
- The specialty areas of Paediatric dentistry, Public Health Dentistry and Special Needs Dentistry do not relate to particular areas of the oral anatomy and are not limited to a certain set of specialised procedures. Rather these practitioners provide general dental care to specialist populations. Their specialist training concerns both the physical and psychological needs of these groups. It is therefore not logical to expect that these practitioners maintain dual registration in order to deliver general dental care more broadly.
- Currently there are no requirements set for the scope of continuing professional development for dentists – how will the Board monitor what areas of dentistry have been covered by specialists (or indeed general dentists) and whether this is appropriate?
- The Board has demonstrated that it is comfortable for other dental practitioners to provide treatment according to their professional judgment. The draft Scope of Practice Registration Standard states that practitioners “must only perform dental treatment for which they have been formally educated and trained in programs of study approved by the Board, and in which they are competent...to provide the best possible care for their patients.” It is therefore

### Registration standard: Specialist

*Please provide your responses to any or all questions in the blank cells below*

important that specialist practitioners be permitted to exercise their professional judgment in deciding whether to provide treatment to a patient themselves or to refer the patient, as permitted for dental hygienists, dental therapists and oral health therapists.

- **There is no evidence that specialists require guidance on their specialty Scope of Practice.** Specialists rely on their ability to use their professional judgment and their established referral systems. These referral systems could be undermined by adding the requirement for General Practitioner Recency of Practice and CPD training to maintain GP registration.
- The ADAVB believes that few specialists would wish to maintain a general registration, either due to cost or time taken to meet registration requirements. Placing this limitation on highly qualified, experienced dentists will be detrimental to the flexibility of the dental workforce, as opportunities for experienced professionals to treat patients will be restricted.
- Dental specialists are highly valued, dedicated members of the dental workforce. It is important for these individuals to be provided with options that expand their experience and allow them to serve the community in ways they wish. For example, if specialists are limited to their scope of specialty, how would they help people in rural areas through a volunteer program or to relieve a person's pain if they are not allowed to provide treatment outside their specialty?
- Specialist dentists are already subject to a large number of regulatory measures and the ADAVB believes that the introduction of simple requirements into the specialist registration standard would satisfy the Board's requirements, without the need for dual registration.

Given the requirement that statutory bodies refer to competition policy principles and guidelines on good regulation, we believe that only the minimum regulation (with its associated cost) necessary to achieve the key objective/s should be imposed. This would be more consistent with guidelines on good regulation, which advocate simplicity and transparency, in the public interest.

4. Is the content and structure of the draft revised specialist registration standard helpful, clear, relevant and more workable than the current standard?

5. Is there any content that needs to be changed or deleted in the draft revised specialist registration standard?

6. Is there anything missing that needs to be added to the draft revised specialist registration standard?

7. Do you agree that the name of the specialty oral pathology should be changed to oral and maxillofacial pathology? (Why or why not?)

8. Do you agree with the minor change to the definition of the specialty oral medicine as outlined? Why or why not?

9. Do you agree with the change to the definition of the specialty of forensic odontology as outlined? Why or why not?

**Registration standard: Specialist**

*Please provide your responses to any or all questions in the blank cells below*

10. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?

We feel that a review period of at least every three years is more appropriate at this time. The Specialist Registration Standard refers to the CPD standard and the Recency of Practice Standard, which are also under review. These Registration Standards need to be tested for their clarity and effectiveness and we feel it is important to have the opportunity to provide feedback more frequently.

11. Do you have any other comments on the draft revised specialist registration standard?



22 July 2014

Attention:  
Dr John Lockwood, Chair  
Dental Board of Australia  
By email: dentalboardconsultation@ahpra.gov.au

Dear Dr Lockwood,

**Supplementary comments on the DBA's Public Consultation on the review of the Professional Indemnity Insurance Registration Standard**

The ADAVB, along with the Federal ADA was pleased to be invited to make our recent submission during the DBA's public consultation on the review of five Registration Standards and CPD Guidelines. Following our submission, the ADAVB wishes to highlight further points regarding the Professional Indemnity Insurance (PII) Standard for dental practitioners who practice in non-clinical areas. I wish to clarify the ADAVB position on this matter. Could we please request that these comments be taken into consideration, alongside our formal submission?

It is the Federal ADA's view that each clinician must have his/her own PII cover, and this position is broadly supported by the ADAVB. We recognise however, that there are registered dental practitioners, in all divisions of the register, who may work in administrative or clinical director roles or other non-clinical positions, who still work within the DBA's definition of 'practice'.

Where registered practitioners who perform non-clinical roles are solely employed in public agencies, their employer indemnity cover is likely to be sufficient to protect the public.

Where these practitioners work in private practices, there may be other issues requiring attention. The Branch works closely with our indemnity insurance provider in a state risk management process which has identified instances of non-practicing principals and managers of private practices who direct their staff to meet fee quotas (often on the basis of providing treatment which was not clinically justified) or to over-service or otherwise create liability for the employee or contractor. We feel that these practitioners should be held accountable under a personal policy rather than hiding their responsibility for bad practice under the umbrella of an employer indemnity.

Application of a generic approach to employer indemnity across both public and private sectors, means that non-clinical practitioners in the private sector may be able to avoid risk management and associated premium adjustments due to their inclusion under a blanket policy. If they avoid having to report conditions placed on cover because of this, then the Board won't be able to risk manage them either.

The ADAVB therefore seeks to clarify that such practitioners, who do not have direct patient contact, still perform duties within the scope of practice as defined, and should have appropriate PII cover for their current circumstances (and for potential historical claims). This can be achieved via an employer indemnity scheme for public sector employees, but which should require a personal insurance contract where the practitioner works in the private sector.

**Australian Dental Association  
Victorian Branch Inc.**

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ask@adavb.org  
[www.adavb.net](http://www.adavb.net)

ABN 80 263 088 594  
ARBN 152 948 680  
Reg'd Assoc No. A0022649E

ADAVB acknowledges that the Board is not in a position to release a standard for every permutation or interpretation of the definition of practice and nor would we expect this. While we acknowledge that the PII Registration Standard needs to be broadly applicable to registered dental practitioners in all divisions of the register, we trust that some adjustment may be possible to protect the public from inappropriate treatment being provided on the instructions or at the direction of a non-practicing manager or practice owner.

I would be pleased to elaborate on this matter if you would like additional information about our concerns.

Sincerely,

A handwritten signature in black ink that reads "Garry Pearson" with a decorative flourish at the end.

Mr. Garry Pearson  
CEO, ADAVB

Email: [garry.pearson@adavb.org](mailto:garry.pearson@adavb.org)



# INFORMATION SUMMARY 2014/15

## ABOUT THE ADAVB INC.

The ADAVB is the professional association of Victorian dentists which aims to

- improve the dental health of all Victorians
- promote the art and science of dentistry
- promote the highest standards of professional dental care
- enhance the professional lives of members

## MEMBERSHIP

- Over 3500 Members in private and public practice, along with students and international dental graduates

## MEMBER SERVICES & FUNCTIONS

- Continuing Professional Development Program
- Dental health education (e.g. Dental Health Week and Facebook page 'Caring for your kids' teeth')
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent and Overseas Graduates' support
- Practice staff Training seminars
- Practice+ (Consulting Services) and PracAdmin Network
- Member Benefits(eg Professional Insurances; preferred suppliers)
- IR advice and representation (via the ADA HR Advisory Service on 1300ADAINC)
- Defence and legal support
- eViDent Dental Practice Based Research Network (in partnership with the Oral Health CRC)
- Quality Assurance (including Member Assistance Program)
- Benevolent Fund
- Reading Room and resource collection
- Advocacy and representations to Government bodies
- Superannuation (Professional Provident Fund)
- Sports, social functions and community and charitable activities
- Publications – Newsletter, Journal, Manuals etc.
- Website, including many members' only resources e.g. employment register (find us at [www.adavb.net](http://www.adavb.net))



## DISPUTE RESOLUTION SERVICES

The Branch provides information to the public on dental matters, and offers a conciliation service to assist patients to resolve disputes with members. Information on treatments, facilities, dental issues and careers is available.



**PRESIDENT**  
Dr Bob Cvetkovic  
BDSc

Bob is a general dentist in Camberwell.

**CEO**  
**Director, eViDent DPBRN**  
Mr Garry Pearson  
MEdSt, HDT (SAC)  
FAIM, MAICD

Garry joined the ADAVB in 1991 after senior executive roles in the Victorian Education Ministry



[www.adavb.net](http://www.adavb.net)

**HISTORY**



The ADAVB was formed in 1928 through the amalgamation of the Odontological Society of Victoria (est. 1884) and the Australian College of Dentistry Alumni Society (est. 1915).

The ADAVB was formally incorporated in 1991.

In April 2008, the ADAVB office relocated to Level 3, 10 Yarra St. South Yarra (opposite the South Yarra Station).

**LEGAL STATUS**

The ADAVB is incorporated under the Associations Incorporation Act (Vic) and as such, it is a not for profit organisation.

**AFFILIATIONS**

The Branch is a member of the national organisation, the Australian Dental Association Inc., and thus provides automatic membership of the Federal association.

The Branch is also a member of:

- Australian Industry Group
- Australian Taxpayers Association, and
- Australian Institute of Management.

**AFFILIATED SOCIETIES/  
GROUPS**

- Australian Society of Orthodontists
- Australian Society of Periodontology
- Australian Society of Endodontology
- Australian Prosthodontic Society
- Australian and New Zealand Society of Pediatric Dentistry
- Various other societies and Dental Study Groups

**REPRESENTATION ON  
STATUTORY AND OTHER  
BODIES**

- Cancer Council of Victoria
- Department of Health reference and working groups
- Department of Oral Health, La Trobe University
- Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne
- RMIT University

**COMMUNICATIONS  
ADVISORS**

Porter Novelli

**BANK**

Westpac, South Yarra Branch

**AUDITORS**

Advantage Advisors (previously known as Bentleys)

**SOLICITORS**

Health Legal

**STAFF**

The Branch employs 21 staff (17.6 EFT), including four senior dentists (each of whom works part time) to provide advice to the public and members