NSW HEALTH

Report of the Review of the Dentists Act 1989

March 2001

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The Dentists Act be amended to include a provision stating that the object of the Act is to "protect the health and safety of members of the public by providing mechanisms to ensure that dental care providers are fit to practise".

Recommendation 2 : Title Restrictions

The current restrictions on use of the titles "dentist", "dental surgeon" and "surgeon dentist" be retained in the Act.

Recommendation 3 : Title Restrictions – Dental Auxiliaries

The Dentists Act be amended to include restrictions on use of the titles "dental auxiliary", "dental therapist" and "dental hygienist".

The Board develop policies under section 12(1)(e) of the Act relating to the use of the titles "dental therapist" and "dental hygienist".

Recommendation 4 : Practice Restrictions

The current "total practice" restriction in the Dentists Act be replaced with "core practice restrictions" to be set out in the Public Health Act.

The core practices listed in the Public Health Act to be as follows:

- any operation on the human teeth or jaws or associated structures; and
- the correction of malpositions of the human teeth or jaws or associated structures; and
- the performance of radiographic work in connection with the human teeth or jaws or associated structures; and
- the mechanical construction or the renewal or repair of artificial dentures or restorative dental appliances; and
- the performance of any operation on, or the giving of any treatment, advice or attendance to any person, as preparatory to, or for the purpose of or for or in connection with the fitting, insertion, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances.

The core practice of use of anaesthetics be retained in the Poisons and Therapeutic Goods Act consistent with similar restrictions for other health professions.

DENTAL THERAPISTS AND DENTAL HYGIENISTS

Recommendation 5 : Restriction on Employment of Dental Therapists

The current restriction should be retained, but be subject to further review once the review of public sector dentistry is completed.

Recommendation 6 : Practice Restrictions on Dental Auxiliaries

The current practices should be revised to ensure consistency with the new core practice restrictions to be introduced under Recommendation 4.

The specific activities which can be practiced by dental therapists and dental hygienists be considered further during the drafting of the new regulations under the Public Health Act practice restrictions.

Any recommendations arising out of the review of public sector dentistry should also be considered when the new regulations are drafted.

Recommendation 7 : Supervision of Dental Auxiliaries

In relation to dental auxiliaries the Dentists act be amended to:

- delete reference to “supervision” and refer instead to “practice oversight”; and
- provide for practice oversight to be defined by guidelines approved by the Director General of the Department of Health, rather than in regulations;

The Oral Health Branch of the Department of Health form a working party including representatives of the dental, dental therapy and dental hygiene professions to develop appropriate guidelines for the Director General’s approval.

ENTITLEMENT TO REGISTRATION

Recommendation 8 : Criminal Convictions

The existing provisions allowing the Board to refuse registration on the grounds of criminal conviction should be retained and in addition, the Act should be amended to:

- <u>extend the range of criminal conduct the Board can consider</u>
  by providing the Board with the power to consider criminal findings where the court has found the matter proven, but no conviction is recorded; and

- <u>establish obligations on the courts to notify the Board of certain matters</u>
  (i) by requiring courts to notify the Dental Board of criminal convictions where the court is aware the convicted person is a registered dentist; and
  (ii) by requiring courts to notify the Dental Board of cases where a sex or violence offence has been proved but no conviction recorded where the court is aware the convicted person is a registered dentist;

(iii) to ensure the notification provisions focus on serious issues by providing for the making of regulations to excuse courts from notifying certain minor offences/convictions (such as, for example, minor traffic offences);

- establish obligations on registrants to notify the Board of certain matters
  (i) by requiring registrants to notify the Board within 7 days, in the event they are
    - convicted of a criminal offence;
    - the subject of a criminal finding in respect of a sex or violence offence;
    - charged with a sex or violence offence alleged to have occurred in the course of the registrant's professional practice;
    - charged with a sex or violence offence relating to a minor;
  (ii) by requiring registrants, as part of the annual registration process, to report to the Board on the previous 12 months in respect of any conviction, charge (including those currently outstanding) or finding as per (i) above over that period.

Recommendation 9 : Continuing Professional Education

The Dentists Act should be amended to:
- allow the Dental Board to require a registrant seeking restoration of registration or an applicant for registration to demonstrate competency;
- require that applicants for renewel of registration declare the professional education activities undertaken over the previous twelve months.

Recommendation 10 : Student Registration

the Dentists Act should be amended to:
- include provisions for the registration of dental students, based on those operating under the Medical Practice Act;
- clarify the provisions relating to the areas in which dental students can practise.

Recommendation 11 : Employment Restrictions

The restrictions on employment of dentists and ownership of dental practices in the Dentists Act be removed.

New provisions be inserted into the Dentists Act to:
- prohibit a person or corporation from:
  (a) directing a dentist to provide a service of a kind that is excessive, unnecessary or not reasonably required for that person's well-being, or
  (b) directing or influencing a dentist such that they engage in conduct that would constitute "unsatisfactory professional conduct" or "professional misconduct".

- include a regulation making power to enable a certain matters to be prima facie evidence of a breach of the prohibition;

- provide that where a company is convicted of an offence under (a) or (b), every director or person concerned with the management of the company is also guilty of an offence unless they had no knowledge of the offence and they exercised due diligence to prevent the contravention;

- set penalties at an appropriate level to discourage corporations from committing this offence (ie 250 penalty units [$27,500] for a first offence and 500 penalty units [$55,000] for subsequent offences);

- provide that the Director-General may, subject to a right of appeal, suspend or disqualify a company or a person who is a proprietor, trustee, beneficiary, director, major shareholder or is otherwise involved in the business of providing dental services or conducting a dental practice from carrying on or being involved in such a business (either generally or at specified premises) where:

  (1) conviction for an offence contained in (a) or (b) has occurred twice within a ten year period ; and
  (2) the Director-General is satisfied that the person or company is no longer fit and proper to carry on, or be involved in carrying on the business of providing dental services or conducting a dental practice;

- make provision to prevent the objectives of the suspension provisions from being thwarted by the adoption of business structures or through business restructuring designed to circumvent the operation of the exclusion provisions.

Note : The Government has decided not proceeded with this recommendation, and has decided to vary the existing restrictions, rather than remove them. For details see the Department of Health Internet site
www.health.nsw.gov.au/csd/llsb/dentistsreview/index.html

Recommendation 12 : Advertising

The provisions in the Dentists Act allowing for the regulation of advertising be retained, but amended to extend the power to make regulations to cover corporations advertising dental services.

COMPLAINTS AND DISCIPLINARY PROCEEDINGS

Recommendation 13 : Two tier Definition

The Dentists Act should be amended to replace the current definition of “professional misconduct” with a two-tiered definition of “unsatisfactory professional conduct” and “professional misconduct”.

Recommendation 14 : Unsatisfactory Professional Conduct

Unsatisfactory professional conduct should be defined to mean:

a. any conduct that demonstrates a lack of adequate knowledge, skill, judgment or care by the dental care provider in the practice of dentistry;

b. contravening (whether by act or omission) a provision of this Act or the regulations;

c. a failure by the dental care provider to comply with an order or determination of the Board or a committee of the Board, or with a condition of registration;

d. a failure by the dental care provider to comply with a direction of the board to provide information with respect to a complaint against the provider;

e. any other improper or unethical conduct relating to the practice of dentistry.

Recommendation 15 : Professional Misconduct

Professional misconduct means unsatisfactory professional conduct of a serious nature which may lead to suspension or deregistration of the dentist.

Recommendation 16 : Grounds for making a Complaint

The Dentists Act should be amended to:

- remove “unauthorised advertising” as grounds on which a complaint can be made, on the basis that this activity will be covered by the revised definitions of “unsatisfactory professional conduct” and “professional misconduct”; and

- replace the current reference to “improper charging” with ‘failure to provide a treatment of value”.

Recommendation 17 : The Disciplinary Structure

The Dentists Act should be amended to:

- ensure that where a complaint involves a question of professional misconduct (ie, conduct of so serious a nature as to warrant removal from the register if proven) the complaint is dealt with via a formal hearing where the registrant has access to legal representation;
- retain, in all other matters including those matters of unsatisfactory professional conduct, the current flexibility in the Act and the discretions vested in the Board.

Recommendation 18 : Dental Tribunal of NSW

The Dentists Act should be amended to:

- establish a NSW Dental Tribunal on similar lines to the medical practice tribunal established under the Medical Practice Act;

- require that all matters of professional misconduct are referred to the Tribunal.

Recommendation 19 : Actions available on Receipt of a Complaint

Section 34(a) of the Dentists Act should be amended to:

- only enable the Board to deal with a complaint at an ordinary Board meeting where that complaint does not involve professional misconduct;
- require the Board to refer any matter involving professional misconduct to the Tribunal; and
- enable the board to refer a complaint to an inspector appointed under section 59 for investigation.

Recommendation 20 : Emergency Power to Suspend

The Dentists Act should be amended to provide the NSW Dental Board with the power to suspend the registration of a person in emergency situations, based on the terms of section 66 of the Medical Practice Act, and including:
- set timeframes for actions and notifications to occur;
- provision for the referral of appropriate cases to be resolved via an impaired registrants process;
- provision for any conditions imposed to be subject to review, pending a full disciplinary hearing before the Tribunal.

Recommendation 21 : Protection of Expert Reports

Section 40 of the Dentists Act be amended to provide that reports prepared for the DCAC are not to be used in any proceedings (other than any disciplinary process arising out of the complaint) without the permission of the person who supplied the report.

Recommendation 22 : Recommendations of DCAC

The Dentists Act be amended to provide that DCAC can recommend to the Board that a matter involves unsatisfactory professional conduct, and provide that where such a recommendation is made, the board must conduct an inquiry or refer the matter to the Tribunal, depending on the level of seriousness.

Recommendation 23 : Action to be taken by the Board after a finding of Unsatisfactory Professional Conduct

Section 47 of the Dentists Act be replaced with the provisions allowing the Board, after a finding of unsatisfactory professional conduct, to impose the following orders:
- caution or reprimand the practitioner;

- require the practitioner to undergo medical or psychiatric treatment or counselling;
- impose conditions on the practitioners registration;
- require the practitioner to complete specified educational courses;
- require the practitioner to report on his or her practice at the times, in the manner and to the persons specified;
- require the practitioner to seek and take advice, in relation to the management of his or her practice;
- require the practitioner to return fees charged for dental treatment.

Recommendation 24 : Action to be taken by the Tribunal after a finding of Professional Misconduct

Amend the Dentists Act to grant the Tribunal the power to make all the orders referred to in Recommendation 23, and in addition, the power to order the practitioner to be removed or suspended from the register.

Recommendation 25 : Board Members sitting in Disciplinary Hearings

Amend the Dentists Act to preclude members of the Dental Board from sitting on the proposed Tribunal.

Recommendation 26 : Power to award Costs

Amend the Dentists Act to grant the proposed Tribunal the power to award costs.

Recommendation 27 : Appeals from Disciplinary Hearings

Establish a right of appeal from decisions of the Tribunal to the Supreme Court, on a point of law or penalty.

Recommendation 28 : Role of the Health Care Complaints Commission

The Dentists Act be amended to include the following provisions to recognise the role of the Health Care Complaints Commission:

- requiring the Board to notify the Health Care Complaints Commission of the recommendations of a DCAC inquiry, and any action the Board proposes to take;

- requiring the Board, in cases of professional misconduct, to provide the Health Care Complaints Commission with an opportunity to appear in the matter before the Tribunal;

- providing the Health Care Complaints Commission with the right to make submissions to a Board inquiry into unsatisfactory professional conduct.

Recommendation 29 : Impaired Registrants

Amend the Dentists Act to incorporate a process for dealing with impaired registrants, including an impaired registrants panel, modelled on the impairment provisions contained in the Medical Practice Act.

Recommendation 30 : Codes of Conduct

The Dentists Act be amended to:

- provide for the Minister to approve a Code of Professional Conduct developed by the Board;
- enable the Minister to direct the preparation of a Code of Professional Conduct;
- require the Board to release a draft Code and impact assessment report for public comment, prior to seeking the Minister's approval.

OTHER ISSUES FOR REFORM

Recommendation 31 : Membership of Board

The composition of the current Board's membership should be altered :

- so that provisions relating to the appointment of an academic member refer to persons involved in the training and education of persons to qualify as dentists rather than a specific institution;

- to provide for an additional community member;

- to provide for an additional dental profession member, nominated by the Minister;

- to provide for additional professional representation from the dental hygienist or dental therapy profession

Recommendation 32 : Tenure of Board Members

The current provisions on terms of appointment of Board members be amended to limit the number of consecutive terms each Board member can serve to no more that three terms of four years each.

1. INTRODUCTION

1.1 Background to Review

The Council of Australian Governments (COAG) Competition Principles Agreement provides that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition, and that the objectives of the legislation can only be achieved by restricting competition. The Agreement also requires that all legislation with a potential anti-competitive effect, including legislation regulating health professionals, be reviewed. In undertaking the Review, Governments agreed to:

- clarify the objectives of the legislation;
- identify the nature of legislative restrictions;
- analyse the likely effects of the restriction on competition and the economy generally;
- assess and balance the costs and benefits of any restrictions identified; and
- consider alternative means for achieving the same result.

The requirements to be considered during a review are set out in Appendix A to this Report. In addition the review also provides an opportunity to conduct a broader review of the overall regulatory scheme applied to dentistry in NSW.

1.2 Conduct of the Review

The Review of the Act has been carried out by the Legal and Legislative Services Branch of the Department of Health. As part of the Review, an Issues Paper seeking public comment was released in August 1999. Approximately three hundred copies of the Paper were distributed to consumers, government bodies, dentists, professional associations and other health care professionals. Twenty-four submissions were received by the Department, as listed in Appendix B to this Report. The Department also conducted a further round of consultations with key stakeholders during the drafting of the Report.

1.3 The Report

The Department has prepared this Report for consideration by the Minister for Health and the NSW Government to meet the requirements of the Competition Principles Agreement, and to consider other matters relating to the overall effectiveness of the Dentists Act and regulation of dentistry.

1.4 Structure of the Report

Part Two Looks at the existing regulation of dentistry in NSW, sets out a profile of dental service providers in NSW and assesses the impact of the legislation on competition;

Part Three Considers the objects of the Act, as well as the current title and general practice restriction model of regulation and sets out recommendations for amendment of the Act in this regard;

Part Four Addresses the current provisions in the Dentists Act impacting on related professional groups such as dental hygienists and dental therapists;

Part Five Examines the barriers to entry to the dental profession established under the Dentists Act through registration criteria and considers a number of proposals including mandatory continuing education;

Part Six Examines provisions of the Dentists Act that restrict commercial conduct, including the restrictions on the employment of dentists;

Part Seven Sets out recommendations in relation to the complaints and disciplinary system operating under the Dentists Act;

Part Eight Addresses the other general legislative reform issues that have arisen since the Act commenced operation.

1.5 Copies of the Report

Copies of this Report may be obtained from www.health.nsw.gov.au/csd/llsb.

2. THE REGULATION Of DENTISTRY AND OBJECTS OF THE ACT

2.1 Introduction

As outlined in the August 1999 Issues Paper, dentists provide a range of health care services to the public, including examination and treatment of the teeth and jaw, and the construction of dentures and dental appliances. As of 1999, there were 3945 dentists registered in NSW[1]. Dentists play the major role in the market for dental services which has been estimated as having a total market value of nearly $748 million, of which dentists make up $715 million[2].

The Issues Paper also recognised that there are a number of professionals other than dentists who provide dental services. For example, dental technicians and dental prosthetists are separate professions regulated under the Dental Technicians Act 1975[3]. Services provided by dental technicians and dental prosthetists generate an estimated turnover of some $28.3 million involving some 71 000 consultations each year[4].

Other related professions include dental therapists (who currently operate exclusively in the public sector)[5], and dental hygienists, who perform an auxiliary role to dentists, performing tasks such as cleaning teeth, removal of sutures and orthodontic archwires, bands and attachments, dental health education and dietary counselling for dental purposes.[6]

2.2 The Dentists Act 1989

The Dentists Act was passed in 1989 and replaced the 1934 Act of the same name. While the Act does not contain a statement of objectives, it operates to protect consumers by maintaining the quality and safety of dental services, and the integrity and competence of dental service providers. The issue of whether the Act should contain a statement of objects is discussed below at paragraph 2.5. The main features of the Act are set out in the following paragraphs.

2.2.1 Role of the Dental Board of NSW

Under sections 6 and 7 of the Act, the Dental Board of NSW is established as an independent statutory corporation to exercise and discharge the powers, authorities, duties and functions conferred by the Act. Section 8 provides that the Board consist of nine members, those being :

- *five dentists elected by dentists in accordance with the regulations;*
- *a person nominated by the Faculty of Dentistry at the University of Sydney;*
- *a barrister or solicitor nominated by the Minister;*

- *a person nominated by the Minister, being an officer of the Department of Health, or an employee of a public health organisation under the Health Services Act 1997; and*
- *a person nominated by the Minister as a representative of consumers.*

In accordance with clause 1 of Schedule 1 to the Act, one of the members of the Board (being a dentist) must also be appointed as President of the Board. Members are appointed for terms of four years and are eligible for re-appointment[7].

2.2.2 The Register

Section 12 of the Act provides for the establishment of a register of dentists. The Act allows a person to be registered as a dentist if :

(i) they are of "good character" [section 15(1)];

(ii) they can demonstrate competence in the practice of dentistry through either the completion of a course of training recognised in the legislation, or through passing an examination prescribed by the regulation, or through registration in another Australian jurisdiction [section 15(1)]; and

(iii) they have knowledge of the English language sufficient to allow them to adequately conduct the practice of dentistry [section 19].

The Board is also entitled to *refuse* registration to a person otherwise entitled to registration if:

(i) they have been convicted of a criminal offence, which having regard to the circumstances in which it was committed, was such it would not be in the public interest for that person to practise dentistry [section 15(2)];

(ii) they are a "habitual drunkard or addicted to any deleterious drug" [section 15(2)(d)];

(iii) the Board is satisfied they do not have sufficient physical or mental capacity to practise dentistry [section 22];

(iv) they have been removed from the register in another jurisdiction due to an act or omission going to their professional conduct which would, if it had occurred in NSW entitled the Board to remove them from the register [section15(2)].

2.2.3 Restrictions on Title

Under section 56 of the Act, it is an offence for any unregistered person to use the title of "dentist", "dental surgeon" or "surgeon dentist". The restrictions also extend to

such persons holding themselves out to be a dentist, or using words, initials or other descriptions which imply that they are a dentist. Under section 55 of the Act, a registered dentist must not use any titles or description other than those which the Board has authorised to be entered into the Register pursuant to section 12(1)(e).

2.2.4 Restrictions on Practice

Section 57 of the Act makes it an offence for an unregistered person to practise dentistry, which is defined under section 4 to *include* :

(a) the performance of any operation and the treatment of any diseases, deficiencies, deformities or lesions on or of the human teeth or jaws or associated structures; and

(b) the correction of malpositions of the human teeth or jaws or associated structures; and

(c) the performance of radiographic work in connection with the human teeth or jaws or associated structures; and

(d) the administration of an anaesthetic agent in connection with any operation on the human teeth or jaws or associated structures; and

(e) the mechanical construction or the renewal or repair of artificial dentures or restorative dental appliances; and

(f) the performance of any operation on, or the giving of any treatment, advice or attendance to any person, as preparatory to, or for the purpose of or for or in connection with the fitting, insertion, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances; and

(g) the performance of any such operation and the giving of any such treatment, advice, or attendance as is usually performed or given by dentists.

The only exceptions provided to this restriction arise where the person falls into one of a series of defined categories, those being registered medical practitioners, radiographers, dental students at a school recognised by the Board, dental technicians and prosthetists, dental therapists and dental hygienists. The activities that can be performed by these last two categories of professionals are also subject to additional conditions imposed under both the Act and Regulations, which are discussed in more detail in para 4.2.2.

2.2.5 Restrictions on the Employment of Dentists

The Dentists Act does not contain a provision expressly prohibiting the ownership of dental practices by non-registered persons. It does, however, contain provisions restricting the *employment* of dentists by non-dentists. Thus, the definition of "professional misconduct" in section 5 of the Act includes:

> *"For fee, salary or other reward, being employed by or associating with, in carrying on the practice of dentistry, a person (within the meaning of subsection (4)) who is not a dentist."*

Section 5(4) of the Act defines "person" to include a body or corporation, but to exclude the following organisations:

> *(a) the Crown;*
> *(b) a public hospital or charitable or philanthropic institution;*
> *(c) a society registered under the Friendly Societies Act 1912;*
> *(d) a council within the meaning of the Local Government Act 1919;*
> *(e) an incorporated practice (as provided for under section 53 of the Act);*
> *(f) any body or corporation who on application made for the purpose has been approved by the Board.*

Section 5(5) states an approval under section 5(4)(f):

> *"is not to be granted unless the Board is satisfied that the interests of the public generally or of any section of the public, other than dentists, warrant the granting of the approval."*

As a result, non-dentists can own dental practices, but only where the Board is satisfied that this "public interest test" is met.

2.2.6 Complaints and Disciplinary System

The Act also seeks to ensure that dentists maintain appropriate standards of professional conduct. This is primarily achieved through the complaints system.

A complaint may be made to the Board (or the Health Care Complaints Commission) that a dentist has been convicted of an offence, has advertised outside the restrictions of the advertising regulations, has charged an "improper amount" for treatment, lacks sufficient capacity to practise, is not of good character or has been guilty of professional misconduct. The term "professional misconduct" is defined in section 5 of the Act. Which sets out a list of specific types of conduct which are to be considered professional misconduct[8].

The disciplinary structure relied on in the Dentists Act to deal with complaints is somewhat different to those established under other health professional registration Acts in NSW. Where a complaint is made to the Dental Board, section 34 of the Act

provides the Board with a range of options. The Board can deal with the complaint directly at an ordinary Board meeting (or via a Board committee), refer it to the Health Care Complaints Commission for investigation or to the Dental Care Assessment Committee (DCAC) for investigation, resolution and/or recommendation, deal with it via a formal Board of Inquiry, or simply decline to deal with the matter.

The Act is also unusual in that it sets no boundaries or guidance as to how the Board should handle any particular complaint, except that the list in section 41 indicates that it was anticipated that the DCAC would consider complaints as to improper charges. In the absence of legislative prescription the Board has developed its own policies and procedures.

In practice complaints received by the Board are referred to a complaints committee, established as a sub-committee of the Board under section 9 of the Act. The complaints committee makes recommendations to the Board as to which of the options available to it should be pursued in any particular case. The Board's policy document states :

> *"…the policy of the Board is that treatment related complaints be referred to the DCAC. Complainants alleging criminal behaviour will be advised to refer the complaint to the police. If a police or Director of Public Prosecutions investigation has taken place, but no prosecution launched, the Board reserves the right to investigate the complaint further. A complaint about advertising standards will be dealt with by the Board. Complaints which involve the public interest may be referred to the Health Care Complaints Commission."*[9]

Matters of serious professional misconduct are dealt with at a formal Board Inquiry under Division 4 of the Act, with less serious matters being dealt with at a board meeting. It is also the Board's policy not to rely on the board meeting procedure, but rather the formal Inquiry process to remove a dentist from the Register[10]. Where the Board makes a finding that the complaint has been substantiated it has, under section 47 of the Act, the power to caution or reprimand a person, impose a fine, remove or suspend the person from the register, or take "take any other action the Board considers appropriate in the circumstances of the case".

The DCAC is made up of three dentists and a consumer representative, and provides the Board with a mechanism through which complaints can be investigated and/or conciliated. The Committee can refer a patient for an independent examination and obtain such other evidence and professional reports and advice as it considers desirable. Where a matter cannot be resolved by the DCAC with the consent of the parties involved, or there are issues which DCAC considers should be brought to the attention of the Board, the Committee can refer the matter back to the Board with a recommendation for action. Section 41 of the Act sets out a list of specific matters that must be considered when the matter referred to DCAC involves charging for dental treatment[11].

2.3 Other Regulatory Mechanisms

Other legislation: The provision of dental services is also regulated through consumer protection laws such as the *Trade Practices Act 1974,* administered by the Australian Competition and Consumer Commission, and the NSW *Fair Trading Act 1987* administered by the NSW Department of Fair Trading. These prohibit dentists from making false and misleading representations in the course of providing a service. The Public Health Act is also relevant, including provisions which prohibit the advertisement or promotion of a health service in a manner that is false, misleading or deceptive or creates an unjustified expectation of beneficial treatment[12]. In addition, the Poisons and Therapeutic Goods Act 1966 restricts access to certain therapeutic drugs to registered dentists.

Civil action: In the case of a dispute between a health professional and a consumer, either party could seek to resolve their differences through the court system, although it is recognised that this is generally an expensive process, unsuitable for minor complaints. As an alternative such matters (as well as fee complaints) can also be heard before a Consumer Claims Tribunal which has the objective of providing a simple low cost mechanism for dispute resolution.

Role of professional associations: In addition to the registration board, professional associations play a role in monitoring standards among dentists.

Other service providers : There are a number of health professionals that provide some of the services that are ordinarily provided by dentists. This includes dental technicians and dental prosthetists, who are subject to a separate statutory regime. All persons providing health services, whether registered or not, are subject to the Health Care Complaints Act.

2.4 Impact of the Legislation on Competition

Legislative controls are generally imposed by Government to address problems that can arise in an unregulated environment. Legislation can, for example, address imbalances of information between service providers and consumers, which would otherwise limit the ability of the latter to make informed choices. Regulatory intervention however, can itself affect competition in the market, and legislative controls will only have positive outcomes for the community where they address problems effectively. In some cases, regulation can create additional problems, which generate new costs for the community as a whole. This can arise in cases where restrictions are ineffective in addressing the identified problems, duplicate other legislative controls or do not address real or significant consumer problems. The principal requirements of the Dentists Act that may have an impact on competition can be summarised as follows:

1. Restricting who can practise “dentistry”, (or any aspect of dentistry), to persons registered under the Act, or persons subject to substantial limitations in relation to the types of task they can perform, and how they perform them,

effectively creates a monopoly on provision of the full range of dental services to registered dentists;

2. Restricting the use of the title "dentist" (and other related titles) to persons registered under the Dentists Act confers a competitive advantage on registrants over other service providers;

3. Restricting the employment of dentists by non-dentists to those approved by the Board creates a barrier to non-dentists owning dental practices or employing dentists to provide dental services;

4. Restricting the employment of dental therapists to the public sector;

5. Requiring dental auxiliaries to operate under the supervision of a dentist;

6. complaints and disciplinary systems, although generally directed at ensuring high standards are adopted by practitioners, may be used to inappropriately focus on the commercial conduct (such as for example where they deal with commercial issues such as advertising or practice ownership);

7. Registration requirements establish barriers to entry to the profession, thereby restricting competition in relation to services provided by that profession;

Competition policy requires that the above restrictions be reconsidered and assessed on the basis of the nett benefit to the public. Both the need for regulation, and the model of regulation relied on are to be justified on the basis that the advantages of regulation outweigh any associated disadvantages, and that these advantages can only be achieved through legislative restriction. These guiding principles have therefore been applied to assess each of the restrictions and potential restrictions outlined above.

2.5 Objectives of the Legislation

While the text of the Dentists Act does not contain a statement of objectives, as with other health professional registration Acts, the Dentists Act 1989 operates to protect consumers by maintaining the quality and safety of dental services, and the integrity and competence of dental service providers. The aim is to minimise the potential risk of harm posed by unqualified, unscrupulous or substandard operators in the market for dental services. The Issues Paper sought submissions on whether the Dentists Act should contain a specific statement of these objects.

Many of the submissions recognised the main objects of the legislation relate to the protection of the public and minimising the risk of harm to persons who require dental services.

For example, the Dental Board stated :

> *The object of the Act is to ensure that the public is protected by only having suitably qualified persons to carry out procedures which are highly invasive and require levels of competency and knowledge in areas such as surgery, infection control and pharmacology.*[13]

The Submission from the Australian Dental Association (NSW Branch) indicated :

> *The primary objective of the Dentists Act is to ensure that the general public receives appropriate standards of dental care"* [14]

There was however, also some divergence of opinion among the submissions as to whether these objects should be included as specific legislative statements in the Dentists Act. A number of submissions[15] considered this was unnecessary. At the other end of the spectrum, the Health Care Complaints Commission argued it was important that the Act clearly spell out the intention of Parliament in this regard.

It should also be noted that by and large, the reviews on other health professional Acts in NSW have recommended a short object clause be included in the Act. There are good arguments to be made that as Parliament is effectively establishing a basis for regulation in the health professional area, there should be consistency across all health professional regulation Acts. As such, the Department proposes to recommend that a statement of objects be included in the Dentists Act.

RECOMMENDATION 1 : INCLUSION OF OBJECTS CLAUSE

THE DENTISTS ACT BE AMENDED TO INCLUDE A PROVISION STATING THAT THE OBJECT OF THE ACT IS TO "PROTECT THE HEALTH AND SAFETY OF MEMBERS OF THE PUBLIC BY PROVIDING MECHANISMS TO ENSURE THAT DENTAL CARE PROVIDERS ARE FIT TO PRACTISE"

3. PROPOSED REGULATORY MODEL FOR DENTISTRY

3.1 Introduction

The current Dentists Act seeks to achieve its objectives through reliance on a highly restrictive model of regulation, namely that of both title and total practice restriction. There is no other regulatory model which is more restrictive or anti-competitive in effect. The Issues Paper sought submissions as to whether this was the most appropriate model for the regulation of dentistry, and requested submissions to give particular attention to both the benefits and costs of the preferred models.

The purpose of this Part of the Report is to review the current model and the restrictions thereunder, by looking at the views expressed in the submissions on the restrictions and the arguments both for and against them. The aim is to determine if, having regard to the costs and benefits to the public, the current model is justified, or whether the model should be amended and made less restrictive.

To do this, some reference must first be made to the various alternative models of regulation. While these were considered in the Issues Paper, it is worth revisiting them in this Report to understand the various options which are available to government.

3.2 The alternative models

The differing regulatory models may be grouped into a number of broad categories as follows[16]:

Model	***How it works***
No-regulation/self-Regulation	No legislation, with dentistry regulated through voluntary professional codes of conduct. Consumers rely on membership of professional associations as a guide to competence, and consumer complaints addressed through reliance on health insurers, the civil law of negligence and operation of the trade practices legislation. *Pro* : this approach would remove barriers to entry into the profession, and disadvantages of restricting competition inherent in regulatory models, and there would be no regulatory costs to be passed on to consumers. *Con* : issues of community safety and consumer choice may not be adequately addressed as there is no means to ensure practitioners comply or adopt codes of practice. Reliance on court action as the means of addressing consumer concerns

	is expensive (and therefore relatively inaccessible to consumers) as well as slow and unwieldy. *On balance, the Department has concluded that the difficulties outlined above indicate this option is unlikely to meet the objective of the legislation which is to minimise the risk of serious harm to members of the public*
Certification or Accreditation	A voluntary process (with a professional or legislative base) where-by practitioners offering dental services could seek "accreditation", with only accredited practitioners entitled to use the title. Monitoring standards and disciplinary action is delegated to the professional association. *Pro* :. Avoids the disadvantages of regulation while still providing a means of addressing public safety and consumer choice issues. *Con* : Professional associations usually focus on promoting their members rights and interests (both professional and commercial), and this focus may from time to time conflict with some public protection issues, for example the (sometimes substantial) costs to members of ensuring adequate infection control standards. There is also potential that regulatory costs will simply be transferred to professional associations. At the same time, a private disciplinary system would not have the same level of transparency and openness to public scrutiny available through a statutory sanctioned scheme In addition, concerns arise that compliance with professional standards could only be enforced where a practitioner chooses to seek accreditation. *On balance, the Department has concluded that the difficulties outlined above indicate this option is unlikely to meet the objective of the legislation which is to minimise the risk of serious harm to members of the public*
Co-regulation	Legislation simply requires practitioners to be members of a relevant professional association. This system can also include limiting the use of specific titles to persons who are association members. As with accreditation, monitoring of standards is delegated to the professional association.

	Pro : as with accreditation, the disadvantages of regulation are reduced while still providing a means of addressing public safety and consumer choice issues *Con* : The concerns which arise in relation to accreditation, are also relevant here. Additional costs may also arise where the government oversights the operation of the professional associations. *The Review has concluded that on balance, the above difficulties above indicate this option is unlikely to meet the objective of the Act, which is to minimise the risk of serious harm to members of the public*
Regulation of Title	Legislation only restricts the use of the title "dentist", and (potentially) titles for other related professions such as "dental hygienist" and "dental therapist", to persons who meet prescribed standards of competency. The restrictions however, are limited to the use of the title alone, and do not prevent other service providers offering dental services. *Pro* : Provides patients with a simple clear mechanism to assist them in determining persons who have adequate training and competency to provide dental services, while also providing a means for monitoring standards through statutorily based, inexpensive disciplinary procedures. *Con* : prescribed training standards can be viewed as "anti-competitive" as they provide a competitive advantage to the limited pool of practitioners who meet the criteria for entry over others who may be equally competent to provide the services, thus providing the potential for diminution of price competition. *Overall, the Department does not consider that this model provides sufficient protection, as it provides no information to consumers about the ongoing competence of practitioners.*
Regulation of Title and Restriction on Practices	Legislation enacted as above, but in addition providing that only those practitioners meeting the prescribed standards of competency are able to either practice dentistry ("complete practice restriction") or, alternatively perform certain key procedures ("core practice restrictions"). Provisions exempting specified groups, providing they perform only prescribed tasks, and/or act under supervision often accompany such legislation. This is the situation which currently applies under the Dentists Act 1989.

	Pro : As for "title restrictions" with the additional advantage of ensuring that high risk professional practices are only carried out by persons with proper training and experience. *Con* : Highly anti-competitive in that it provides a monopoly for the "recognised" group of practitioners in the practice of certain professions or procedures, with the accompanying potential for diminution in price competition and service innovation. It is also argued that there is often limited evidence to support the community risk said to be inherent in some of the restricted practices. *On balance, the Department considers that while the public protection objectives of the Act require restriction of some "core practices", there is not sufficient evidence to warrant the retention of a complete practice restriction.*

3.4 The Current Act

There was overall support for the continued registration and regulation of dentistry[17]. For example the Health Care Complaints Commission noted :

> *Dental practitioners occupy a very important position in society derived from their education, specialist knowledge, registration and practice. What and how they practise affects in a fundamental way the quality of life of their patients. This fact alone separates their services from other goods and services sold in the market place*[18].

The Australian Society of Orthodontists also made strong representations as to the special nature of health services, something they considered is not readily catered for in the principles underpinning the Competition Principles Agreement. The Society's submission stated :

> *Nowhere does the scope of these simple economic principles address the first and absolutely primary concept of ethical health care provision which is to "do no harm" to the patient, as first expressed in the Hippocratic Oath. Indeed there is no provision within the economic rationalist paradigm to discuss either ethical behaviour, harm minimisation, protection of the public or maintenance of professional standards*[19].

It must also be recognised however, that the NSW Dentists Act reflects the most restrictive of legislative models, as it establishes two layers of restrictions, imposing limitations on both the use of the title "dentist" and the ability of unqualified individuals to practise dentistry. While the aim of the restrictions may well be to protect the public, consideration must also be given to the disadvantages inherent in the restrictions, and whether some other, less restrictive regulation could not achieve the same end.

3.4.1 Title Restrictions

(a) Nature of the Restrictions

As noted at para 2.2.3 above, section 56 of the Act makes it an offence for any unregistered person to use the title of "dentist", "dental surgeon" or "surgeon dentist". The restrictions also extend to such persons holding themselves out to be a dentist, or using words, initials or other descriptions which implies that they are a dentist. While this approach may be said to assist consumers in choosing services, it also provides a competitive advantage to a limited number of practitioners such that patients may be forced to pay higher prices. Given this, a clear public interest must be shown to warrant the continuation of the restriction.

(b) Submissions

The submissions received by the Review showed broad support for the retention of the current title restrictions. All the submissions which addressed this issue indicated that the restrictions on title provided a simple, cost effective means of ensuring the public can readily identify persons trained to provide a range of dental services. For example :

> *Titles are important only insofar as they enable or assist the public to clearly identify the nature of the service provider and the services they are qualified to provide … the information conveyed … in terms of relative skill, knowledge and experience of the holder, is an efficient and valuable communication mechanism*[20].

Other submissions reflected the same arguments, with the Dental Board referring to the traditionally high awareness of the meaning of the titles "dentist" and "dental surgeon" among the public[21]. The Health Care Complaints Commission, referring to the disparity in knowledge between consumer and health practitioner noted:

> *It is highly unlikely that the vast majority of patients will ever be in a position to judge for themselves the relative merits of treatment options or the quality of care they receive from practitioners given their lack of knowledge and given the continuing changes in technology accessed by practitioners*[22].

The Department has given careful consideration to the submissions. While a restriction on title is anti-competitive, it is clear that the titles as they are now regulated provide consumers with valuable information and assistance in making treatment choices. As such, it is proposed to recommend that the current title protections be retained.

RECOMMENDATION 2 : TITLE RESTRICTIONS

THE CURRENT RESTRICTIONS ON USE OF THE TITLES "DENTIST", "DENTAL SURGEON" AND "SURGEON DENTIST" BE RETAINED IN THE ACT.

(c) Title Restrictions for related professions?

The Issues Paper also raised the question of whether the titles of "dental hygienist" and "dental therapist" should be provided with title protection.

Those submissions addressing the issue argued that these dental auxilliary titles should also be protected[23]. The contention was that these titles also engender a degree of public recognition that assists members of the public to make informed health care choices. None of the submissions linked title to the type of work performed, or the fact that it was generally performed under the supervision of a dentist, a distinction made by the Issues Paper. The submissions however, concentrated on the value of the title protection to consumers, and the fact that protecting dental auxiliary titles would ensure the general community could rely on these titles when seeking services from a dental practice.

For example, the Australian Dental Association, although it did not refer to specific dental auxiliary professions, indicated it believed that "each member of the dental team should be readily identified by titles appropriate to their level of training"[24].

The Dental Board submitted :

> *Title restriction for both these auxiliaries (ie, therapists and hygienists) would allow the same powers of training standard maintenance that apply to registered dentists and thus be consistent with the view … that title restriction in dentistry confers a public benefit."*

Further, the Board also indicated it :

> *would view title restriction to be essential should there be any reduction in the current practice supervision requirements"*[25]

These views were echoed by the NSW Health Funds Association, and the Dental Hygienists Association, which stated that title protection:

> *"provides assurance to the public that individuals representing themselves as Dental Hygienists have met required qualifications, thereby ensuring the public health and safety."*[26]

It is also noteworthy that other state reviews on dental practice legislation have also concluded it is appropriate to protect dental auxiliary titles. The Victorian Report[27] concluded protection of the title "dental auxiliary" to be appropriate given hygienists and therapists are directly responsible for the carrying out of exposure prone and high risk procedures, and in order to ensure consistency vis a vis those professionals providing dental services. This conclusion was reached notwithstanding the fact that this Review also recommended the retention of the existing supervisory requirements for both hygienists and therapists.

Given this, and having regard to the tenor of the submissions on this issue, it is considered that consumers need to have information to make informed decisions about who has the training and skills to perform *dental services*, whether that professional be a registered dentist, or a dental auxiliary, such as a dental therapist or dental hygienist. It is also recognised that establishing title protection for each profession regulated by the Dentists Act – and dental auxiliaries are regulated under that Act[28] – would ensure consistency across the area of dental care. More importantly, it would also provide a clear message to consumers that persons using these titles have a certain level of training and competence to perform a range of intrusive procedures.

By recommending title protection the Review is also effectively recommending the registration of the two main dental auxiliary professions. This means making these practitioners subject to the entire regulatory scheme of the Act, including:

- requirements to meet initial criteria for registration, including not only recognised qualifications, but also other requirements, such as for example, that applicants be of good character;

- the complaints and disciplinary provisions of the Act, which, in serious cases, allow a registrant to be removed from the register;

- recording of registrants on a separate register;

- other obligations under the Act and Regulations, including for example, requirements in relation to infection control and record keeping.

The question also arises as to which titles should be recognised, in particular, whether legislative recognition should be given to the "dental auxiliaries", or whether the two specific titles of therapist and hygienist should be protected. It is apparent that this area of the practice of dentistry is changing and developing and the potential exists for new types of auxiliary positions to be developed. This suggests a need for flexibility. At the same time, imposing a registration scheme as is suggested here, will operate to reduce this flexibility. The Victorian Report addressed this tension by deciding to recognise the broad term "dental auxiliary", noting:

> *The generic term dental auxiliary is a flexible title that will accommodate an evolving area of professional practice in response to changing dental needs.… It is expected that dental auxiliaries will continue to be registered in the current areas of dental therapy and dental hygiene. It is possible that other titles may become relevant and deemed appropriate by the Board as the scope of competencies evolve over time."*[29]

It is therefore proposed to follow the approach taken in Victoria, and to provide protection to the title of dental auxiliary. In addition however, it is also proposed to provide specific recognition for the titles of dental therapist and dental hygienist. This recommendation is made in recognition of the inherent "information value" in

these titles. It is envisaged that these titles, and the qualification requirements which attach to them could be addressed via the "use of title" provisions in section 12(1)(e) of the Act. Under these provisions (discussed at para 8.4.2), the Board can authorise a registered dentist to use additional titles and descriptions to describe him or herself. The Board has used this provision to develop guidelines for the use of specialist dental titles. It is suggested that similar policies, reflecting appropriate training requirements, could also be developed by the Board to provide guidance to dental auxiliaries on the use of the titles "dental therapist" or "dental hygienist".

It is important to recognise that recognising the title of "dental auxiliary" in the legislation will also have broader consequences to those outlined above, particularly, the it must be recognised that the general recommendations contained in this Report may be equally applicable to all "dental care providers", being both registered dentists and dental auxiliaries and should be considered accordingly.

RECOMMENDATION 3 : TITLE RESTRICTIONS – DENTAL AUXILIARIES

THE DENTISTS ACT BE AMENDED TO INCLUDE RESTRICTIONS ON USE OF THE TITLES "DENTAL AUXILIARY", "DENTAL THERAPIST" AND "DENTAL HYGIENIST".

THE BOARD DEVELOP POLICIES UNDER SECTION 12(1)(E) OF THE ACT RELATING TO THE USE OF THE TITLES "DENTAL THERAPIST" AND DENTAL HYGIENIST".

3.4.2 Practice Restrictions

The Issues Paper emphasised that restrictions of this sort can only be justified if there is evidence to indicate that there is benefit to the community inherent in the restrictions, and that benefit is sufficient to outweigh the restrictive character of the provisions.

(a) Total practice & core practice restrictions

There are two types of practice restrictions. First, an Act may impose limited restrictions, which only apply to the performance of identified "*core practices*". While restrictive, such limitations may be justified if the restrictions can be shown to be in the public interest. Thus, restricting the practice of specific activities identified as having the potential to cause significant harm to individuals who have been trained to perform these tasks safely, may be warranted.

Second, an Act may seek to impose a restriction on the entire range of activities performed by a particular profession. This form of "*total practice restriction*" is extremely difficult to justify, as it is most unlikely that every aspect of professional practice carries risk of significant harm if carried out by providers outside the relevant professional group.

(b) Restrictions in the current Dentists Act

The Dentists Act currently relies on a "total practice restriction" which covers the entire range of professional practice. Under the terms of section 4 of the Act, the practice of dentistry is defined to *include* :

> *(a) the performance of any operation and the treatment of any diseases, deficiencies, deformities or lesions on or of the human teeth or jaws or associated structures; and*
> *(b) the correction of malpositions of the human teeth or jaws or associated structures; and*
>
> *(c) the performance of radiographic work in connection with the human teeth or jaws or associated structures; and*
>
> *(d) the administration of an anaesthetic agent in connection with any operation on the human teeth or jaws or associated structures; and*
>
> *(e) the mechanical construction or the renewal or repair of artificial dentures or restorative dental appliances; and*
>
> *(f) the performance of any operation on, or the giving of any treatment, advice or attendance to any person, as preparatory to, or for the purpose of or for or in connection with the fitting, insertion, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances; and*
>
> *(g) the performance of any such operation and the giving of any such treatment, advice, or attendance as is usually performed or given by dentists.*

Whilst paragraphs (a) – (f) of the above definition set out a number of core dental practices, the catch all provision of paragraph (g) has the effect of capturing all the practices a dentist generally engages in. The detailed definition in section 4 is supported by section 57 of the Act, which makes it an offence for an unregistered person to practice, or hold themselves out to practise, dentistry. The only exceptions recognised are where the person falls into one of a series of defined categories, those being registered medical practitioners, radiographers, dental students at a school recognised by the Board, dental technicians, dental prosthetists, dental therapists and dental hygienists.

The activities that can be performed by these last two categories of professions are also subject to additional conditions imposed under the Dentists Act and Regulations. The range of the exceptions provided for therapists and hygienists are discussed further in Part 4. Before such issues can be addressed however, consideration must first be given as to whether the practice restriction currently set out in the Act, or indeed any practice restriction in dentistry, is warranted. The

Issues Paper has already drawn attention to the fact that total practice restrictions cannot be justified without substantial evidence of public risk, and that even directed "core practice" restrictions require supporting evidence. It was also recognised however that the practice of dentistry involves a range of high risk activities. Restricting the practice of these activities arguably provides a means of protecting the public from inadequately trained or incompetent practitioners who could otherwise cause (potentially) very serious injury in providing such services.

The breadth of the current practice definition in section 4 however, goes well beyond this stated intent. In particular, subclause (g) seeks to encompass "*any such operation and the giving of any such treatment, advice, or attendance as is usually performed or given by dentists"*. This clause is so broad as to require a specific provision in the Regulation to allow dental hygienists to provide dental health education and dietary counselling for dental purposes.

The Review has concluded that broad, generalised restrictions, such as that provided for in section 4(g), cannot be justified. No evidence was provided to the Review to support its retention. Furthermore, it self-evidently covers activities that are clearly not inherently dangerous if undertaken by other than a dental practitioner. As such, the recommendations for amendment of the practice restrictions includes a proposal to delete subsection(g) from the Act.

The Review has also concluded however that narrower, less anti-competitive restrictions on the "core practices" of dentistry can be more readily supported by evidence, if confined to specific procedures. Potentially high-risk procedures include:

Area of practice	Potential risk	Current Restriction
Use of radiation Equipment	Overexposure of sensitive organs if not applied correctly;	Section 4(c)
Treatments Involving prescribed Drugs	Potential for interactions with local anaesthesia which may be life threatening if not managed properly;	Section 4(d)
Infection prone procedures	Practice of dentistry shows a potential for transmission of blood borne diseases;	Section 4(a), (b), (d) (f) and (g)
Dental treatment	damage to surrounding teeth, soft tissue or existing restorations.	Section 4(e), (f) and (g)

In assessing the risk which may be inherent in each of these practices, it is worth considering how the current statutory restrictions relate to other regulatory mechanisms in NSW. These can be instructive, both in reflecting government

recognition of the need to regulate in this area, as well as highlighting what may be alternative means of addressing risk.

Use of Radiation Equipment

The performance of radiographic work "on the human teeth or jaws" is currently restricted under sections 4(c) and 57 of the Act. These provisions restrict this activity being performed other than in a public hospital or by or at the request of a medical practitioner or dentist.
X-ray equipment used in dental practices uses ionising radiation. While the risks involved in the use of radiation in a dental practice are relatively low compared to some other uses, inappropriate use and over-exposure can have severe effects on both patients and service providers. The risk of radiation in dental practice has been recognised by the National Health and Medical Research Council which has published a *Code of Practice for Radiation Protection in Dentistry* (1987).

Similarly, The NSW Environmental Protection Authority (EPA) has established Dentistry Radiation Guidelines[30] specifically directed at the use of x-ray equipment in the dental service environment. From 11 February 2002, equipment used for dental diagnostic purposes will be required to meet the requirements of these guidelines in order to be registered under the Radiation Control Act. It is important to note, that while these EPA Guidelines recognise a public health risk in this area, they address it primarily through seeking to improve the standard of *equipment* and monitoring the performance of *equipment*. They do not address risk issues which arise from the inappropriate application or use of equipment by an untrained operator using ionising radiation in the provision of dental services. The practice restriction in the Dentists Act, by restricting performance of such radiographic work to trained persons, complements these guidelines and addresses this risk. As such, the Review considers that the current restriction on this activity should be retained.

Access to and use of prescribed drugs

While the provisions of the Dentists Act contain restrictions on the use of anaesthetics as part of the current practice restrictions, it is important to note that these provisions currently effectively perform two quite separate functions, both of which need to be addressed.

(a) Access to drugs

Under sections 4(d) and 57, the Act prevents persons who are not dentists from administering an "anaesthetic agent in connection with any operation on the human teeth or jaws or associated structures". Access to and supply of prescribed drugs (ie, schedule 4 substances) is however, also regulated by the Poisons and Therapeutic Goods Act. This legislation restricts general access to a range of therapeutic and diagnostic drugs by other than certain registered groups, including dentists. The Poisons and Therapeutic Goods Regulation also clearly set out the

circumstances in which a dental therapist is entitled to be in possession of certain specified S4 substances, including those used in anaesthesia.

Given the tight controls placed on access to drugs under the Therapeutic Goods and Poisons legislation, there appears no basis for restating the same restrictions in the Dentists Act. As such, the Review has concluded that while there was clear evidence indicating that the restriction be retained, there is no need for it to continue to operate in two legislative instruments. One of the restrictions should be removed. Given the nature of the Poisons and Therapeutic Goods Act the Review considers the most appropriate action is to retain the access restriction in the Poisons and Therapeutic Goods Act, and delete the relevant practice restriction in the Dentists Act.

(b) use of drugs

As noted above, however, the restrictions on the use of anaesthetic under the Act also has a second function, in that the Dentists Act also provides for the regulation of *how* dental care providers entitled to access S4 drugs can use those drugs. In this regard, section 67(2) of the Dentists Act currently contains a regulation making power allowing the making of regulations:

> *(i) prohibiting or regulating the use of any anaesthetic, or an anaesthetic of a specified kind or description, in the practice of dentistry*

Under this power, regulations have been made to regulate how dentists can perform anaesthetic procedures. These regulations prevent general anaesthesia being administered by anyone but a medical practitioner who is a specialist in anaesthesia, or is accredited for the purposes of administering any general anaesthetic at a public or private hospital where surgery may lawfully be carried out. Simple sedation by a dentists is also further restricted to persons with additional training, or who are assisted in the process by a registered nurse with special training, or another dentist[31]. The Regulation also imposes restrictions on what anaesthetic procedures dental therapists can perform using anaesthetics.

These special restrictions on how anaesthesia and anaesthetics are used reflect the serious complications that can arise for patients who undergo both general anaesthesia and intravenous sedation. Indeed, the additional restrictions over dentists' use of anaesthetics arose out of the death in 1987 of a patient while under intravenous sedation in connection with a dental procedure. In his report on the death, the Coroner emphasised the need for persons administering and assisting in the administration of such procedures to have appropriate training, and referred the issue to the Department of Health. The increased restriction on general and simple anaesthesia in dentistry contained in the regulations were the result.

Given this history, the Review proposes to recommend that the regulatory requirements on *how* dental care providers (ie, both dentists and dental auxiliaries) use anaesthetic agents should be retained. This is however, best achieved through

the existing specific regulation making powers in section 67(2)(i) which address the use of anaesthetics by persons authorised to access drugs, rather than simply restating restrictions already established in other legislation. The Review therefore proposes to recommend the retention of the current regulation making power under the Act to ensure appropriate safety standards in the use of these substances.

Infectious diseases

Dentistry carries with it a risk of infectious disease for both patients and providers. Dental practices, particularly those listed in section 4(a), (b), (d) and (f) of the Act, involve invasive procedures requiring surgical entry into body tissue, or the manipulation, cutting or removal of oral or peri-oral tissue during which bleeding can occur[32]. Such work is carried out in an environment where there is frequent spraying and splashing of blood and bloody saliva. As a result, dental care providers and their patients may be exposed to infectious diseases via several routes of infection, including:

- direct contact with blood, oral fluids or other secretions;
- indirect contact with contaminated instruments, operatory equipment or environmental surfaces; or
- contact with airborne contaminants present in either droplet spatter or aerosols or oral and respiratory fluids.

It is important to recognise that while some other health professionals may from time to time be required to perform similar activities, for dental care providers this is a routine part of practice. Further, the nature of the practice of dentistry, operating in the confined space of the human mouth, means the risk of exposure is more acute due to the day to day risk of percutaneous sharps exposure via handling of numerous dental instruments without a direct visualisation of the treatment area.

The nature of the risk to both patients and care providers is also serious, including exposure to diseases such as hepatitis B and C, CJD and HIV through needle stick injuries. These conditions are chronic, and can be fatal. While workers can be innoculated against hepatitis, no such protection is available for CJD or HIV. There is also the risk of exposure to other viruses which infect the upper respiratory tract such as mycobacterium tuberculosis, staphylococci and streptococci[33].

While investigations in this area have indicated that the risks of exposure is relatively low[34], the health risks are, as outlined above, quite substantial. There have been published reports of nine clusters of infection with HBV (hepatitis B virus) associated with treatment by an infected dental care provider between 1970 and 1987[35]. There have also been a published report of transmission of HIV to six patients of an infected dentist in Florida[36]. Epidemiological and laboratory data indicate the infections in these cases were probably from the care provider to the patient, rather than patient to patient[37]. Concern over cases such as these lead many jurisdictions, including NSW, to introduce strict infection control guidelines applying to both

exposure prone procedures in the public sector[38] and to registered dentists under Part 6A of the Dentists (General Regulation) 1996.

There have been no recent reports of infection incidents similar to those outlined above, and it is arguable that this is at least to some extent due to increased surveillance and regulation in this area. Current management of potential exposure in dentistry relies on the fact that exposure prone procedures are only performed by individuals with appropriate levels of training and who are also obliged to comply with the extensive infection control requirements under the Dentists (General) Regulation. Given the nature of this evidence, the Review has concluded that the evidence of potential risk of infection inherent in the practices listed in section 4(a), (b), (d) and (f) of the Act is serious, and justifies recommending the retention of these restrictions.

Given the seriousness of the public health risk arising here, the Review has also needed to consider whether the practices listed in these subsections capture the full range of exposure prone procedures in dentistry. In particular, concerns have arisen that the current categories, which focus on the treatment of disease and correcting incorrectly positioned teeth, fail to address other exposure prone procedures involved in cleaning, maintenance and disease prevention. This question needs to be asked, given that it is proposed to remove the broad restriction in section 4(g) which would otherwise capture any procedures not covered in the list. After considering these issues, the Review has decided to recommend the inclusion of an additional core practice, specifically designed to ensure coverage of these procedures, which may involve intentional or inadvertent entry into soft tissues, to cover “any operation on the human teeth or jaws or associated structures”.

Dental treatment

A range of dental treatment relating to the prescribing, making and fitting of dentures and dental appliances are covered by both sections 4(e) and (f). The process of designing and constructing artificial dentures requires a sound knowledge of the masticatory system, principles of occlusion and infection control, intra-oral soft tissue pathology, radiography and the interpretation of radiographs. The risk factors associated with this treatment are considerable and are associated with resorption of the residual ridge, the emergence temperomandibular disorders, muscle dysfunction, destabilisation of the occlusion including overreduction of vertical dimension of occlusion and diverse pathologies in the denture–contacting mucosa. The modifications of the denture-bearing tissues and the temperomandibular joints are difficult to control with prosthetic therapy and may result in complete invalidation of the masticatory apparatus lesion. The repeated ulceration from an ill-fitting denture could have more serious consequences resulting in an oral cancerous lesion[39].

Denture use increases with age, with the 65 and over age group being the highest uses of dentures. Descriptive epidemiological studies indicate that the incidence rates for cancer of the oral cavity and pharynx are greater in older adults[40]. It is essential that persons treating this cohort of patients have the skills and expertise to detect the early sign and symptoms of oral carcinoma as prognosis of the disease is

dependent on early detection and treatment. Use of medications and adverse drug reactions have a higher incidence in the elderly. These reactions may manifest in the mouth and related structures and persons treating these patients should be competent in identifying them[41].

Given the risk factors identified above, and the serious and potentially irreversible side effects of poor treatment in this area, the Review is of the view that there is a need to retain a practice restriction in this area.

(c) Core Practice Restrictions and the Public Health Act

Finally, consideration needs to be given as to the most appropriate legislative vehicle for these practice restrictions. In this regard it is noted that the primary justification for each of the restrictions discussed above is to protect public health and safety, the public being in many cases both patient and practitioner. Further, the restrictions are not dental-specific, in that they provide exemptions for non-dental service providers (such as medical practitioners) to provide the restricted service. Given these two factors, it is considered that any continuing restrictions on these practices, would be better dealt with under the Public Health Act 1991. This both reflects the central public protection purpose of the restrictions and, in relation to other health professions, enhances the objectivity and transparency of enforcement.

RECOMMENDATION 4 : PRACTICE RESTRICTIONS

THE CURRENT "TOTAL PRACTICE" RESTRICTION IN THE DENTISTS ACT BE REPLACED WITH "CORE PRACTICE RESTRICTIONS" TO BE SET OUT IN THE PUBLIC HEALTH ACT

THE CORE PRACTICES LISTED IN THE PUBLIC HEALTH ACT TO BE AS FOLLOWS:

- ANY OPERATION ON THE HUMAN TEETH OR JAWS OR ASSOCIATED STRUCTURES; AND
- THE CORRECTION OF MALPOSITIONS OF THE HUMAN TEETH OR JAWS OR ASSOCIATED STRUCTURES; AND
- THE PERFORMANCE OF RADIOGRAPHIC WORK IN CONNECTION WITH THE HUMAN TEETH OR JAWS OR ASSOCIATED STRUCTURES; AND
- THE MECHANICAL CONSTRUCTION OR THE RENEWAL OR REPAIR OF ARTIFICIAL DENTURES OR RESTORATIVE DENTAL APPLIANCES; AND
- THE PERFORMANCE OF ANY OPERATION ON, OR THE GIVING OF ANY TREATMENT, OR ADVICE TO ANY PERSON, AS PREPARATORY TO, OR FOR THE PURPOSE OF FITTING, INSERTION, ADJUSTING, FIXING, CONSTRUCTING, REPAIRING OR RENEWING OF ARTIFICIAL DENTURES OR RESTORATIVE DENTAL APPLIANCES.

THE CORE PRACTICE OF "USE OF ANAESTHESTICS" BE RETAINED, BUT BE PLACED IN THE POISONS AND THERAPUETIC GOODS ACT 1966, CONSISTENT WITH SIMILAR RESTRICTIONS FOR OTHER HEALTH PROFESSIONS.

4. DENTAL THERAPISTS AND DENTAL HYGIENISTS

4.1 Current limitations

Section 57 of the Dentists Act, provides the basis for the regulation of dental therapists and dental hygienists. This provision establishes the offence of unregistered persons practising dentistry, and also contains the exemptions under which dental therapists and dental hygienists operate. The Dentists (General) Regulation 1996 also details further conditions under which these two professions operate. A copy of the relevant clauses of the Regulation is set out in Appendix C to this Report.

4.1.1 Dental Therapists

Sections 57(c) and (e) of the Act regulate the ambit of the role of dental therapists by describing their right to practise as being limited to :

> *(c) the doing or performing by persons with prescribed training who are officers or employees of the Department of Health or employees of the Health Administration Corporation or a public hospital of such part of the practice of dentistry as may be prescribed, while carrying out under such conditions as may be prescribed in respect of any such part of the practice of dentistry, dental treatment provided by the Minister to school children and preschool children;*
>
> …
>
> *(e) the doing or performing by persons with prescribed training of such part of the practice of dentistry as may be prescribed, while carrying out under the supervision of dentists and under such conditions as may be prescribed, dental treatment provided to the public in public hospitals or other prescribed institutions;*

The practice of dental therapists is further limited to the specific activities listed in clause 17(2) of the Dentists (General) Regulation 1996.

4.1.2 Dental Hygienists

The role of a dental hygienist is determined by section 57(4)(f) of the Act , which limits the practice of dental hygiene to:

> *(f) the doing or performing by persons with prescribed training of such part of the practice of dentistry, related to the provision of dental hygiene services, as may be prescribed, under the supervision of dentists and under such conditions as may be prescribed*;

The practice of dental hygienists is also is further limited to the specific activities listed in clause 19(2) of the Dentists (General) Regulation 1996.

4. 2 Issues for Reform

4.2.1 Limitation of Dental Therapists to the Public Sector

The statutory limitation of dental therapists to employment in the public sector was identified as one of the main anti-competitive provisions dealt with by the Issues Paper. While this restriction only applies to dental therapists, the issues arising in the discussion have implications for the role of both therapists and hygienists, and as such, the Review will address this question first, before going on to the issues relating to practice restrictions, supervision and title.

While a number of the submissions stated in very strong terms that the public sector restriction should remain, little evidence was provided as to the public benefit flowing from the limitation. The limitation therefore remains difficult to justify on competition policy grounds. The submissions arguing for the retention of the restrictions included that of the HCF, which stated:

> *Within the public sector therapists operate in a salaried setting. This mode of remuneration favours the likelihood of modern conservative dental treatment (optimal intervention dentistry). Were therapists to move into a fee-for-service setting, … there would be inevitable pressure to do more services per patient. This would be a retrograde outcome in terms of aggregate financial cost to the community and also in terms of tooth conservation.*[42]

The Dental Board of NSW also indicated:

> *The Board believes the provision of dental therapy services within the public sector has worked to the benefit of the public and should continue to be supported. The Board would need to see careful cost benefit analysis that the provision of dental services by dental therapists in the private sector would lead to more economic services provision whist maintaining the current high standards of dentistry within Australia. … The Board is of the view that there is, at present, no evidence to justify an extension of dental therapy practice into the private sector*[43] *.*

A number of other submissions however supported the removal of the restriction. For example, a submission from a dental specialist stated:

> *"There is a great hypocrisy and contradiction of having a dental therapist work locally to my speciality practice giving bilateral block injections, doing restorations and extracting teeth, but this individual is not able legally to work within my own private practice doing the most superficial of clinical tasks…the anomaly needs to be rectified as a matter of urgency and the pool of dental therapists available in this State needs to be harnessed in providing supportive dental health care to the public.*[44]

The Dental Therapists Organisation compared the situation of therapists with that of hygienists, who have operated in the private sector since 1996, noting no evidence existed to justify the additional limitations which continue to be imposed on therapists.[45] This organisation particularly emphasised that the restrictions effectively denied therapists not employed in the public sector the right to gainful employment[46]

The NSW Dental Therapists Association[47] encapsulated many of the arguments in favour of removing the restriction as follows :

- Use of dental therapists in the private sector will provide more economic dental services. The Association observed that dentist delegation of tasks to a therapist would enable dentists to focus on more complex procedures. The submission cited studies indicating increased productivity ranging from 30-80% in adding an auxiliary to "an already existing team of a dental and chairside assistant".

- More efficient use of dental therapy workforce The Association provided data from the submission made to the Victorian Review which indicated that up to 60% of therapists trained in Victoria are not currently in the workforce, and, since 1977 while 403 therapists have graduated, only 140 are in employment [48]. Evidence provided to the Review by the Dental Therapists Organisation suggests a similar situation in NSW, with approximately 600 dental therapists being trained in NSW since 1974[49].

- Increased accessibility to services In this regard, reference was made to a range of marginalised groups in the community who may not have ready access to dental services.

The last point raised, in relation to the need to increase access of the public to dental services, is worth further comment as this issue was critical in the establishment of dental therapy in NSW and remains central to the debate of how therapists should operate in the future.

Unlike medical practitioners, dentists are generally not entitled to government reimbursement for the cost of their services, meaning the medicare rebate system does not operate for most dental services[50]. At the same time, dental services may be costly, meaning persons unable to afford these services, or the costs of private health insurance, cannot readily access services[51]. This gap needs to be filled by the public sector.

Further, the health needs of the community are also changing. At the time dental therapists were first trained, the central dental health concern revolved around ensuring all school age children had access to dental services. The services they provided were designed to meet this need. While there is a continuing need for school dental services[52], with an aging population, and an aging population retaining their teeth into later life, the dental health needs of the community are changing.

> *The decrease in tooth loss and edentulism, together with an expanding ageing population, has resulted in an increasing number of people who are retaining their teeth into later life. This sector of the population has more complex dental needs such as multisurface coronal restorations, restorations for root caries and tooth abrasion, as well as increasing need for dental health education and periodontal care.*[53]

This was also reflected in the Submission from NCOSS, which stated :

> *People aged 45-64 in the lowest 20% of household incomes are eight times more likely to have no natural teeth and 1.7 times more likely to wear a denture than people in the wealthiest 20% of household incomes….A greater proportion of Health Care Card holders than non-Card holders reported social impacts of dental disease – embarrassment about their appearance, avoidance of food, and the pain and suffering of tooth ache"*[54]

In planning and providing dental services, the public sector needs to take into account these changing needs, and, in this regard, the Dental Therapists Association makes some valid comments on the role that dental therapists could play in future service provision.

However, critical questions remain on two levels. First , whether the level of training of dental therapists is sufficient to allow them to meet these broader needs, and second, the potential impact on and cost to the public sector if the public employment restrictions were lifted.

On the first point, the submissions are divided over the extent to which the training provided to dental therapists is sufficient to allow them to practise in a broader context, specifically, with adults. While dental therapy groups argue the skills are present, the Australian Dental Association indicated that, as currently trained, dental therapists could not meet many of the needs outlined above, as "dental therapists are trained to provide routine treatment to school children. Their training does not embrace the treatment of adults in any respect". The Australian Dental Association also stated that as a result:

> *"The fact that many of these groups within the community require complex treatment, it would be irresponsible, if not dangerous, to allow dental therapists to treat them.*[55]

It is recognised that this issue largely goes more to the question of the practice restrictions imposed on dental therapists rather than their limitation to the public sector. It is also relevant in this discussion however, as the competencies of dental therapists and the boundaries set on their practice will directly impact on the role they can play in the provision of public dental services.

On the second point, relating to the potential impact removing the restriction may have on public sector services, it is noted that reviews in other jurisdictions have

tended to recommend the removal of the restriction, notwithstanding a recognition that there will be implications for the public sector. NSW however must consider additional factors, namely, as outlined above, the fact that the public sector is currently the sole educator for therapists in this State, whereas in other jurisdictions, the training for dental therapists is provided through the tertiary education sector[56]. In NSW training is completely subsidised by NSW Health through funding of the Westmead College of Dental Therapy. If dental therapists were to be allowed the right of practice in the private sector, the NSW Health system needs to reconsider what if any role it will continue to have in educating auxiliaries.

Drawing these two points together, as well as considering the changing community needs for dental health care, the Oral Health Branch of the Department of Health is in the process of drawing up terms of reference to allow for the conduct a comprehensive review of training and service needs in relation to dental care services in the public sector. This will include consideration of current courses offered to both dental hygienists and dental therapists, competencies of auxiliaries and the best means of providing public dental care into the future. A central part of the review will necessarily focus on the publicly funded training of therapists. It is therefore proposed to retain the status quo, until this comprehensive review of public sector training needs reports.

RECOMMENDATION 5 : RESTRICTION ON EMPLOYMENT OF DENTAL THERAPISTS

THE CURRENT RESTRICTION SHOULD BE RETAINED, BUT BE SUBJECT TO FURTHER REVIEW ONCE THE REVIEW OF PUBLIC SECTOR DENTISTRY IS COMPLETED.

4.2.2 Practice Restrictions

The broad practice restriction issues have already been addressed in Chapter 3, with Recommendation 4 proposing a move from a "total practice" restriction in the current Dentists Act to "core practice" restrictions in the Public Health Act. Such a move will necessarily require a reconsideration of the current list of practices for both dental therapists and dental hygienists to ensure that they appropriately reflect the new "core practices". Such revision would occur once the amendments proposed in this Report were made.

In the course of the Review, a number of submissions have also been made as to the nature and content of the practices dental therapists and dental hygienists are entitled to perform, with some suggestions made for expansion of these practices[57].

(a) Practice restrictions on dental therapists

Only two submission received by the Review indicated that the practice restrictions on dental therapists should be altered. The Submission of the NSW Dental

Therapists Association set out a list of five specific practices it considered therapists should be able to carry out. These were :

- stainless steel crowns;
- use of an elevator in order to carry out extractions;
- construction of mouthgards for children;
- use of OPG x-ray;
- removal of orthodontic bands and associated processes.[58]

The Association conceded however that while such procedures would "complement and enhance" current services, training courses for dental therapists would need to be modified to include an appropriate level of training[59]. NCOSS also argued for the removal of practice restrictions over dental therapists, indicating it finds :

> *"…the current divisions in tasks to be arbitrary and supports instead a division of roles which is based on the complexity of the treatment required … removing the barriers to dental therapists providing a broader range of services would provide the community with greater access to dental care."*[60]

(b) Practice restrictions on dental hygienists

While many submissions indicated the current range of restrictions were appropriate and should remain[61], others made suggestions for extension of practice, or for inclusion of certain identified practices.

For example the Dental Hygienists Association of Australia (DHAA) raised specific concerns with clause 20(1)(b) of the regulation, which states a hygienist can only provide services where the treatment to be carried out is "in accordance with a written treatment plan prepared by a supervising dentist". The DHAA stated this was "redundant, given that the treatment is clearly within the scope of dental hygiene"[62].

The Australian Society of Orthodontics referred specifically to the provisions of clause 19(2), indicating that hygienists' duties should be extended to include the "placement and removal of non-metallic separators"[63]. The Health Funds of NSW also referred to the need for a "relaxation on the controls on hygienists" but gave no reason for this, or examples of the additional types of activities hygienists should be entitled to perform[64].

(c) Conclusion

As noted above at para 4.2.2, the issue of the nature of the specific practice restrictions will need to be addressed when regulations are made under the new practice restriction provisions of the Public Health Act. It is important to recognise

that the terms of the Subordinate Legislation Act require where new regulations are made, a Regulatory Impact Statement must be drafted and circulated to interested stakeholders, to ensure a full and proper assessment of the costs and benefits of the regulation. This process will require careful examination of each of the practices proposed for inclusion in the regulation, and should therefore provide an opportunity for the specific practices raised by stakeholders to be considered in detail.

(d) Review of Public Sector Dentistry

As noted above, part of the Review being prepared by Oral Health Branch into public sector dental services will involve looking at the competencies of both dental therapists and dental hygienists. The results of this review may therefore provide further data to factor into this process.

RECOMMENDATION 6 : PRACTICE RESTRICTIONS ON DENTAL AUXILIARIES

THE CURRENT PRACTICES SHOULD BE REVISED TO ENSURE CONSISTENCY WITH THE NEW CORE PRACTICE RESTRICTIONS PROPOSED UNDER RECOMMENDATION 4;

THE SPECIFIC ACTIVITIES WHICH CAN BE PRACTISED BY DENTAL THERAPISTS AND DENTAL HYGIENISTS BE CONSIDERED FURTHER DURING THE DRAFTING OF THE NEW REGULATIONS UNDER THE PUBLIC HEALTH ACT PRACTICE RESTRICTIONS.

ANY RECOMMENDATIONS ARISING OUT OF THE REVIEW OF PUBLIC SECTOR DENTISTRY SHOULD ALSO BE CONSIDERED WHEN NEW REGULATIONS ARE DRAFTED

4.2.3 Supervision of Dental Therapists

(a) Views expressed in the submissions

As noted at para 4.1.1 above, under the terms of section 57(4)(e), dental therapists are required to operate "under the supervision of dentists". The Dentists (General) Regulation expands on this in clause 18, as follows :

> *(1) A dental therapist may perform those parts of the practice of dentistry referred to in clause 17 only under the supervision of the Chief Dental Officer of the Department or a dentist authorised by the Chief Dental Officer to supervise treatment by dental therapists.*
>
> *(2) It is sufficient compliance with this clause if the Chief Dental Officer or any other dentist authorised under subclause (1):*
>
> *(a) would be available, within a reasonable time, to assist the dental therapist if assistance were required, and*

> *(b) is aware that he or she may be called on to provide such assistance.*

The views expressed in submissions received by the Review varied widely on the validity of this restriction. Some submissions argued for the complete removal of any supervision requirements, others suggested some revision of the dentist-therapist relationship, and others simply indicated that the current requirements should remain. By and large, the division of views tended to reflect the different professional perspectives of the dental and dental therapy professions.

For example, the submissions received from the NSW Dental Therapist Association, strongly argued that the term "supervision" incorrectly reflected the true nature of the practice relationship between dental therapists and dentists, which was described more as a matter of referral between professionals. The Association indicated :

> *The Association shares the view expressed in the Issues Paper that the current supervision requirements are extremely anti-competitive. It believes that the activities prescribed are in fact part of normal practice and are therefore more appropriately addressed without the involvement of legislation"*[65]

and further:

> *"The Association's experience to date suggests that most Dental Therapists in NSW work with no direct supervision"*[66]

On this last point, the Association supplied the Review with material resulting from a survey of dental therapy services in NSW directed at ascertaining the actual level of current supervision of dental therapists. The survey results indicated that supervising dental officers do not check treatment plans or instruct dental therapists clinical decisions "on a daily, patient by patient basis"[67]. Instead, the relationship was reported as largely being on a referral basis, or when the treatment is beyond the dental therapist's expertise, or through irregular contact with the dental officer or community dental health programs officer.[68] The survey found that the supervising dental officer was not present at the clinic "at all times", but was generally available within a 30 minute period if there was an emergency dental situation.[69]

The views contained in this survey were echoed by the Dental Therapists Organisation, which, while not advocating the removal of the supervision requirements, noted that the way in which dental therapy services are provided in NSW makes the requirement to act "under supervision" of a dentist "farcical"[70]. It should be recognised however, that while in lay terms the nature of the professional interaction outlined above hardly reflects direct, personal supervision it does reflect the current terms of clause 18 of the Dentists (General) Regulation.

The NSW Dental Therapists Association recommended that the above evidence suggested that dental therapists should have "autonomy" of practice, and

supervision requirements should be removed. In the executive summary to their submission, they indicated that the supervisory relationship should be replaced with "practice guidelines stipulating established referral patterns"[71]. This was also reflected in the submission provided by NCOSS[72].

Other submissions took a different view on this issue. The NSW Branch of the Australian Dental Association, as noted above, recommended the phasing out of dental therapists in NSW. In relation to the question of supervision the view was put that the government should "strictly maintain current provisions relating to treatment services and supervision"[73].

The Australian Society of Orthodontists directed its concerns to the current level of training and stated that supervision of dental therapists is "fundamental", indicating that:

> *"dental therapist and dental hygienist training and qualification was provided on the basis that supervision by a registered dentist would be required at various levels… unsupervised dental practice by dental therapists and hygienists would require diagnostic and treatment planning skills that can only be achieved through comprehensive courses in anatomy, physiology, pharmacology, biochemistry, material science, microbiology, neurology, radiology, and other areas that are not part of dental therapist and dental hygienist training"*[74]

They concluded it would be "irresponsible and dangerous" to allow unsupervised practice.

Another submission from a private dentist supported the role of dental therapists, but noted :

> *"it is equally apparent that their services cannot be provided without the supervision of a fully trained dentist. This is not to say that such a supervisor is necessary to "constantly look over their shoulder". These therapists usually gain sufficient experience to know when to call for help and it is most important for their professional confidence that such help be immediately available, either physically, or in the form of advice.*[75]*"*

Submissions from NSW health insurers also indicated support for a level of supervision to be retained. For example, the submission from the HCF stated :

> *"diagnosis and management of diseases of the teeth and of the tissues supporting teeth often require a high level of knowledge and analytical skill. The education and training to meet this is need is comprehensively covered in undergraduate and post-graduate dentist training. Dental therapists however have significantly less training, both qualitatively and in time spent. Their training program is designed with the understanding that they will operate only under dentist supervision, therefore, unless a significant change were to be*

> *made to dental therapists training programs they require supervision … no less than is currently in place."*[76]

(b) Conclusion of the Review

Having considered the submissions, two specific issues appear to arise. First, whether the current training of dental therapists is sufficient to allow them to work autonomously, and second whether the current descriptions under the Act adequately or appropriately reflect the manner in which the interaction between dentists and dental therapists has developed.

On the first point, the Review considers that on balance, the evidence provided to the review does not support amendments to the Act to allow dental therapists to work autonomously, and without any supervision by a dentist. While the Review acknowledges the information provided by the NSW Dental Therapists Association suggests in practice there is no direct personal supervision of dental therapists, it does not accept that this provides grounds to argue for the complete removal of practice oversight of therapists. In drawing this conclusion, regard was had to the material provided in the submissions, and advice obtained from Oral Health Branch of the Department.

The Review concurs with the recommendation and rationale provided in the Final Report of the review of Victorian dental legislation, which stated that while it recognised "dental therapists work within the level of their competencies under minimal supervision … the public benefit case for autonomous practice by dental therapists has yet to be demonstrated on the basis of clinical evidence."[77]

On the second issue, however, as to whether the current language used in the Act adequately or properly reflect current practice, the Review has concluded there is a need for reconsideration. It is recognised that dental therapists in the public sector do operate with minimal "supervision", and indeed, the description of the role of the supervising dental officer as described in clause 18 of the Regulation recognises a relationship between dentist and therapist is not one of direct, day to day personal supervision, but places the dentist more in a practice oversight role. It is also true that throughout health care, service providers are increasingly developing care models that involve multi-disciplinary professional teams, and such approaches were cited with approval by all submissions which commented on this issue.

Recent practice also suggests that interprofessional and clinical issues such as this are better addressed through clinical guidelines, which are more flexible and which can be revised and updated more readily than regulations. Reliance on guidelines would also allow the issues of private and public sector supervision to be adequately addressed, should the public sector restriction be lifted at the end of the public dental service review noted above at para 4.2.1. As such, the Review is therefore proposing first, that the Act refer to "practice oversight" rather than "supervision". Second, the details of what is involved in practice oversight be contained in guidelines approved by the Director General of the Department of Health, rather than

in regulations. Third, the Oral Health Branch of the Department of Health form a Working Party including representatives of the dental and dental therapy professions to develop appropriate guidelines for the Director General's approval.

4.2.4 Supervision of Dental Hygienists

The current supervision requirements for dental hygienists working in the public sector are the same as for dental therapists[78] For hygienists working in the private sector however, the Dentists (General) Regulation 1996 requires that the supervising dentist be a dentist:

(a) Who is on the premises at the time at which the treatment is carried out, and

(b) Who would be available, within a reasonable time, ti assist the dental hygienist if assistance were required, and

(c) *Who is aware that he or she may be called on to provide such assistance*

The views expressed in the Submissions in relation to this restriction broadly supported its retention. During consultation however, some groups indicated to the Review that there were also grounds to review the manner in which the supervision requirements imposed on dental hygienists operated. In this regard, the Dental Hygienists Association suggested applying the guidelines approach to hygienists would also assist in developing the role of auxiliaries into new "high need" service areas.

The specific example given was to provide guidelines for the use of dental hygienists in nursing homes, where patients can be too frail; or ill to obtain basic dental cleaning services in the normal manner. Guidelines would allow a hygienist, operating under a treatment plan prepared by a dentist, to work within the nursing home, thus allowing residents to access services without leaving the facility.

4.2.5 Conclusion

In drawing these conclusions on both dental therapists and dental hygienists, the Review also notes that part of the review being developed by Oral Health Branch into public sector dental services will involve looking at the training competencies of both dental therapists and dental hygienists. The results of this review may therefore provide further data on the appropriate form of guidelines on practice oversight, and as such, any recommendations from this review should be considered by the Oral Health Branch Working Party.

RECOMMENDATION 7 : SUPERVISION OF DENTAL AUXILIARIES

IN RELATION TO DENTAL AUXILIARIES, THE DENTISTS ACT BE AMENDED TO:

- DELETE REFERENCE TO "SUPERVISION" AND REFER INSTEAD TO "PRACTICE OVERSIGHT"; AND

- PROVIDE FOR PRACTICE OVERSIGHT TO BE DEFINED BY GUIDELINES APPROVED BY THE DIRECTOR GENERAL OF THE DEPARTMENT OF HEALTH, RATHER THAN IN REGULATIONS;

THE ORAL HEALTH BRANCH OF THE DEPARTMENT OF HEALTH FORM A WORKING PARTY INCLUDING REPRESENTATIVES OF THE DENTAL AND DENTAL THERAPY PROFESSIONS TO DEVELOP APPROPRIATE GUIDELINES FOR THE DIRECTOR GENERAL'S APPROVAL.

4.2.6 Title Restriction

The broad issue of title restrictions under the Act was discussed in some detail in Chapter 3 of this Report, which concluded that the use of the title "dental auxiliary" along with those of "dental hygienist" and "dental therapist" should be restricted. As noted there, such restriction will mean that provisions will need to be incorporated into the Act to allow for the recognition of qualifications, and the establishment of a separate dental auxiliary register.

5. ENTITLEMENT TO REGISTRATION

5.1 Criteria for Initial Registration

Paragraph 2.2.2 above has already outlined the criteria for registration under the Dentists Act. While all health professional Acts establish similar criteria, they are particularly important in relation to this legislation, as without registration a person can neither call themselves a dentist, nor practise dentistry.

While the rationale for imposing registration criteria is primarily to provide protection to consumers and maintain the quality and safety of dental services, artificially high entry levels will impose restrictions on the number of people able to obtain registration, with a resultant negative impact on competition. Similarly, where the barriers to entry may not in themselves appear onerous, they may in turn rely on access to educational courses and supervision opportunities that in turn create barriers to entry into the profession.

Each of the registration criteria established by the Act, whether imposed as a positive requirement for registration, or provided as a basis for the Board to refuse registration, has been assessed in accordance with the Competition Principles Agreement.

5.1.1 Good character

As noted in the Issues Paper[79] the rationale for a requirement of "good character" is to ensure that disreputable people are precluded from practising dentistry. The requirement is particularly important where there may be issues relating to prior sexual misconduct or fraudulent activity that need to be addressed when an applicant seeks registration.

Submissions to the review were strongly in favour of retaining a character requirement. The Health Care Complaints Commission addressed the matter in some detail, and quoted the NSW Supreme Court to explain why character is relevant to registered health professionals:

> *the right to practise affords a practitioner privileges and opportunities which are not available to others….clinical capacity is by no means the only consideration to which regard is to be had in determining whether a person is appropriate to practice medicine. It is necessary that the public be protected against those who, though having the appropriate clinical skills, do not have the character appropriate for the opportunities and privileges which the right of practice gives.*[80]

The submissions also indicated no support for the suggestion that the term "good character be defined more narrowly, given the detail in which the matter has been addressed by the judicial system.

The Review is therefore not proposing to recommend any change to the "good character" requirement set out in section 15(1), other than to expand its application to dental auxiliaries, which is a consequence of recommendation 3. It should be retained as an essential part of satisfying the legislative objective of protecting the public. In considering these issues, due regard is also had to the fact that there is no evidence to indicate that the requirement of good character has been a significant barrier to entry to the dental profession, suggesting that in practice it has only had a very limited anti-competitive effect.

5.1.2 Competence demonstrated by Recognised Qualifications

At the time the Issues Paper was released, courses of dental practice recognised under the Act were generally limited to courses run in other Australian states and New Zealand and those run in the United Kingdom and the Republic of Ireland.

Since the establishment of the Australian Dental Council (ADC) in 1993 however, Australian States and Territories have been moving to a process of recognising courses in accordance with those courses accredited by the ADC. As a result of this development, from 2000 courses from the UK and Republic of Ireland will no longer be recognised. All overseas trained dentists[81] will be required to demonstrate their qualifications via an examination conducted by the ADC. The concerns raised in the Issues Paper as to the potential for the restrictions on entry to be unfair because they set different standards depending on where the overseas qualification was obtained have therefore largely been addressed.

While it is recognised that this development has effectively reduced the number of qualifications recognised under the Act to those accepted under mutual recognition and trans-tasman mutual recognition schemes, the alternative, to establish a comprehensive system for the regular assessment of all overseas dental qualification courses (whether such a scheme was conducted at a state or federal level) would be cost prohibitive. The critical issue is to ensure that individual's with overseas training have available to other means to prove their competence, such as that currently available under the Act through examinations conducted by the ADC. The Department is therefore not proposing to recommend any change to the current process for recognition of courses, other than to include provision for the recognition of dental auxiliary courses, as a consequence of recommendation 3.

5.1.3 Adequacy of Language

The submissions received by the Review generally supported the retention of the requirement in section 19 that a person is not entitled to be registered unless they can show "knowledge of the English language adequate for the conduct of the practice of dentistry". The proficiency in language was considered to be essential for diagnosis, communication and continuing education.

Consideration also needs to be given to the type and complexity of activities undertaken by registered dentists. While the situations where a dentist may be called on to act in an emergency will be relatively rare, overall the complex nature of many dental services mean that practitioners need sufficient proficiency in English to be able to effectively communicate the nature of the condition and proposed treatment. The Review is therefore not proposing to recommend any change to the section 19 requirement for proficiency in English.

5.1.4 Criminal Convictions

The criminal justice system can provide information relevant to whether a person should be conferred registration. Currently the Dental Board is entitled to refuse registration of a person who has been convicted of a criminal offence, where the act or omission which lead to the conviction was such "as to render the person unfit in the public interest to practice his or her profession". Conviction for an offence is also listed as a ground on which a complaint can be made against a practitioner under section 31 of the Act. Criminal convictions may also be relevant to whether an applicant is of good character. Clearly, the Board when determining whether a conviction renders a person unfit to practise in the public interest must act in a manner which is fair, consistent, unbiased and not base its decisions on irrelevant considerations.

As noted in the Issues Paper, the need to ensure adequate screening of health professionals who provide services to children and other vulnerable people has become a matter of increasing public concern in recent years. For example, all registered health professionals (including dentists) who obtain appointments in NSW public hospitals must first be subject to a criminal record check. In addition legislation recently introduced in NSW prohibits persons with certain criminal convictions from undertaking or seeking child-related employment[82]. In recognition of these developments, the Issues Paper proposed a number of additional provisions to assist the Board in reaching determinations on these matters. Namely:

- creating a legislative requirement for courts to notify the Board of any criminal conviction involving a registered dentist;

- providing the Board with the power to consider criminal verdicts where the court has found the charge proven but choose to record no conviction; and

- creating a statutory obligation on registered dentists to notify the Board in the event they are charged or convicted of an offence, where the charges or conviction relate to conduct which occurred in the course of professional practice.

Retention of the existing provisions was supported by the submissions received by the Review. There was also some support for allowing the Board to act in respect of verdicts where the court has found the matter proven but no conviction was recorded

(formerly known as "556A's")[83]. Indeed, the submission from the Health Care Complaints Commission recommended that a wider range of offences should be covered by the reporting provision, including those arising outside the course of a professional practice. Given the discussion in the Report, it is also proposed that these obligations apply to dental auxiliaries.

It should also be noted that in this area, there has been a move to standardise provisions across all health professions. As such, since the Issues Paper was released further consideration has been given to the appropriate form of criminal conviction provisions in the context of developing other health professional bills currently before Parliament[84]. This process has allowed for the development of a more focussed approach, establishing distinctions between general criminal matters and those involving allegations of sexual misconduct or violence, and distinctions where the criminal matter arises out of conduct during the course of practice, or involves a minor. To ensure consistency with the revised approach adopted in these Bills, the original proposals suggested in the Issues Paper have been revised, as follows.

RECOMMENDATION 8 : CRIMINAL CONVICTIONS

THE EXISTING PROVISIONS ALLOWING THE BOARD TO REFUSE REGISTRATION ON THE GROUNDS OF CRIMINAL CONVICTION SHOULD BE RETAINED AND IN ADDITION, THE ACT SHOULD BE AMENDED TO :

EXTEND THE RANGE OF CRIMINAL CONDUCT THE BOARD CAN CONSIDER

BY PROVIDING THE BOARD WITH THE POWER TO CONSIDER CRIMINAL FINDINGS WHERE THE MATTER IS PROVEN, BUT NO CONVICTION IS RECORDED; AND

ESTABLISH OBLIGATIONS ON THE COURTS TO NOTIFY THE BOARD OF CERTAIN MATTERS

(I) BY REQUIRING COURTS TO NOTIFY THE DENTAL BOARD OF CRIMINAL CONVICTIONS WHERE THE COURT IS AWARE THE CONVICTED PERSON IS A REGISTERED DENTIST ; AND

(II) BY REQUIRING COURTS, TO NOTIFY THE DENTAL BOARD OF CASES WHERE A SEX OR VIOLENCE OFFENCE HAS BEEN PROVED BUT NO CONVICTION RECORDED WHERE THE COURT IS AWARE THE OFFENDER IS A REGISTERED DENTIST;

(III) TO ENSURE THE NOTIFICATION PROVISIONS FOCUS ON SERIOUS ISSUES BY PROVIDING FOR THE MAKING OF REGULATIONS TO EXCUSE COURTS FROM NOTIFYING CERTAIN MINOR OFFENCES/CONVICTIONS (SUCH AS, FOR EXAMPLE, MINOR TRAFFIC OFFENCES);

ESTABLISH OBLIGATIONS ON REGISTRANTS TO NOTIFY THE BOARD OF CERTAIN MATTERS

(I) BY REQUIRING REGISTRANTS TO NOTIFY THE BOARD, WITHIN 7 DAYS, IN THE EVENT THEY ARE :

- CONVICTED OF A CRIMINAL OFFENCE;

- THE SUBJECT OF A CRIMINAL FINDING IN RESPECT OF A SEX OR VIOLENCE OFFENCE;
- CHARGED WITH A SEX OR VIOLENCE OFFENCE ALLEGED TO HAVE OCCURRED IN THE COURSE OF THE REGISTRANT'S PROFESSIONAL PRACTICE
- CHARGED WITH A SEX OR VIOLENCE OFFENCE RELATING TO A MINOR;

(II) BY REQUIRING REGISTRANTS, AS PART OF THE ANNUAL REGISTRATION PROCESS, TO REPORT TO THE BOARD ON THE PREVIOUS 12 MONTHS IN RESPECT OF ANY CONVICTION, CHARGE (INCLUDING THOSE CURRENTLY OUTSTANDING)OR FINDING AS PER (I) ABOVE, OVER THAT PERIOD.

5.1.5 Refusal of Registration on the basis of drug/alcohol abuse or incapacity

The rationale for the Board's power to refuse registration on both the ground that a person is a "habitual drunkard or addicted to any deleterious drug" or lacks mental or physical fitness is based on the need to protect the public. These requirements also seek to maintain the standards of competence for the profession. In both instances, the Board is required to have regard to the impact of the incapacity or addiction on the person's ability to practice, and make a determination accordingly.

All the submissions addressing this point indicated strong support for the retention of these provisions. As indicated in the Issues Paper, the provisions can be readily justified as a means of ensuring that standards of registered professionals are maintained for reasons of public safety. The Department is therefore not proposing to recommend any change to this requirement, other than to extend its operation to dental auxiliaries, as a consequence of recommendation 3.

5.2 Continuing Registration

One of the main objectives of the Dentists Act is to provide patients with information about the ongoing competence of practitioners. In the case of ongoing registration there is heavy reliance on the initial registration criteria, the complaints/disciplinary system and the practitioner's professional obligations to maintain his/her skills.

There is also provision in section 13 to allow the Board to require a dentist to demonstrate that they have the requisite skills to practice dentistry, but this only applies to registrants who have become unfinancial and seek to be restored to the register. They do not address the issue of maintaining the standards of those who remain on the register.

The Issues Paper raised the question of whether strategies need to be developed to enable health professional registration boards to play a more active role in the ongoing maintenance of professional standards. Strategies identified included annual competency testing and continuing professional education. In raising this issue, the Issues Paper noted that any reforms in this regard would need to show

evidence that the current Act is failing to ensure that practitioners maintain standards at an appropriate level.

5.2.1 Mandatory Continuing Education and Registration Issues

Practitioner participation in continuing professional education is desirable and can be seen as an essential component of professionalism. A number of submissions addressed the issue of continuing education. Most submissions agreed that keeping abreast of new developments and maintaining up to date skills was an important part of the professional ethos. There was however, far less support for making such continuing education a mandatory requirement for continued registration. Concerns were raised as to the cost of implementing such a system, and the relatively limited evidence available to support assertions that the process does in fact maintain and develop the skills of professionals.

A number of submissions did however indicate strong support for mandatory continuing education. The Australian Dental Association, while noting the diversity of opinions on mandatory continuing education, indicated it considered such provisions:

> *(would) ensure that certain levels of skill and knowledge, as well as current philosophies of diagnosis and treatment modalities, are maintained by registered dentists*[85]

A submission from the Faculty of Dentistry at the University of Sydney also addressed this issue in some detail, and noted what it called "strong evidence" that:

> *nearly all complaints regarding treatment that are resolved by the Dental Board or are subject to civil action are made against dentists who have had little or no participation in continuing education in any form*.[86]

The Faculty also drew attention to the fact that mandatory continuing education is part of a dentist's professional obligations in many overseas jurisdictions.

The Health Care Complaints Commission stated that:

> *it is important that dentists continue to upgrade their knowledge and skills and remain competent due to the nature of the services they provide. Practitioners have a professional responsibility to maintain their knowledge and skills. Many practitioners without some sort of coercion may not voluntarily undertake ongoing education."*[87]

Notwithstanding these arguments little, if any evidence was provided to the Review to show how mandatory continuing education will maintain or raise standards of practice. On the other side of the debate, it is clear that substantial costs will arise in the establishment and maintenance of a system of MCE. It would also appear that there is a considerable degree of voluntary continuing education within the profession, raising questions, reflected in some submissions, as to what would be

achieved by making continuing education mandatory. Given this, and the clear expense involved in establishing any such scheme, imposing a requirement that registrants undertake mandatory continuing education remains difficult to justify at this stage.

The Department however, recognises the arguments raised to support MCE. It is also recognised that while the central justification for health professional registration is to protect the public, registration acts largely deal with the competency issue as an entry level issue only. Thus, legislation such as the Dentists Act rely heavily on entry requirements which demonstrate a person has acquired a sufficient level of knowledge to practise competently, but say very little about how those standards are to be maintained once registration has been granted.

With this in mind, the Department is proposing two amendments to the Act to address this issue. First, the current powers granted the Board under section 13(7) to review the competence of a dentist who has become unfinancial, will be extended to incorporate the revised provisions of Schedule 1 to the Medical Practice Act, which set out procedures for the Board to conduct inquiries on competence. This power is useful in cases where there is some question over whether the applicant meets the entry criteria, as it allows the Board to gather additional information before making a decision on the application. The scope of this power was discussed in the Review of the Medical Practice Act Issues Paper[88] and Final Report[89].

Second, the Department is also proposing that as part of the process for annual renewal of registration dentists will be required to make a declaration about continuing professional education activities undertaken in the previous 12 months. By requiring practitioners to consider the amount of professional education they have undertaken, the profile of continuing education will be increased.

Declarations will also give the NSW Dental Board data on the types of practitioners who are receiving professional education, its standard, relevance to practice and the types of organisations delivering education. This information will provide an improved basis for evaluating whether the current system is adequate or if it could be improved and for formulating effective strategies to address any areas of concern that are identified.

RECOMMENDATION 9 : CONTINUING PROFESSIONAL EDUCATION

THE ACT SHOULD BE AMENDED TO:

- ALLOW THE DENTAL BOARD TO REQUIRE A REGISTRANT SEEKING RESTORATION OF REGISTRATION OR AN APPLICANT FOR REGISTRATION TO DEMONSTRATE COMPETENCY;
- REQUIRE THAT APPLICANTS FOR RENEWAL OF REGISTRATION DECLARE THE PROFESSIONAL EDUCATION ACTIVITIES UNDERTAKEN OVER THE PREVIOUS TWELVE MONTHS.

5.2.2 Competency Assessment

One way of ensuring that health service providers maintain their skills and remain up to date with developments in the profession is through regular competency assessment. Such proposals usually involve the registration authority reconsidering the competency of registrants annually, on registration.

While the Health Care Complaints Commission indicated strong support for regular competency assessments[90], other submissions addressing the issue raised concerns that the costs involved in administering an effective and comprehensive scheme would be prohibitive[91].

The NSW Dental Board also pointed out there was no evidence to justify the cost of such assessments on an annual basis, but did indicate some support for a performance assessment process to be available where questions are raised as to the competency of an individual dentist. However, given the views in the submissions and the lack of evidence to support this, and the proposal in Recommendation 9 to allow for consideration of competence at registration or renewal, the Review is not proposing to recommend the introduction of regular competency assessments at this time.

5.2.3 Information to be provided by applicants for renewal of registration

The Issues Paper referred to a range of information which could be required by the Board before registration occurs. Some of these issues have already been addressed earlier in this Report, in particular information about criminal convictions (Recommendation 8) and continuing education activities (Recommendation 9, above). One additional issue raised in the Paper was whether applicants should also be required to declare any civil settlements made in respect of a claim by a patient in the previous twelve month period.

There was little support for this proposal in the submissions[92] and indeed, many indicated strong opposition. Arguments against the proposal largely reflected the view that settlement of a civil claim did not of itself reflect on the skill or competence of a registrant (something which is within the jurisdiction of the Board) but in many cases reflected only good business judgement (something which is not). The Review will not therefore recommend a requirement to report settled civil cases.

5.3 Student Registration

5.3.1 Registration of Dental Students

Provisions already exist for student registration under the Medical Practice Act, and suggestions have been made to reproduce this system in other health professional legislation. Dental students must, in order to complete their degree, undertake clinical placements in health care facilities. While such placements are supervised, students are required to provide services and have close personal contact with

patients. In addition, in the dental context, procedures performed by students as part of their clinical placements during their studies can be exposure prone. This raises real public health issues where a student is actively infectious with (for example) hepatitis B or HIV. Under the Medical Practice Act model, the impairment provisions can be utilised to support and assist students with an impairment, and avoid potential public health risks. This allows such problems to be managed and resolved before there is a risk of injury to a patient, or before it detrimentally affects the student's career. While only a few submissions addressed the issue, those that did, including submissions from the NSW Dental Board and the Australian Dental Association (NSW Branch) indicated strong support.

The Department is of the view that provisions for student registration should only be included in health professional acts where the nature of practice of that profession indicates that the provisions could provide some professional support and public protection function. In the case of the dental profession due regard has been had to these issues, in particular the inherent "exposure prone" nature of many dental procedures. Given this, and the nature of procedures likely to be performed by students, the Department has concluded it would be appropriate for the medical model for student registration to be adopted in the Dentists Act.

5.3.2 Placements for Dental Students

A second issue which arose during consultation on the Issues Paper relates more directly to the current provisions which exempt dental students from the practice restrictions applying to prevent unregistered persons from practising dentistry. Section 57(4)(b) only allows students to practise dentistry if the practice is carried on at "any hospital attached to the University of Sydney or at any other hospital recognised by the Board as a training school for students in dentistry." The Review has been advised that increasingly student placements in a community or rural setting are being considered, and are desirable to allow students to learn in the full range of practice settings. The current Act provides limited flexibility in this regard as it only allows the Board to approve "hospitals". It is therefore proposed to amend the Act to make it clear that student practice can occur in a broader range of settings.

RECOMMENDATION 10 : STUDENT REGISTRATION

THE DENTISTS ACT SHOULD BE AMENDED TO:

- INCLUDE PROVISIONS FOR THE REGISTRATION OF DENTAL STUDENTS, BASED ON THOSE OPERATING UNDER THE MEDICAL PRACTICE ACT
- CLARIFY THE PROVISIONS RELATING TO THE SETTINGS IN WHICH DENTAL STUDENTS CAN PRACTISE

6. COMMERCIAL CONDUCT

The current Dentists Act contains a number of restrictions on commercial conduct that have an anti-competitive effect. These restrictions were examined in some detail in the Issues Paper. That Paper also indicated submissions to the Review would need to demonstrate a clear public benefit if these commercial restrictions were to be retained.

6.1 Restrictions on employment of dentists

Any restrictions on ownership of dental practices are highly anti-competitive. Their main justification arises out of concerns that non-dentists are not subject to the same professional obligations and duties as registered dentists, and that as a result the commercial imperatives of operating a practice could lead to an erosion in the quality of services, over servicing and general lack of accountability.

The nature of the existing employment restrictions is set out more fully in paragraph 2.2.5 of this Report. While these restrictions have in the past operated to severely limit the numbers of non-dental owners of dental practices, their ambit was substantially eroded by the NSW Court of Appeal in 1996.[93] While this judgement may have reduced the anti-competitive manner of application of the employment restrictions, the provisions remain anti-competitive.

The majority of submissions received by the review on this issue supported the removal of the current restrictions. Submissions from dentists and dental organisations did not support any change, but argued for the retention of existing restrictions. Submissions on behalf of health funds argued for their removal. The Dental Board of NSW supported the removal of the restriction, on the proviso that an effective alternative means of protecting dentists from commercial pressures was provided.

The most comprehensive arguments against the removal of the employment restrictions were set out in the submission from the Australian Dental Association (NSW Branch) which made the following points:

- There is a danger that corporate style dental services will concentrate on the provision of those services which generate the highest return to the exclusion of services which are less lucrative;

- It is a matter of public record that in the case of medical practices owned by non-medical entities, they have generally been shown to fall well below acceptable standards in many areas;

- There is no evidence to suggest any public benefit in allowing non-registered persons to own dental practices;

- The current arrangements operate at minimal cost and encourages competition;

While little material evidence was provided to substantiate or support some of these assertions, it should be noted that they reflect the concerns raised in other submissions. Considering these views the Department recognises there is merit in the argument that to allow for "non-dental" ownership without any sort of check or limitation, could undermine the professional basis on which dental services have traditionally been supplied.

In this regard the concerns raised by the Australian Dental Association in respect of medical practices is timely, and reflects increasing concerns in this area. For example, the "Report of the Ministerial Committee of Inquiry into Impotency Treatment Services in NSW" raised serious issues of concern about a number of clinic practices and their potential to be contrary to the interests of patients. In evidence put before the Committee a former administrator of a clinic indicated that:

> *"practitioners employed by the clinics reportedly tended to be young doctors who had previously performed locum duties, often with the larger 24 hours medical centres… Medical practitioners received an hourly rate or a fixed percentage of their gross daily takings which were made up of the sales of the medication as well as the Medicare charges. The fixed percentage ranged from 20-25 per cent of the gross takings of the day based on the doctor's negotiations with the clinic. The ex-administrator advised that clinics charged over ten times the estimated wholesale costs for injections and for syringes. Appointments were made for the doctors every 15 minutes, and patients were routinely advised they required 30 treatment doses provided in multi-dose vials as this was the basis of the "treatment program"….If doctors failed to sell the injectable medication to a set percentage of their patients, the medical directors "brought this to their attention". Training of the doctors was described as essentially limited to 'a few basic principles… as if ... selling cars or selling real estate".*[94]

The potential for corporate practices and policies to compromise patient care was considered in the context of extensive legal proceedings instituted against National Medical Enterprises Inc ("NME") in the United States. Serious allegations arose about the activities of psychiatric, substance abuse and physical rehabilitation hospitals that were owned by NME. Former employees of NME described a corporate culture that prized profits above all else and involved maximising the financial return for the company on each patient. A number of company policies have been identified which pressured medical practitioners to provide medical services in such a way that patient care could be compromised.

Hospitals, day procedure centres and nursing homes are already subject to a number of regulatory controls. However, facilities that are outside these contexts are not required to be licensed. As such, the same conduct will be treated differently depending upon whether the perpetrator is a registered practitioner or a corporate owner. That is, whilst registered dentists who employ other dentists can be subject to disciplinary action for improperly influencing professional conduct, non-dentist

employers would not be subject to any sanctions if they engaged in similar conduct. Although responsibility for professional standards should ordinarily rest with the dentist, the current system gives non-dentist employers an unfair advantage over dentist employers.

While recognising the these concerns they are not sufficient to warrant the retention of the current restrictions if there is another way to protect employed dentists from improper influence, which is both less restrictive and effectively places corporations on the same regulatory footing as individual registrants. In this regard, page 40 the Issues Paper set out proposals for a series of legislative provisions designed to protect employed dentists without the same anti-competitive effect of the existing provisions. These new provisions would impose penalties for employers found guilty of such conduct, up to and including excluding unscrupulous investors from the dental care market.

It should be stressed that none of the submissions received by the Review arguing for the retention of the employment restrictions provided any material to indicate why this more focussed and less anti-competitive approach was inferior to the current restrictions. One of the main arguments for retention of existing limitations raised in these submissions was the proposition that large corporate practices may result in regional monopolies, particularly in regional NSW, and hence a diminution of competition. The information available to the Review however suggests that this is unlikely, and instead indicated the real potential for the expansion of the market through the entry of new corporate entities was minimal.

Advice from the Dental Board indicates that approvals are currently granted to seven organisations, in relation to sixteen separate dental clinics around NSW[95] The organisations involved are either health insurance funds or related entities or universities who have established clinics for the use of students. More importantly, since the 1995 decision from the Court of Appeal in the NIB Case[96] substantially reduced the restrictive nature of these provisions and effectively opened up the market, the only applications for new clinics come from health funds who already hold existing approvals. No other non-dental corporate owner has therefore sought to enter the market. This clearly suggests that concerns expressed to the review that the removal of the restriction would lead to a diminution of competition through the entry into the market of large corporations is unfounded.

Given the above, the offence provisions proposed in the Issues Paper would appear better suited to provide a degree of well targetted regulation for the benefit of the public. The Department therefore recommends that the current employment restrictions be removed and replaced with legislative provisions directed at the protection of the public. It is the Department's view that these measures will eliminate the potential risks that arise where professional obligations are overridden by commercial considerations. As no entry requirements are set for non-dental practitioners who wish to provide dental services, the impact on competition is marginal.

RECOMMENDATION 11 : EMPLOYMENT RESTRICTIONS

THE RESTRICTIONS ON EMPLOYMENT OF DENTISTS AND OWNERSHIP OF DENTAL PRACTICES IN THE DENTISTS ACT BE REMOVED.

NEW PROVISIONS BE INSERTED INTO THE DENTISTS ACT TO:

- PROHIBIT A PERSON OR CORPORATION FROM:
  (A)DIRECTING A DENTIST TO PROVIDE A SERVICE OF A KIND THAT IS EXCESSIVE, UNNECESSARY OR NOT REASONABLY REQUIRED FOR THAT PERSON'S WELL-BEING, OR
  (B)DIRECTING OR INFLUENCING A DENTIST SUCH THAT THEY ENGAGE IN CONDUCT THAT WOULD CONSTITUTE "UNSATISFACTORY PROFESSIONAL CONDUCT" OR "PROFESSIONAL MISCONDUCT".

- INCLUDE A REGULATION MAKING POWER TO ENABLE A CERTAIN MATTERS TO BE PRIMA FACIE EVIDENCE OF A BREACH OF THE PROHIBITION;

- PROVIDE THAT WHERE A COMPANY IS CONVICTED OF AN OFFENCE UNDER (A) OR (B), EVERY DIRECTOR OR PERSON CONCERNED WITH THE MANAGEMENT OF THE COMPANY IS ALSO GUILTY OF AN OFFENCE UNLESS THEY HAD NO KNOWLEDGE OF THE OFFENCE AND THEY EXERCISED DUE DILIGENCE TO PREVENT THE CONTRAVENTION;

- SET PENALTIES AT AN APPROPRIATE LEVEL TO DISCOURAGE CORPORATIONS FROM COMMITTING THIS OFFENCE (IE 250 PENALTY UNITS [$27,500] FOR A FIRST OFFENCE AND 500 PENALTY UNITS [$55,000] FOR SUBSEQUENT OFFENCES);

- PROVIDE THAT THE DIRECTOR-GENERAL MAY, SUBJECT TO A RIGHT OF APPEAL, SUSPEND OR DISQUALIFY A COMPANY OR A PERSON WHO IS A PROPRIETOR, TRUSTEE, BENEFICIARY, DIRECTOR, MAJOR SHAREHOLDER OR IS OTHERWISE INVOLVED IN THE BUSINESS OF PROVIDING DENTAL SERVICES OR CONDUCTING A DENTAL PRACTICE FROM CARRYING ON OR BEING INVOLVED IN SUCH A BUSINESS (EITHER GENERALLY OR AT SPECIFIED PREMISES) WHERE:
  (1) CONVICTION FOR AN OFFENCE CONTAINED IN (A) OR (B) HAS OCCURRED TWICE WITHIN A TEN YEAR PERIOD; AND

  (2) THE DIRECTOR-GENERAL IS SATISFIED THAT THE PERSON OR COMPANY IS NO LONGER FIT AND PROPER TO CARRY ON, OR BE INVOLVED IN CARRYING ON THE BUSINESS OF PROVIDING DENTAL SERVICES OR CONDUCTING A DENTAL PRACTICE;

- MAKE PROVISION TO PREVENT THE OBJECTIVES OF THE SUSPENSION PROVISIONS FROM BEING THWARTED BY THE ADOPTION OF BUSINESS STRUCTURES OR THROUGH BUSINESS RESTRUCTURING DESIGNED TO CIRCUMVENT THE OPERATION OF THE EXCLUSION PROVISIONS.

Note : The Government has decided not proceeded with this recommendation, and has decided to vary the existing restrictions, rather than remove them. For details see the Department of Health Internet site
www.health.nsw.gov.au/csd/llsb/dentistsreview/index.html

6.2 Restrictions on Advertising

Section 67(2) of the NSW Dentists Act provides for the making of regulations *"specifying the manner in which and the extent to which a dentist is authorised to advertise".* The provision also allows regulations to cover "non-dental" organisations providing dental services under section 5(4) of the Act, and the signage used on buildings in which a dentist practises. Clause 16 in Part 4 of the Dentists (General) Regulation 1996 provides that advertisements relating to dental services must not:

(a) be false misleading or deceptive, or
(b) create an unjustified expectation of beneficial treatment, or
(c) promote the unnecessary or inappropriate use of dental services, or
(d) claim or imply superiority for a dentist in the practice of dentistry, or
(e) be likely to bring the profession into disrepute

Failure to comply with these provisions attracts a fine of up to $550. In addition to the requirements of Part 4, the Fair Trading Act also prevents dentists from engaging in false, misleading or deceptive conduct, and the requirements of Part 2A of the Public Health Act specifically target the false promotion of health services.

Provisions in the Dentists Act

Nearly all the submissions that considered this issue supported the retention of the regulation making power and the terms of the current regulation. The HCF indicated that it considered that the terms of the 1996 regulation were "more protective of the public than anti-competitive in their nature and effect". The Submissions of both the Dental Board of NSW and the Australian Dental Association agreed with the position of the Health Care Complaints Commission quoted in the Issues Paper that :

> *consumer protection legislation alone does not adequately protect consumers. The Commission considers that demonstrably false, misleading or deceptive advertising is not the only conduct in this area from which members of the public and the professions require protection. Further, Fair Trading and other similar legislation is generally inaccessible to most health care consumers and accordingly, the Commission considers it is not an appropriate mechanism for the maintenance of professional standards*[97].

Obviously the extent to which advertising restrictions impact on competition depend very much on the precise terms of the regulation. Those in the current Dentists (General) Regulation are largely directed toward public protection, rather than professional advantage.

On balance, the Department has concluded that the current provisions allowing the making of regulations for advertising, should be retained for the following reasons.

- Continued regulation highlights to the profession that inappropriate advertising practices are unacceptable and may constitute unsatisfactory professional conduct.

- Removal of the power to regulate advertising would mean that in circumstances where evidence was available of advertising that was false, misleading or deceptive and there was direct evidence of an adverse patient outcome that warranted disciplinary action, the matter would have to be dealt with in two different forums.

- Prosecution of advertising breaches by dentists involves an assessment of the veracity of any claims made. The NSW Dental Board is well placed to undertake this task.

Provisions in the Dentists (General) Regulation 1996

The terms of the Regulation in relation to advertising are generally modelled on consumer protection legislation. The only restriction that does not conform to this model is the prohibition on registered practitioners claiming or implying superiority a dentist in the practice of dentistry. In other national competition reviews, the Department has noted that this "prohibition on claims of superiority" results in less informed consumers and constrains normal forms of competitive behaviour. Further, this prohibition has been progressively removed from regulations governing other registered health professionals[98]. As such, this Review considers that this particular section of the Regulation cannot be justified, and that any regulatory restrictions on the advertising of dental services should, in line with advertising restrictions applying to other professions, be modelled on consumer protection legislation.

It is also important to recognise that the terms of the Subordinate Legislation Act require where new regulations are made, a Regulatory Impact Statement must be drafted and circulated to interested stakeholders, to ensure a full and proper assessment of the costs and benefits of the regulation. This process will require careful examination of each of the specific advertising restrictions proposed, and will therefore provide an opportunity to more comprehensively consider them.

RECOMMENDATION 12 : ADVERTISING

THE PROVISIONS IN THE DENTISTS ACT ALLOWING FOR THE REGULATION OF ADVERTISING BE RETAINED, BUT AMENDED TO EXTEND THE POWER TO MAKE REGULATIONS TO COVER CORPORATIONS ADVERTISING DENTAL SERVICES.

7. COMPLAINTS AND DISCIPLINARY PROCEEDINGS

7.1 Introduction

One of the main objects for the regulation of health professionals is to protect the public from incompetent and unethical practitioners. An effective disciplinary system plays a central role in ensuring this object is met. The Issues Paper identified five specific "guiding principles" to assist in developing an effective system of discipline: Namely:

- the system must be accountable to the public;
- procedural fairness must apply to all parties in the process, be they the complainant, the practitioner, or witnesses before an inquiry;
- the overriding consideration should be the protection of the public interest, rather than professional interests or economic efficiency of the process;
- eminent members of the profession should be involved in adjudicative bodies;
- to ensure a broader community perspective and to enhance public confidence, adjudicative bodies should also include a lay member(s).

A statutory disciplinary system which meets these criteria will protect the public by enforcing standards among registered dentists, and reduce the incidence of adverse events and unethical conduct. Clearly disciplinary investigations and hearings involve costs for the NSW Dental Board, the Health Care Complaints Commission and registered practitioners. These costs however, are outweighed by the benefits produced from removing from the market, or proscribing the conduct of, incompetent or unethical practitioners.

While alternatives to a professional disciplinary system do exist (for example professional associations monitoring standards, or legal action at common law or under the Trade Practices Act) such systems do not achieve the protective objectives of the Act. They cannot prevent practitioners who have been found to have practised unethically or incompetently from continuing to practise dentistry, or allow for such practitioners to have conditions imposed on their practice.

7.2 The Submissions and the Recommendations

Overall, few of the submissions received by the Review (other than that from the NSW Dental Board and the Health Care Complaints Commission) considered the disciplinary system established under the Act in great detail. Indeed, there appeared to be a view that the system worked well in that it was effective, timely, efficient and achieved the desired result of protecting the public. The Department has generally

accepted this assessment, and as can be seen from the discussion which follows, the proposed changes are not designed to revise the whole system of discipline relied on under the Act, but rather aimed at updating and refining the existing provisions, in line with the principles outlined at the beginning of this Part.

7.3 Grounds for Complaint

The grounds on which a complaint can be laid was one of the issues identified for reform in the Issues Paper. Currently, section 31(1) of the Act states a complaint can be made to the NSW Dental Board that a dentist

(a) has been convicted of an offence (in NSW or elsewhere);

(b) has advertised otherwise than in accordance with the regulations;

(c) has charged an improper amount in relation to dental treatment ;

(d) has been guilty of "professional misconduct";

(e) lacks sufficient mental or physical capacity to practise dentistry ;

(f) *is not of good character*

The key criteria in this list is that dealing with "professional misconduct". Indeed, it is arguable that some of the other current grounds for making a complaint form part of this concept. As such, it is proposed to consider the question of "professional misconduct" first before considering the other grounds for complaint.

7.3.1 Professional misconduct

Currently section 5 of the Act contains a single definition of "professional misconduct". This definition reflects the common law definition that misconduct is conduct which attracts the "gross reprobation" of one's peers. The definition also extends the common law definition by giving specific examples of certain conduct. Two major issues have been raised by the Review in respect of professional misconduct.

(a) Should there be a two-tiered definition?

As noted in the Issues Paper, professional registration Acts passed in more recent years (such as the Nurses Act 1991 and the Medical Practice Act 1992) have introduced a two-tier system with definitions of both "unsatisfactory professional conduct" and "professional misconduct". The two-tier approach aims to overcome concerns that the single definition of "professional misconduct" could be read down by courts to limit disciplinary action to only the most serious cases, that is, those

where suspension or removal from the register may be considered. Establishing a category of "unsatisfactory professional conduct" for those less serious cases where strike off or suspension is unlikely, ensures appropriate action (such as for example, counselling or education courses) can be taken in all cases. The Department therefore recommends the introduction of a two-tier statutory definition of "unsatisfactory professional conduct" and "professional misconduct", with :

- "unsatisfactory professional conduct" to be defined in similar terms to the definition of "professional misconduct" (see the discussion below) ; and

- "professional misconduct" to be defined as unsatisfactory professional conduct of a serious nature which may lead to suspension or deregistration of the dentist.

(b) What should be included in the definition?

The proposal to have a two-tiered approach to misconduct still requires reliance on a statutory definition, and the actual content of such a definition also needs to be addressed. The current definition set out in section 5 of the Act, establishes a list of specific types of conduct to be considered as "professional misconduct". While the majority of these categories remain relevant, a number have become outdated and it is therefore proposed to revise the current categories. In order to assist in clarifying the Department's proposals, Table 2 (at Appendix D to this Report) has been prepared outlining the current definition and proposed changes.

The proposed revisions will necessarily apply to both the definition of "professional misconduct" and the definition of "unsatisfactory professional conduct". They are, very generally, designed to increase the flexibility of the definition, while updating it to reflect the current standard definition in other NSW health professional Acts. The specific rationale for the changes are as follows :

- *Section 5(b):* The submission from the Australian Society of Orthodontists suggested that a specific provision be introduced to ensure dentists do not use a specialist title unless it is entered in the register. Currently, it is a breach of section 55 to use a title not approved for entry in the register under section 12(1)(e). These provisions will be retained, and such actions will therefore remain a breach of the Act, and hence fall within the definition of unsatisfactory professional misconduct, and can be dealt with accordingly.

- *Section 5(c):* the current section provides that breaches of specific conditions can be dealt with as misconduct. It is considered that this provision would be more flexible and useful if it referred more broadly to a "failure to comply with an order or determination of the Board, or with a condition of registration". The NSW Dental Board in its submission supported such an inclusion.

- *New section* : in order to assist the board in dealing with complaints, and to make this section consistent with other health professional legislation, another provision

similar to section (c) will be added, making it unsatisfactory professional conduct to "fail to comply with a direction of the board to provide information with respect to a complaint against the provider."

- *Sections 5(d) & (e):* more recent definitions in NSW health professional Acts do not include restrictions on the use of a practitioner's name in connection with a practice, nor make a failure to comply with such provisions misconduct. While it has been agued that this ensures the Board can readily identify an individual dentist against whom a complaint has been made, there is no evidence to suggest how this assists.

  Such provisions also have a clear anti-competitive element, and reinforces the employment restrictions in subsection (4)(f). As such, it is proposed to remove them.

- *Section 5(f) :* the issue of whether the legislation should continue to regulate the employment of dentists by non-dentists has already been addressed in detail in Part 6 of this Report. In keeping with the recommendation 11 it is proposed to delete reference to these restrictions from the definition.

- *Section 5(g)* currently, this provision allows a finding of professional misconduct simply on the basis that a person is a "habitual drunkard or addicted to any deleterious drug". While there is no doubt that the consequences of such conduct may have implications for the practitioners skill or judgement, or ethical conduct of his or her practice, it will not of itself be unsatisfactory professional conduct or professional misconduct.

  As such, while a ground for making a complaint on the basis of an impairment (which would cover this category) will be included in the Act, the provision to make it a finding of misconduct will be removed. This is consistent with the Medical Practice Act.

- *New section* : once again, more recent legislation includes this broad provision, to ensure that any other conduct which might be considered unethical or improper is clearly within the ambit of misconduct and unsatisfactory professional conduct. This would, for example, ensure cases of excessive over-servicing or excessive overcharging of patients could be dealt with in this manner.

RECOMMENDATION 13 : TWO TIER DEFINITION

THE DENTISTS ACT SHOULD BE AMENDED TO REPLACE THE CURRENT DEFINITION OF "PROFESSIONAL MISCONDUCT" WITH A TWO-TIERED DEFINITION OF "UNSATISFACTORY PROFESSIONAL CONDUCT" AND "PROFESSIONAL MISCONDUCT".

RECOMMENDATION 14 : UNSATISFACTORY PROFESSIONAL CONDUCT

UNSATISFACTORY PROFESSIONAL CONDUCT SHOULD BE DEFINED TO MEAN:

A. ANY CONDUCT THAT DEMONSTRATES A LACK OF ADEQUATE KNOWLEDGE, SKILL, JUDGMENT OR CARE BY THE DENTAL CARE PROVIDER IN THE PRACTICE OF DENTISTRY;

B. CONTRAVENING (WHETHER BY ACT OR OMISSION) A PROVISION OF THIS ACT OR THE REGULATIONS;

C. A FAILURE BY THE DENTAL CARE PROVIDER TO COMPLY WITH AN ORDER OR DETERMINATION OF THE BOARD OR A COMMITTEE OF THE BOARD, OR WITH A CONDITION OF REGISTRATION;

D. A FAILURE BY THE DENTAL CARE PROVIDER TO COMPLY WITH A DIRECTION OF THE BOARD TO PROVIDE INFORMATION WITH RESPECT TO A COMPLAINT AGAINST THE PROVIDER

E. ANY OTHER IMPROPER OR UNETHICAL CONDUCT RELATING TO THE PRACTICE OF DENTISTRY

RECOMMENDATION 15 : PROFESSIONAL MISCONDUCT

PROFESSIONAL MISCONDUCT MEANS UNSATISFACTORY PROFESSIONAL CONDUCT OF A SERIOUS NATURE WHICH MAY LEAD TO SUSPENSION OR DEREGISTRATION OF THE DENTIST

7.3.2 Criminal conviction, lack of capacity and lack of character

These three grounds for making a complaint reflect three of the main criteria an applicant must meet before he or she can be registered as a dentist. The merits and public benefits of these criteria have already been addressed in Para 5.1.4. Given the conclusions reached there, it is considered that these matters remain appropriate grounds for making a complaint.

7.3.3 Unauthorised advertising as a breach of discipline

The question of advertising has already been dealt with in Para 6.2 of this Report, where it was recommended that the NSW Dental Board continue to play a role in policing advertising by registered dentists. As such, breaching the advertising standards set out in clause 16 of the Dentists (General) Regulation, will continue to fall within the definition of “unsatisfactory professional conduct” and “professional misconduct”. There is therefore no need for separate reference to be made to advertising as a grounds for complaint.

7.3.4 Charging improper amounts for dental treatment

As noted in the Issues Paper, the Dentists Act is unique in NSW health professional Acts, in that it includes specific reference to the issue of improper charging for treatment as a ground for complaint. None of the submissions received by the Review addressed this provision. The arguments made in the Issues Paper as to the potential for the provision to be used to police commercial, rather than professional, conduct remain. During the consultation period members of the profession noted that the provision was predicated on a readily calculable or accepted standard charge for treatment, something which was unrealistic[99].

At the same time, it is clear that many dental complaints revolve around the nature of treatment, and whether the patient obtained value for money in the treatment. As such, it is proposed to replace "improper charging" with "failure to provide a dental service of value". It is important to emphasise that this will not provide the Board with a mechanism to set or regulate fees charged but rather to assess whether treatment of value has been provided to the patient and make appropriate orders with regard to the fees charged for that treatment.

RECOMMENDATION 16 : GROUNDS FOR MAKING A COMPLAINT

THE DENTISTS ACT SHOULD BE AMENDED TO:

- REMOVE "UNAUTHORISED ADVERTISING" AS GROUNDS ON WHICH A COMPLAINT CAN BE MADE, ON THE BASIS THAT THIS ACTIVITY WILL BE COVERED BY THE REVISED DEFINITIONS OF "UNSATISFACTORY PROFESSIONAL CONDUCT" AND "PROFESSIONAL MISCONDUCT"; AND
- REPLACE THE CURRENT REFERENCE TO "IMPROPER CHARGING" WITH 'FAILURE TO PROVIDE A DENTAL SERVICE OF VALUE"

7.4 The Disciplinary Structure

7.4.1 Introduction

The disciplinary system relied on under the Dentists Act is somewhat different from those adopted by other health professional registration Acts, most notably in the use of a Dental Care Assessment Committee. The Issues Paper canvassed other models which could be used to deal with complaints, such as a two-tier professional standards committee/tribunal model.

After consideration of the submissions and review of other health professional Acts, the Department has concluded that the current structure established in the Dentists

Act should be retained. The views put in the submissions reinforce the view that the DCAC model[100] is an effective way of dealing with consumer complaints, the vast majority of which relate to the less serious end of the misconduct scale. It is also efficient in responding to claims in a prompt manner, and is a less costly alternative for consumers than pursuing legal action through the courts.

It should be noted that two submissions[101] did propose that the system of discipline operating under the Medical Practice Act and Nurses Act should be introduced into the Dentists Act. While these submissions did not include any detailed discussion as to why this was the preferred option, one reason given was that the existing structure:

> *"is not sufficiently transparent in its adjudication process, also the lack of formal legal advice available to it increases the chance of legal error and breaches of natural justice"*[102]

While the Department recognises some submissions have raised such concerns, two points should be made. First, the medical and nursing model is designed to address the needs of the two largest health professional groups in NSW[103], who (consequentially) also have a large volume of complaints, many of which arise from service provision in hospitals. During the NCP Review process, the Department has concluded that the smaller professions who have fewer complaints and who operate largely in a private practice non-institutional setting, would be better served by a DCAC-like model. As a result, the Department has therefore recommended the introduction of an Assessment Committee structure for a number of other professions[104]. Retention of DCAC is in keeping with these recommendations.

Second, any concerns which have arisen with DCAC can be more readily addressed by revision, not replacement, of the current system. It is noted that many aspects of the current disciplinary scheme arise from administrative practices adopted by the Board, rather than provisions set out in the Act. Under the current terms of the Act, for example, the Board could refer all complaints received by it to a Board of inquiry, or alternatively, deal with even the most serious matter at a regular board meeting[105]. In practice however, the Board ensures natural justice is addressed by administratively requiring that complaints involving serious misconduct (ie, those where a practitioner could be struck off the register) be referred to a formal hearing (currently a Board of Inquiry) where the practitioner has access to legal representation[106].

The Department recognises the value of a flexible legislative scheme such as that provided by the current Act. At the same time however, it must be recognised that this flexibility needs to be balanced against the criteria of accountability, transparency and natural justice. These suggest certain key elements should be set out in the legislation, rather than in administrative guidelines. The recommendations made in this Part of the Report are designed to ensure this balance is met.

7.4.2 Implications of the two-tiered definition for the disciplinary structure

Before discussing the specific amendments being proposed in this Report, some reference must be made to the manner in which the proposed adoption of a two-tier definition of misconduct will impact on the disciplinary structure. In most other health professional Acts, one of the main purposes of the two tier definition is to identify those most serious cases of misconduct (which must be dealt with by a Tribunal) and those lesser matters of "unsatisfactory professional conduct" (which can be dealt with by a Professional Standards Committee). While it is not proposed to introduce a professional standards committee structure into the Dentists Act, the distinction between lesser and more serious matters will still be used to determine what matters can be addressed by the Board directly and what matters must be referred on to a more formal hearing. Thus:

- where a complaint involves professional misconduct (ie, is considered serious enough that, if proven, it would lead to deregistration) the Act will require that the complaint be referred to a formal hearing where the practitioner has access to legal representation; and

- in other cases, where the complaint involves a question of unsatisfactory professional conduct (or some lesser matter) it will be dealt with by the Board, or as the Board directs.

RECOMMENDATION 17 : THE DISCIPLINARY STRUCTURE

THE DENTISTS ACT SHOULD BE AMENDED TO:

- ENSURE THAT WHERE A COMPLAINT INVOLVES A QUESTION OF PROFESSIONAL MISCONDUCT (IE, CONDUCT OF SO SERIOUS A NATURE AS TO WARRANT REMOVAL FROM THE REGISTER IF PROVEN) THE COMPLAINT IS DEALT WITH VIA A FORMAL HEARING WHERE THE REGISTRANT HAS ACCESS TO LEGAL REPRESENTATION;
- RETAIN, IN ALL OTHER MATTERS INCLUDING THOSE MATTERS OF UNSATISFACTORY PROFESSIONAL CONDUCT, THE CURRENT FLEXIBILITY IN THE ACT AND THE DISCRETIONS VESTED IN THE BOARD.

7.4.3 Disciplinary Bodies under the Act

It is implicit in Recommendation 17 that the formal hearing to determine if a practitioner should be struck off the register should not only accord that practitioner a right to legal representation, but also ensure a level of procedural fairness, accountability and independence commensurate with the possible outcome – ie the loss by that practitioner of his or her means of livelihood.

Currently however, all disciplinary matters are determined by the Board, either during the course of an ordinary board meeting, or with the board sitting as a formal Board of Inquiry, exercising the powers of a Royal Commission. While the Review

considers it is appropriate for the board to continue to address and resolve the less serious complaints of unsatisfactory professional conduct, it considers it more appropriate that matters of professional misconduct are referred to an independent Tribunal for consideration and determination. An independent tribunal, constituted separately from the Board will ensure there is a level of procedural fairness commensurate with the potential penalties that can be imposed.

It is relevant to note that the submission from the NSW Dental Board, while strongly supporting the existing system, conceded that :

> *The present system of the Board sitting as a tribunal with powers of a Royal Commission would be better conducted by an independent Dental Tribunal with three members appointed by the Governor"*[107].

The Department therefore proposes to recommend that a NSW Dental Tribunal be established to deal with matters of "professional misconduct". As indicated in the Issues Paper, it is proposed that the Tribunal will be constituted along similar lines to the Medical Tribunal and the Nurses Tribunal, that is :

- it will be constituted by four persons, two members of the dental profession, one lay person and a barrister or solicitor;
- at least one of the professional members will be drawn from the same discipline as the respondent to the complaint;
- the barrister or solicitor will act as chair person of the Dental Tribunal; and
- the powers of the Tribunal in respect of the collecting of evidence, the calling witnesses and the procedures to be adopted in hearings will be set out in the Dentists Act, and will reflect those provisions applying under the Medical Practice Act;

RECOMMENDATION 18 : DENTAL TRIBUNAL OF NSW

THE DENTISTS ACT SHOULD BE AMENDED TO:

- ESTABLISH A NSW DENTAL TRIBUNAL ON SIMILAR LINES TO THE MEDICAL TRIBUNAL ESTABLISHED UNDER THE MEDICAL PRACTICE ACT;
- REQUIRE THAT ALL MATTERS OF PROFESSIONAL MISCONDUCT ARE REFERRED TO THE DENTAL TRIBUNAL.

7.5 The Complaints Process

7.5.1 Complaints to be verified by Statutory Declaration

Currently, the Dentists Act requires all complaints must be verified by a statutory declaration. The Health Care Complaints Act contains a similar provision, which requires the statutory declaration to be made *prior to a complaint being referred to*

investigation. The aim is to ensure that complaints are genuine and to discourage frivolous or vexatious complaints. The Final Report of the Review of the Health Care Complaints Act[108] concluded that the requirement to obtain a statutory declaration prior to investigation could not be justified and resulted in unnecessary delays in the conduct of disciplinary investigations. That report instead recommended that a statutory declaration should only be required at the point at which a complaint is referred for disciplinary action.

The submissions to this Review largely took the position that the requirement for a statutory declaration be retained in the Dentists Act. It should also be recognised that the DCAC disciplinary model will generally involve complaints being referred to DCAC, and the patient whose treatment is under question, being further examined by an independent expert, at the Board's expense. Such examinations can be costly, and requiring a complainant to verify the bona fides of the complaint via a statutory declaration prior to this process commencing, goes some way to preventing these costs to being incurred unnecessarily.

Consideration has therefore been given as to whether retention of these requirements under the Dentists Act would create a conflict with the recommendations of the review of the Health Care Complaints Act. The Department has concluded that no serious conflict would arise. Complaints made to the Dental Board can continue under their existing process. This will simply mean that where the Health Care Complaints Commission is requested by the Board to investigate a matter, a statutory declaration would already have been obtained. It is therefore proposed to retain the current statutory declaration provisions in section 31(3)(c) as they are.

7.5.2 Options available to the Board on receipt of a complaint

Currently, where a complaint is made to the Dental Board, section 34 of the Act provides the Board with a range of options. It can:

(a) deal with the complaint at an ordinary Board meeting;

(b) refer the matter to a committee of the Board for investigation and recommendation,

(c) refer the matter to the Health Care Complaints Commission for investigation;

(d) refer the matter to the Dental Care Assessment Committee for investigation, resolution and or recommendation;

(e) deal with the matter via a formal Board of Inquiry (where the Board can exercise the powers of a Royal Commission);

(f) decline to deal with the matter.

Generally, it is considered that each of these options remains valid, subject to the following changes :

- in line with Recommendation 17, an ordinary board meeting with its attendant informality should only deal with less serious matters. It is therefore proposed to amend section 34(a) to make it clear that a complaint can only be dealt with in this manner where it does *not* involve professional misconduct.

- the role of board inspectors should also be recognised, allowing the Board to refer matters to an inspector for investigation;

- the reference to a formal Board of inquiry should, in keeping with recommendation 18 be replaced with reference to the NSW Dental Tribunal.

RECOMMENDATION 19 : ACTIONS AVAILABLE ON RECEIPT OF A COMPLAINT

SECTION 34(a) OF THE DENTISTS ACT SHOULD BE AMENDED TO

- ONLY ENABLE THE BOARD TO DEAL WITH A COMPLAINT AT AN ORDINARY BOARD MEETING WHERE THAT COMPLAINT DOES NOT INVOLVE PROFESSIONAL MISCONDUCT;
- REQUIRE THE BOARD TO REFER ANY MATTER INVOLVING PROFESSIONAL MISCONDUCT TO THE DENTAL TRIBUNAL; AND
- ENABLE THE BOARD TO REFER A COMPLAINT TO AN INSPECTOR APPOINTED UNDER SECTION 59 FOR INVESTIGATION.

7.5.3 Emergency powers to suspend registration

Under the Medical Practice Act the Medical Board may *at any time*, suspend a practitioner from the register for thirty days, or impose conditions on that practitioner's practice. Such action can, however, only be taken where it is necessary "for the purpose of protecting the life or the physical or mental health of any person". The power is designed to operate in cases where immediate action is warranted. Emergency orders are made only in exceptional cases. In the 12 months ending 30 June 1997 the Medical Board had only used the power three times.

The Issues Paper noted that there are strong public policy reasons for a registration board to have and exercise this power tor the protection of the public. Generally, the submissions received by the Review supported the inclusion of emergency provisions in the Dentists Act. The Department is of the opinion that the nature of dental practice is such that the inclusion of emergency powers is appropriate, and therefore proposes to recommend that the Act be amended to include similar emergency provisions to those set out in section 66 of the Medical Practice Act. It is also proposed the provisions will provide for :

- timeframes for the relevant actions and notifications;
- referral of appropriate cases to an Impaired Registrants process;
- review of any conditions imposed, pending a full disciplinary hearing.

RECOMMENDATION 20 : EMERGENCY POWER TO SUSPEND

THE DENTISTS ACT SHOULD BE AMENDED TO PROVIDE THE NSW DENTAL BOARD WITH THE POWER TO SUSPEND THE REGISTRATION OF A PERSON IN EMERGENCY SITUATIONS, BASED ON THE TERMS OF SECTION 66 OF THE MEDICAL PRACTICE ACT, AND INCLUDING:

- SET TIMEFRAMES FOR ACTIONS AND NOTIFICATIONS TO OCCUR ;
- PROVISION FOR THE REFERRAL OF APPROPRIATE CASES TO BE RESOLVED VIA AN IMPAIRED REGISTRANTS PROCESS;
- PROVISION FOR ANY CONDITIONS IMPOSED TO BE SUBJECT TO REVIEW, PENDING A FULL DISCIPLINARY HEARING BEFORE THE TRIBUNAL.

7.5.4 Expert Reports Prepared for the Dental Care Assessment Committee

Under the terms of the Act, DCAC is authorised to obtain "such dental, medical, legal, financial, or other advice as it thinks necessary or desirable to enable it to exercise its functions". The Issues Paper noted that similar provisions in the Health Care Complaints Act also prevent the use of this advice in legal proceedings (other than the disciplinary proceedings for which the advice was obtained). The only exception is where the person who provided the advice consents to the use of his or her advice in that other venue.

The Department considers it appropriate that reports obtained by the DCAC enjoy the same level of protection as those prepared during an investigation by the Health Care Complaints Commission. In order to protect the supply of expert reports to DCAC, and the candour with which the opinions they contain are expressed, it is recommended that the Dentists Act be amended to prevent the use of reports obtained by DCAC in legal proceedings other than disciplinary proceedings arising out of a DCAC investigation[109].

RECOMMENDATION 21 : PROTECTION OF EXPERT REPORTS

SECTION 40 OF THE DENTISTS ACT BE AMENDED TO PROVIDE THAT REPORTS PREPARED FOR THE DCAC ARE NOT TO BE USED IN ANY PROCEEDINGS (OTHER THAN ANY DISCIPLINARY PROCESS ARISING OUT OF THE COMPLAINT) WITHOUT THE PERMISSION OF THE PERSON WHO SUPPLIED THE REPORT.

7.5.5 Role of DCAC and Recommendations of DCAC

Currently, under section 42 the DCAC can make recommendations to the Board on a range of matters, namely :

(a) recommend a refund of money paid for the dental treatment in question;
(b) recommend that the patient withhold payment of fees;
(c) recommend the payment of dental fees, consequential to any remedial treatment;
(d) recommend that the dental treatment is acceptable or that the fees are reasonable;
(e) recommendation the patient pay the fee considered reasonable by the Committee;
(f) recommend the practitioner be cautioned or reprimanded;
(g) make such other recommendations as may be considered necessary.

The Board then has a discretion as to whether to follow the DCAC recommendation, or to choose to pursue one of the other options available to it under section 34 Sections 42(2)(a) to (e) each deal with various recommendations in relation to payment or charging of fees for treatment. Section 42(2)(f) and (g) however, give the DCAC a role in recommending more formal action by the Board, either by reprimanding the practitioner (under section 42(2)(f)) or making some other recommendation (under section 42(2)(g)).

As noted above, the proposal to create a two-tier definition of misconduct is based on the premise that matters involving professional misconduct – ie those of such a serious nature, that if proven, the practitioner could be suspended or struck off the Register, will be referred to a Tribunal for consideration.

In the interests of accountability and transparency, where DCAC comes to a view that a matter referred to it may involve unsatisfactory professional conduct or professional misconduct, the DCAC should be entitled to make a recommendation that the matter be dealt with as such. On receipt of such a recommendation, the Board will then be obliged to conduct an inquiry. If the matter is serious, then the general requirement that the Board refer such matters to the Tribunal, will ensure the issue is heard at that level.

Given that these proposals provide for the Board to retain its role as an adjudicative body on complaints raising questions of unsatisfactory professional conduct, issues of transparency and conflict of interest arise, if the Board is able to dismiss a complaint that DCAC has recommended be the subject of an inquiry. The Department therefore recommends these changes to section 42.

RECOMMENDATION 22 : RECOMMENDATIONS OF DCAC

THE DENTISTS ACT BE AMENDED TO PROVIDE THAT DCAC CAN RECOMMEND TO THE BOARD THAT A MATTER BE DEALT WITH AS A COMPLAINT OF UNSATISFACTORY PROFESSIONAL CONDUCT, AND PROVIDE THAT WHERE SUCH A RECOMMENDATION IS MADE, THE BOARD MUST CONDUCT AN INQUIRY OR REFER THE MATTER TO THE TRIBUNAL, DEPENDING ON THE LEVEL OF SERIOUSNESS.

7.5.6 Action which can be taken after a finding of misconduct

Currently, under section 47 of the Act, where it has been determined that a practitioner is guilty of misconduct, the options available to the disciplinary body are limited to cautioning or reprimanding the person, removing or suspending the person from the register, or imposing a fine. There is also a more general power stating that the Board may "take any other action the Board considers appropriate in the circumstances of the case".

More recently enacted health professional Acts do not rely on a general power to "take any action" the disciplinary body sees fit. Instead, these Acts provide a more comprehensive list of alternatives for a disciplinary body to consider. These lists meet accountability and natural justice criteria by making sure the practitioner is aware of all alternative outcomes they may face. They also tend to more directly reflect the protective nature of this jurisdiction, and do not include the power to impose a fine, which is a more punitive power.

In order to maximise the range of options available, while ensuring individual practitioners are informed of the penalties they may face, the Department proposes to recommend that section 47 be amended to include the following powers:

- order that a person seek and undergo medical or psychiatric treatment or counselling;
- direct conditions relating to the person's practice be imposed in the person's registration;
- order the person to complete such educational courses as are specified by the disciplinary body;
- order the person to report on his or her practice at the times, in the manner and to the persons specified by the disciplinary body;
- order the person to seek and take advice, in relation to the management of his or her practice, from such persons as are specified by the disciplinary body;
- order the person to return fees charged for dental treatment.

It is proposed to remove the ability of the disciplinary body to take any other action it thinks fit, and to impose fines. On this last point, it is recognised that a number of submissions argued that the power to impose fines be retained. As indicated in the Issues Paper however, evidence as to the "protective" role played by a fining power would need to be provided to justify its continuance. No such evidence has been provided to the Review.

The revised powers proposed in section 47 will be available to both the Board and the Tribunal, with one exception. The power to suspend or deregister a registered practitioner will be vested exclusively in the Tribunal.

RECOMMENDATION 23 : ACTION TO BE TAKEN BY THE BOARD AFTER A FINDING OF UNSATISFACTORY PROFESSIONAL CONDUCT

SECTION 47 OF THE DENTISTS ACT BE REPLACED WITH THE PROVISIONS ALLOWING THE DENTAL BOARD, AFTER A COMPLAINT IS SUBSTANTIATED, TO IMPOSE THE FOLLOWING ORDERS:

- CAUTION OR REPRIMAND THE PRACTITIONER;
- REQUIRE THE PRACTITIONER TO UNDERGO MEDICAL OR PSYCHIATRIC TREATMENT OR COUNSELLING;
- IMPOSE CONDITIONS ON THE PRACTITIONERS REGISTRATION;
- REQUIRE THE PRACTITIONER TO COMPLETE SPECIFIED EDUCATIONAL COURSES;
- REQUIRE THE PRACTITIONER TO REPORT ON HIS OR HER PRACTICE AT THE TIMES, IN THE MANNER AND TO THE PERSONS SPECIFIED
- REQUIRE THE PRACTITIONER TO SEEK AND TAKE ADVICE, IN RELATION TO THE MANAGEMENT OF HIS OR HER PRACTICE;
- REQUIRE THE PRACTITIONER TO RETURN FEES CHARGED FOR DENTAL TREATMENT

RECOMMENDATION 24 : ACTION TO BE TAKEN BY THE TRIBUNAL AFTER A FINDING OF PROFESSIONAL MISCONDUCT

AMEND THE ACT TO GRANT THE PROPOSED TRIBUNAL THE POWER TO MAKE ALL THE ORDERS REFERRED TO IN RECOMMENDATION 23, AND IN ADDITION, THE POWER TO ORDER THE PRACTITIONER TO BE REMOVED OR SUSPENDED FROM THE REGISTER

7.6 Other Issues Arising from the Disciplinary provisions

7.6.1 Board Members sitting on the Dental Tribunal

One other aspect of the disciplinary system that has been raised in other reviews relates to the right or ability of Board members to sit on disciplinary tribunals. The majority of the submissions to the Review agreed that it would be appropriate to preclude Board members from sitting on a disciplinary tribunal. While including such a prohibition in no way suggests Board members would be partial or act in an otherwise inappropriate manner, the provision will ensure the tribunal is seen to be impartial and independent.

7.6.2 Power to award costs

The costs incurred in prosecuting and defending a disciplinary matter can be substantial, particularly in those proceedings where legal representation is provided

for. Under the Medical Practice Act, the Medical Tribunal has the power to award costs. Such a power can be useful in that it can deter vexatious or frivolous proceedings. The Department therefore proposes to empower the Dental Tribunal to award costs.

7.6.3 Appeals from disciplinary hearings

Section 51 of the Dentists Act sets out the circumstances in which an appeal can be made to the District Court consequential to disciplinary action. These grounds however, are drafted to reflect those circumstances in which an aggrieved dentist may choose to exercise a right of appeal. They do not provide grounds, for example, for a prosecuting body (such as the Health Care Complaints Commission) to appeal to the District Court. The Medical Practice Act, by comparison, provides detailed provisions for all relevant parties to disciplinary proceedings to appeal. The Department therefore proposes to introduce provisions into the Dentists Act allowing an appeal to the Supreme Court, in similar terms to that currently operating in the Medical Practice Act.

7.6.4. Notification of conditions on registration

In a number cases heard by Professional Standards Committees established under the Medical Practice Act, situations have arisen where conditions have been imposed on a practitioner's registration which involve an appreciable cost burden on the employer. There have also been instances of conditions being imposed where the employer has not been notified of the decision or given an opportunity to appear before the relevant tribunal to provide advice as to the practicality of conditions proposed.

The Issues Paper raised two possible solutions to address these problems. First, a provision requiring the disciplinary body to provide a a third party (such as a current employer) who might be adversely affected by the imposition of conditions on a practitioner's registration, the opportunity to be heard before that body. Second, the Board (dealing with matters of unprofessional conduct) and the Dental Practice Tribunal (dealing with matters of professional misconduct) would be required to provide a copy of any condition imposed to that third party. While not all submissions to the review addressed this issue, those that did generally supported these proposals, as outlined in the Issues Paper.

7.6.5 Obligation on registered practitioners to notify possible misconduct

The Health Care Complaints Commission has indicated it is of the view that health professional registration Acts should contain provisions to compel a registered practitioner to notify where he or she has grounds to suspect a colleague is not competent to practice or has been guilty of sexual misconduct. The Commission reiterated this view in its submission to this Review :

> *"The Commission supports mandatory notification on competency and sexual misconduct grounds. This is consistent with the professions obligations to ensure the safe and effective delivery of dental services to the public."*[110]

This reflects the views raised in some other health professional Act reviews that argued practitioners have an inherent responsibility to protect the public. This argument also notes that patients are frequently unable to assert their rights, and as such, mandatory notification should be pursued.

Against this it should be noted, there was only very limited support for mandatory notification in submissions received by this Review. There are also a range of difficulties in including such a requirement in the Act.

For example, making notification mandatory could be counterproductive in that it could lead to evasive behaviour on the part of practitioners at risk. Further, effective enforcement would be difficult . It would for example, be necessary to establish that a practitioner was aware of a fellow practitioner's lack of competence. Non-regulatory options, such as education programs by the Board and professional associations are likely to be far more effective in ensuring such conduct is reported.

Given this, the Department does not propose at this stage to recommend the inclusion of a mandatory reporting provision in the Act.

RECOMMENDATION 25 : BOARD MEMBERS SITTING IN DISCIPLINARY HEARINGS

AMEND THE DENTISTS ACT TO PRECLUDE MEMBERS OF THE DENTAL BOARD FROM SITTING ON THE PROPOSED TRIBUNAL

RECOMMENDATION 26 : POWER TO AWARD COSTS

AMEND THE DENTISTS ACT TO GRANT THE PROPOSED TRIBUNAL THE POWER TO AWARD COSTS.

RECOMMENDATION 27 : APPEALS FROM DISCIPLINARY HEARINGS

ESTABLISH A RIGHT OF APPEAL FROM THE PROPOSED TRIBUNAL TO THE SUPREME COURT ON A POINT OF LAW OR PENALTY

7.7 Role of the Health Care Complaints Commission

The Issues Paper recognised the importance of ensuring that the Health Care Complaints Commission continued to play a role at appropriate stages in the disciplinary process.

The Department therefore proposes that the Act be amended to recognise the role of the Health Care Complaints Commission at certain specific points in the disciplinary process. The revised scheme will build on the existing provisions in both the Health Care Complaints Act and the Dentists Act, to recognise the role of the Commission as follows:

- Ensure that the Board and the Health Care Complaints Commission notify each other of complaints received, and consult on the best method of dealing with that complaint. Provisions to ensure this occurs already exist in Division 2 of Part 2 of the Health Care Complaints Act;

- Provide the Board with the option of referring a complaint to the Health Care Complaints Commission for investigation. These provisions already exist under section 34 of the Act. The Health Care Complaints Commission can also require matters to be investigated under the Health Care Complaints Act.;

- Require the Board to provide the Health Care Complaints Commission with the report and recommendations of DCAC and also notify the Commission of any action the Board proposes to take. This is a new provision;

- For matters of professional misconduct, provide the Health Care Complaints Commission with an opportunity to prosecute the matter before the Dental Tribunal. This is a new provision, designed to ensure that the expertise of the Health Care Complaints Commission can be called on in serious cases.

RECOMMENDATION 28 : ROLE OF THE HEALTH CARE COMPLAINTS COMMISSION

THE ACT BE AMENDED TO INCLUDE THE FOLLOWINGPROVISIONS TO RECOGNISE THE ROLE OF THE HEALTH CARE COMPLAINTS COMMISSION:

- REQUIRING THE BOARD TO PROVIDE THE HEALTH CARE COMPLAINTS COMMISSION WITH THE REPORT AND THE RECOMMENDATIONS OF DCAC, AND ANY ACTION THE BOARD PROPOSES TO TAKE;

- REQUIRING THE BOARD, IN CASES OF PROFESSIONAL MISCONDUCT, TO PROVIDE THE HEALTH CARE COMPLAINTS COMMISSION WITH AN OPPORTUNITY TO APPEAR IN THE MATTER BEFORE THE DENTAL PRACTICE TRIBUNAL

- PROVIDING THE HEALTH CARE COMPLAINTS COMMISSION WITH THE RIGHT TO MAKE SUBMISSIONS TO A BOARD INQUIRY INTO UNSATISFACTORY PROFESSIONAL CONDUCT;

7.8 Impaired Registrants Panel

Under the terms of the current Act, the Board has broad powers to "deal with a complaint at a meeting of the Board". The submission from the ADA indicated that this gave sufficiently broad powers to allow the Board to consider matters of impairment at a Board meeting. The Dental Board echoed this view, indicating that to date, very few impaired registrants had come to attention, and that in this regard, the fact that a complaint could be made as to capacity under 31(1)(f) was sufficient to address these cases.

While these comments have been carefully considered, natural justice issues also need to be addressed, given the interaction between the impairment system and the more formal disciplinary process. As noted in the Issues Paper, while impairment schemes operate on a voluntary basis, with a practitioner agreeing to submit to conditions on his or her practice, it has a direct link to the disciplinary process. Thus, where a registrant does not agree to the conditions recommended by the impairment body, or later breaches the conditions, the Board must then consider whether disciplinary action is warranted, including whether it is a case of unsatisfactory professional conduct.

Clearly, the Board acting as both the impairment body and the disciplinary body, raises questions about pre-judgment if an impairment matter is later dealt with as a complaint. Reliance on a separate impaired registrants panel avoids this potential. For this reason the Review has concluded that the Act should be amended to adopt the complete impaired registrant panel system currently operating under the Medical Practice Act.

RECOMMENDATION 29 : IMPAIRED REGISTRANTS :

AMEND THE DENTISTS ACT TO INCORPORATE A PROCESS FOR DEALING WITH IMPAIRED REGISTRANTS, INCLUDING AN IMPAIRED REGISTRANTS PANEL, MODELLED ON THE IMPAIRMENT PROVISIONS CONTAINED IN THE MEDICAL PRACTICE ACT.

7.9 Codes and professional misconduct

The Issues Paper raised a number of questions in relation to the desirability of providing for Codes of Conduct under the NSW Dentists Act. Various options were suggested, including providing for a breach of a code to be a breach of professional conduct, or form the basis of a complaint.

There was very little support for the introduction of codes of practice from the submissions received by the Review. While, for example, the Health Care Complaints Commission supported such Codes for "the educative value they have for health care consumers and for the members of the profession", the Commission also noted that it would not support the Code being an automatic breach of

discipline.[111] A number of other submissions took the view that the efficient operation of the existing disciplinary system demonstrated there was simply no need for such Codes.[112] The NSW Dental Board, while considering there was no (current) need to develop codes, also recognised that "the ability to formulate a code would be advantageous".[113]

The submission from the NSW Dental Therapists Association strongly supported the use of a code as a necessary part of the more formal recognition of dental therapists under the Act. This Submission stated :

> *"A Code of Practice could provide the benchmark for standards of conduct and practice amongst Dental Therapists, if not a wider range of dental health professionals."* [114]

The issues raised by the Submission suggest that codes should not automatically be considered matters of professional misconduct. This is not to conclude, however, that such codes would not add value to the disciplinary process. Codes of professional conduct could be used by disciplinary bodies to assist in defining standards of acceptable practice, they could also serve as a guide for practitioners as to the expected standard of conduct or practice. Importantly, they would also be readily accessible and provide information to consumers as to the standards of practice expected of practitioners and provide information to assist consumers in selecting a practitioner.

It should also be remembered that recommendation 3 of this Report proposes to extend the title protections established under the Act to dental auxiliaries such as dental therapists and dental hygienists. Recommendation 3 will also see such professionals subject, for the first time, to a statutory disciplinary scheme. In such circumstances the use of codes to guide these professions may have added value.

It is also important to consider that since such Codes can restrict market behaviour and impose compliance costs on members of a profession, it is necessary to determine whether such a provision is consistent with the Competition Principles Agreement. Alternatives to the model used in other professional registration Acts were also identified for consideration to ensure that Codes are not anti-competitive or otherwise contrary to the public interest, and that adequate consultation occurs during development of the Code. These include adopting the Code by Regulation, Ministerial approval or disallowance by Parliament.

Critically, the potential anti-competitive effect of Codes can only really be considered once the content of the Code is known. It is therefore essential that the processes for developing the Code ensures that appropriate consultation occurs and that regard is had to the costs and benefits of specific restrictions, and alternatives.

It is therefore proposed to establish a process in the legislation for developing codes of conduct to ensure that the matters they addresses are appropriate and that they does not enshrine anti-competitive practices or sanction conduct that is not in the

public interest. It is therefore proposed that any draft Code should be released for public comment along with an impact assessment report, and could only be made with the approval of the Minister. This will ensure that the Code is appropriate and targeted to real public interest issues. The report will be developed in accordance with criteria that will be broadly similar to those set down for the preparation of regulatory impact statements under the Subordinate Legislation Act 1989.

It is also proposed to allow the Minister to direct the preparation of a code of conduct on a particular issue, although not the content of the code. This proposal is designed ensure that serious issues of consumer or professional concern which come to the attention of government are promptly and adequately addressed.

The issue remains as to whether a breach of the code should form grounds for a complaint. If the complaint were proved it would then form the basis for the imposition of disciplinary sanctions. The key issue in determining whether disciplinary sanctions should be imposed is whether the conduct complained of constitutes unsatisfactory professional conduct or professional misconduct, and not whether the Code has been breached. This approach has been taken in recent amendments to the Medical Practice Act.

RECOMMENDATION 30 : CODES OF CONDUCT

THE DENTISTS ACT BE AMENDED TO :

- PROVIDE FOR THE MINISTER TO APPROVE A CODE OF PROFESSIONAL CONDUCT DEVELOPED BY THE BOARD;
- ENABLE THE MINISTER TO DIRECT THE PREPARATION OF A CODE OF PROFESSIONAL CONDUCT ON A PARTICULAR ISSUE, BUT NOT THE CONTENT OF ANY CODE;
- REQUIRE THE BOARD TO RELEASE A DRAFT CODE AND IMPACT ASSESSMENT REPORT FOR PUBLIC COMMENT PRIOR TO SEEKING THE MINISTER'S APPROVAL;

8. OTHER ISSUES FOR REFORM

Since the Dentists Act was last remade in 1989, a number of issues have been canvassed for inclusion in schemes of professional regulation. The Review of the Dentists Act therefore also provides an opportunity to consider some of these issues in the context of the dental profession.

8.1 Records

8.1.1 Retention of records

Section 67(2)(n) of the Dentists Act provides for Regulations to be made :

> *"prescribing the records to be kept by persons engaged in the practice of dentistry, or any part of the practice of dentistry, and the time for which any such records shall be kept".*

Clause 23 of the Dentists (General Regulation) 1996 contains detailed provisions on the types of records to be kept in respect of dental services.

The majority of submissions supported the continuation of these requirements as being in the best interests of the public and the profession. Such requirements facilitate high quality patient care, and accurate patient records will be of assistance to regulating authorities, dentists and patients in the event there is a need to determine the cause of an adverse event, for subsequent litigation or complaints proceedings. The Department therefore proposes to retain the records provisions as they are.

8.1.2 Patient access to records

The right a patient may or may not have to see his or her medical records has been an issue of considerable topicality since Breen's case[115]. In that case, the High Court of Australia concluded that there is no right recognised by the common law requiring a health practitioner to grant a patient access to his or her health record.

While there has been considerable activity in enacting legislation in this regard in some jurisdictions (most notably the ACT, with the introduction of the Health Records (Privacy and Access) Act), and recommendations for a more comprehensive review in NSW (see the recommendations of the Final Report of the Review of the Health Care Complaints Act), most submissions to this review did not support access to records provisions in the Dentists Act.

The Department is also of the view that the access issue is of equal importance to persons using the services of unregistered practitioners. As such, the question should be considered as a separate issue relevant to all professional groups, both registered and unregistered. Further, with increasing reliance on storage and

transmission of records via electronic means, it is arguable that the issue would be best approached from a federal level. In this regard, it should be noted that in April 2000, the Federal Government introduced the Privacy Amendment (Private Sector) Bill 2000 into the Commonwealth Parliament. This legislation applies to private organisations and individuals including health professionals. If passed, it will provide patients with a right to access health records held by private practitioners, except in circumstances where access would pose a serious threat to the life or health of any individual. The Review therefore considers that any further development in this area should occur in the context of considering the provisions of this legislation.

8.2 Mandatory Disclosure of Fees

The question of whether professionals should be obliged under health professional registration legislation to notify their patients of the fees charged for professional services has been raised in the course of each health professional act review.

The submissions received in the Review of the Dentists Act on this point were very mixed. Those made by or on behalf of health professionals generally argued that while as a matter of "good practice" dentists should provide full disclosure of fees, such a requirement should not be included in legislation, or if it were, would be difficult to enforce.

By contrast, the Health Care Complaints Commission submitted:

> *…a practitioner should provide as much information to the patient as is possible. That information and advice should include all options … and an estimate of all costs associated with the proposed treatment.*[116]

This was also reflected in the submission of the NSW Health Funds Association, which concluded that such disclosure, prior to commencing treatment, was in the public interest.[117].

The Department supports the concept of practitioners providing information to patients on the cost of any proposed care. At the same time however, it is appreciated that there may be practical difficulties with enforcing a duty to provide full fee disclosure to patients prior to the commencement of treatment and that this is not the only strategy for achieving the desired outcome. The Department therefore proposes to make no recommendation on this issue.

8.3 Requirement to have Professional Indemnity Insurance

Section 67(2)(l) of the Dentists Act currently allows regulations to be made in relation to the "civil liability" of dentists and incorporated dental practices, specifically :

(i) requiring dentists and incorporated practices to effect professional indemnity insurance or other insurance or indemnity arrangements;

(ii) specifying the insurers or indemnifiers with whom the insurance or indemnity arrangements are to be effected

(iii) specifying the nature and extent of the insurance or indemnity arrangements and other matters relating to the insurance or indemnity arrangements; and

(iv) *requiring the provision of information as to the insurance or indemnity arrangements effected;*

At present, no regulation has been made under this power. As noted in the Issues Paper, in 1997 the Australian Dental Association indicated they were of the view that dentists should be required, as a precondition of registration, to obtain such cover. While only a few submissions addressed this question, most of those that did[118] were supportive of such a requirement. The Dental Board of NSW was an exception in this regard, raising concerns not so much with the concept, as the difficulty in administering such a system.

As noted in the Issues Paper, the Department of Health, in conjunction with the Attorney-General's Department, is currently considering a range of issues concerning indemnity issues for all health professions. It is proposed to leave detailed consideration of professional indemnity insurance until such time as this process concludes.

8.4 Use of Titles

Section 55 of the Dentists Act prevents a dentist using *any* title in relation to his or her practice of dentistry unless that title has been approved by the Board for entry into the register under section 12(1)(e). This provision grants the Board very broad discretionary powers over the use of both practice related and non-practice related titles.

8.4.1 Use of "non-dental" titles

At present, the Board exercises its discretion to prevent dentists using qualifications not directly related to the practice of dentistry. In its submission to this Review, the Board also indicated that it considered this policy should be retained in legislation, as the titles have no relationship to the practice of dentistry.

In other health professional act reviews where this issue has arisen, the Department has tended to recommend the removal of limitations on the use of non-practice related titles, on the basis that practitioners should be able to communicate to patients other information which may be relevant to treatment choices[119]. The Issues Paper on the Dentists Act also referred to the public benefit that would flow from consumers having increased information about treatment.

Most submissions received by the Review were either silent on the issue, or indicated the current restrictions on non-dental qualifications should be retained. The rationale behind these submissions was based on the limited relevance such

titles and descriptions would have to consumers seeking dental services. Dentistry is a narrowly focussed area of health practice, and there are few if any titles or descriptions (outside certain specialist titles dealt with at para 8.4.2 below) which can be said to provide information relevant to consumers in making treatment choices. Indeed, it may be further argued that allowing such information to be used could create false understanding or expectations in consumers as to the relevance of the non-dental qualifications to their treatment, and as a result be misleading.

While this argument has merit, to the extent that a person seeks to use the non-dental titles in connection with dental practices, it does not support a blanket limitation on dentists being able to inform patients where they also provide a broader range of services. Indeed, the current terms of the relevant provision, section 12(1)(e) specifically refers to descriptions being used "in relation to himself or herself *as a dentist or the practice of dentistry* by the dentist". Clearly, as Recommendation 4 proposes changing the "practice of dentistry" restriction to a "core practice restriction", section 12(1)(e) will also need to be amended accordingly. However, given it's close linkage to providing dental services, it is proposed to otherwise retain the existing provisions as they are.

8.4.2 Use of specialist titles

The broad discretion noted at para 8.4 above also applies to the use of specialist titles, such as orthodontist, prosthodontist etc. In relation to these specialist titles, the Dental Board of NSW has policies (referred to in the Issues Paper) designed to ensure a consistent approach to recognition and use of specialist descriptions. As noted in the Issues Paper, this scheme effectively amounts to a de facto title regulation system, and thus can be subject to the same criticisms outlined in respect of title in Part 3.3.1 above**.** As noted there, such restrictions can only be justified if it can be demonstrated that limitations they represent are in the public interest.

All submissions received in response to the Review either supported, or were silent on the issue of specialist title. The strongest arguments in favour of the retention (and indeed strengthening) of the restrictions came from groups representing specialist dentists[120]. These submissions refer to the high standards set by the Dental Board in allowing the use of specialist titles as indicative of the substantial degree of skill and training which must be undertaken by dentists before they can use a specialist title. It was also argued that the title provides consumers with help in assessing competency and selecting appropriately qualified providers.

The Academy of Australian and New Zealand Prosthodontists stated :

> *Specialist title establishes an acceptable minimum standard of training at a higher level and results in the existence of a register of those qualified at this level and results in the existence of a register of those qualified at this level. The register is a public document, is easily accessible and has such is valuable to all interested parties such as patients, health care providers, government authorities, health funds, solicitors etc* [121]

The Australian Society of Orthodontists (NSW Branch) argued :

> *Dental Specialist Registers are not anti-competitive as they do not place barriers on trade. They do not prohibit a generalist from working in specialist fields … Specialist Registers do however allow all health care consumers to discriminate and thus make an informed choice as to the appropriate level of care required for their problem.*[122]

Given these submissions and the improved information flow to consumers from recognition of specialist titles, the Department considers that there is a public interest in retaining a means of limiting the use of specialist dental titles. It is important to recognise that, as noted by the Australian Society of Orthodontists, this is not a practice restriction. It does not in any way limit a generalist dentist from providing specialist services, or indeed prevent a person granted use of a specialist description from performing general dentistry.

Once it is accepted that there is a public interest in recognising specialist descriptions, the question arises as what is the most appropriate means of achieving this. Currently, the system operates through detailed administrative policies established by the Board under section 12(1)(e) of the Act. Several submissions[123] while supporting the current arrangements, suggested that the specialist description should be provided more formal protection under the Act. The Issues Paper also referred to the possibility of incorporating specialist descriptions into a Code.

In considering all the evidence however, the Department has concluded that the system currently in operation should be retained as is. In reaching this conclusion the Department has had regard to the evidence as to the current system, which is open, accountable and transparent, and also provides a degree of flexibility which would not be so readily available if the restrictions were applied in the legislation.

8.5 Dental Board of NSW

8.5.1 Composition of the Board

Section 8 of the Act provides that the Board consist of nine members and is constituted as follows:

- *five dentists elected by dentists in accordance with the regulations;*
- *a person nominated by the Faculty of Dentistry at the University of Sydney;*
- *a barrister or solicitor nominated by the Minister;*
- *a person nominated by the Minister, being an officer of the Department of Health, or an employee of a public health organisation under the Health Services Act 1997;*
- *a person nominated by the Minister as a representative of consumers.*

The Issues Paper sought submissions on whether the composition and/or size of the Board should be changed. Responses to the Issues Paper varied on this point,

largely concentrating on whether there should be more representation from related or allied professions or other organisations with an interest in the area[124]. After considering these submissions, the Department is proposing the following changes to Board membership:

Academic Membership: It remains important that the Board have access to the special expertise and experience which an academic member can provide, and to ensure links are maintained with institutions responsible for the training of dentists. As suggested in the Issues Paper however, it is considered that the naming of a specific institution undermines the potential for new courses to be developed and offered. As such, the Department has concluded that it would be more appropriate for the Act to refer to a person appointed from nominees of institutions "involved in the training and education of persons to qualify as dentists".

Community Membership : The Act provides for one member to represent the interests of the community. In its submission on the Review[125] the Health Care Complaints Commission submitted that up to a third of board members should represent consumer interests. The Department recognises the importance of adequate consumer participation, and therefore proposes that the membership of the Board be increased to provide for an additional community member.

Professional Membership: One issue which has arisen during the development of the Report relates to the current workload of the Dental Board, and particularly the range of activities and committees requiring the advice of the registered dentist members of the Board. In discussions with the Board, a proposal was raised with the Review to increase the dental professional membership of the Board from 5 to 6, to ensure there is sufficient professional expertise available to the Board to fulfil all these activities. It is therefore proposed to provide for an additional member drawn from the dental profession, to be nominated by the Minister.

Part Four of this Paper discussed the current restrictions imposed on the practice of dental therapists and dental hygienists. The recommendations made there clearly have a flow on effect to the role of the Board, and hence the proposed membership of the Board. The Department therefore proposes to provide for an additional member to be a dental auxiliary, ie either a dental hygienist or dental therapist.

RECOMMENDATION 31 : MEMBERSHIP OF BOARD

THE COMPOSITION OF THE CURRENT BOARD'S MEMBERSHIP SHOULD BE ALTERED :

- SO THAT PROVISIONS RELATING TO THE APPOINTMENT OF AN ACADEMIC MEMBER REFER TO PERSONS INVOLVED IN THE TRAINING AND EDUCATION OF PERSONS TO QUALIFY AS DENTISTS RATHER THAN A SPECIFIC INSTITUTION;
- TO PROVIDE FOR AN ADDITIONAL COMMUNITY MEMBER;

- TO PROVIDE FOR AN ADDITIONAL DENTAL PROFESSION MEMBER, NOMINATED BY THE MINISTER
- TO PROVIDE FOR ADDITIONAL MEMBER DRAWN FROM THE DENTAL HYGIENIST OR DENTAL THERAPY PROFESSION

8.5.2 Tenure of Board Members

Under clause 3 of Schedule 1 to the Dentists Act, members of the NSW Dental Board are appointed for a period of 4 years, and are eligible for re-appointment. There is no limit on the number of terms a member can serve, creating a potential for extremely long term membership. The Issues Paper contrasted this situation with that under the Medical Practice Act 1992, where a limit of three consecutive terms is established. As noted in the Issues Paper, the draft template for health professional legislation in Western Australia provides that Board members are limited to serving two terms of four years each.

The majority of the submissions received in response to the Issues Paper supported the establishment of some limit to the number of consecutive terms each Board member can serve. The main concerns raised were to ensure that such limitations would not undermine the expertise developed by sitting board members, which is seen as a valuable asset in the continued smooth functioning of the Boards.

The Department considers that by limiting the number of consecutive terms of office to a total of twelve years, with each term not to exceed four years, a board's ability to benefit from the fresh perspectives of new members would be enhanced but at the same time provide sufficient scope for the retention of the corporate memory of the organisation. This conclusion reflects the results of other NSW other health professional act reviews[126].

RECOMMENDATION 32 : TENURE OF BOARD MEMBERS

THE CURRENT PROVISIONS ON TERMS OF APPOINTMENT OF BOARD MEMBERS BE AMENDED TO LIMIT THE NUMBER OF CONSECUTIVE TERMS EACH BOARD MEMBER CAN SERVE TO NO MORE THAT THREE TERMS OF FOUR YEARS EACH

Appendix A : Terms of Reference of the Review of the Dentists Act 1989

1. The Terms of Reference for the review are in accordance with the terms for legislative review set out in the Competition Principles Agreement. The guiding principles of the review are that legislation should not restrict competition unless it can be demonstrated that:

   (i) the benefits of the restriction to the community as a whole outweigh the costs; and

   (ii) the objectives of the legislation can only be achieved by restricting competition.

2. Without limiting the scope of the review, the Department shall:

   (i) clarify the objectives of the legislation and their continuing appropriateness;

   (ii) identify the nature of the restrictions on competition;

   (iii) analyse the effect of the identified restrictions on competition on the economy generally;

   (iv) assess and balance the costs and benefits of the restrictions; and

   (v) consider alternative means for achieving the same results including non legislative approaches.

3. When considering the matters in (2), the review should also identify and consider potential problems for consumers seeking to use dental services (that is, market failure), which need to be or are being addressed by the legislation.

4. In addition to considering the matters identified above, the Department will consider:

   (i) the effectiveness of the current Act, in particular registration requirements and disciplinary arrangements; and

   (ii) consistency with the Health Care Complaints Act 1993.

5. The review shall consider and take account of relevant regulatory schemes in other Australian jurisdictions, and any recent reforms or reform proposals, including those relating to competition policy in those jurisdictions.

6. The review shall consult with and take submissions from the profession, relevant industry groups, Government and consumers.

Appendix B : List of Submissions

1.	Private Submission
2.	Fairfield Dental Clinic (South Western Sydney Area Health Service)
3	Dental Hygienists Association (NSW Branch)
4	Southern Cross University Students Representative Council
5	Dr Ken Marshall
6	The Dental Therapists Organisation (including a later supplementary submission)
7	Australian Health Management Group
8	Academy of Australian and New Zealand Prosthodontists
9	Australian Society of Orthodontists (NSW Branch) (including a later supplementary submission)
10	NSW Dental Therapists Association (including a later supplementary submission)
11	Ms Bethia Jocelyn Bowers
12	Health Contribution Fund of Australia (HCF)
13	Continuing Education Committee of the Faculty of Dentistry, University of Sydney
14	Dental Board of NSW
15	Chris Strong
16	Australian Dental Association (NSW Branch)
17	Dr John S Smyth
18	NSW Health Funds Association
19	Oral Health Branch of the Department of Health
20	David Walker
21	Health Care Complaints Commission
22	Dr Peter Etcell, Dr David Jones and Dr David Moffet (joint submission)
23	NSW Council of Social Services (NCOSS)
24	Dr A. A. Mills
25	Associate Professor James K Hawkins

Appendix C : Conditions on Dental Therapists and Dental Hygienists

(Part 5, Dentists (General) Regulation 1996)

17. **Dental therapists**

(1) For the purposes of section 57 (4) (c) and (e) of the Act, a person with prescribed training is a person:

(a) who has successfully completed the course of training for dental therapists provided by the Department, or

(b) who has such other qualifications as are recommended by the Chief Dental Officer of the Department and approved by the Board for the purposes of this clause.

(2) For the purposes of section 57 (4) (c) and (e) of the Act, the parts of the practice of dentistry that may be performed by dental therapists are the following:

(a) the dental examination of preschool and school children,

(b) the cleaning and polishing of teeth and restorations,

(c) the topical application to teeth of sealants, medicaments and preventive coatings,

(d) the removal of dental calculus not involving surgical techniques requiring incisions,

(e) the application of topical anaesthetics,

(f) the giving of supraperiosteal or mandibular nerve block injections of local anaesthetics not involving, in either case, any other regional, intra-osseous or intra-ligamental anaesthesia,

(g) the extraction of deciduous or permanent teeth not involving either surgical techniques or incisions,

(h) the pulp capping of deciduous or permanent teeth and the pulpotomy of deciduous teeth,

(i) the restoration of deciduous or permanent teeth by the use of materials other than cast metals, gold foil or porcelain,

(j) intra-oral radiography,

(k) the taking of impressions, at the written request of a dentist, for use in study models, mouthguards and removable orthodontic appliances,

(l) dental health education

(m) dietary counselling for dental purposes.

(3) For the purposes of section 57 (4) (e) of the Act, a health service controlled by an aboriginal community is a prescribed institution.

18. Treatment by dental therapists

(3) A dental therapist may perform those parts of the practice of dentistry referred to in clause 17 only under the supervision of the Chief Dental Officer of the Department or a dentist authorised by the Chief Dental Officer to supervise treatment by dental therapists.

(4) It is sufficient compliance with this clause if the Chief Dental Officer or any other dentist authorised under subclause (1):

(c) would be available, within a reasonable time, to assist the dental therapist if assistance were required, and

(d) is aware that he or she may be called on to provide such assistance.

19. Dental Hygienists

(1) For the purposes of section 57 (4) (f) of the Act, a person with prescribed training is a person:

(a) who has undertaken a course of studies in dental hygiene approved by the Board for the purposes of this clause, or

(b) who has successfully completed an examination in dental hygiene approved by the Board for the purposes of this clause.

(2) For the purposes of section 57 (4) (f) of the Act, the parts of the practice of dentistry that may be performed by a dental hygienist are the following:

(a) pre-operative and post-operative instruction,

(b) the irrigation of the mouth,

(c) the insertion and removal of surgical packs,

(d) the application and removal of rubber dam,

(e) the polishing of restorations,

(f) simple prophylaxis,

(g) the topical application of coatings, sealants, fluoride solutions and preventive medicaments,

(h) the scaling of supra-gingival and sub-gingival calculus deposits from the teeth,

(i) root planing,

(j) the removal of sutures,

(k) the selection of orthodontic bands,

(l) the removal of orthodontic archwires, bands and attachments,

(m) intra-oral radiography,

(n) the taking of simple impressions for study casts,

(o) the recording of periodontal disease, - dental health education,

(p) dietary counselling for dental purposes.

20. Treatment by dental hygienists

(1) A dental hygienist may perform those parts of the practice of dentistry referred to in clause 19 only if:

(a) the treatment to be carried out does not involve the cutting of oral or dental tissue, and

(b) the treatment to be carried out by the dental hygienist is in accordance with a written treatment plan prepared by a supervising dentist, and

(c) the requirements of subclause (2) or (3), as appropriate, are complied with.

(2) A dental hygienist other than a dental hygienist employed under the direction, control and supervision of the Chief Dental Officer of the Department must be supervised by a dentist:

(a) who is on the premises at the time at which the treatment is carried out, and

(b) who would be available, within a reasonable time, to assist the dental hygienist if assistance were required, and

(c) who is aware that he or she may be called on to provide such assistance.

(3) A dental hygienist employed under the direction, control and supervision of the Chief Dental Officer of the Department must be supervised by the Chief Dental Officer or a dentist authorised by the Chief Dental Officer to supervise treatment by dental hygienists.

(4) It is sufficient compliance with subclause (3) if the Chief Dental Officer or any other dentist authorised under that subclause:

(a) is on the premises at the time at which the treatment is carried out, and

(b) would be available, within a reasonable time, to assist the dental hygienist if assistance were required, and

(c) is aware that he or she may be called on to provide such assistance.

Appendix D : Changes to misconduct definitions

Section	***Content***	***Change***
5(a)	any conduct that demonstrates a lack of adequate knowledge experience skill, judgment or care by the dentist in the practice of dentistry; and	Retain;
5(b)	the dentist's contravening (whether by act or omission) a provision of this Act or the regulations; and	Retain. This provision will also cover any breaches of the advertising provisions or misuse of specialist titles;
5(c)	practising dentistry contrary to a requirement made of, or condition imposed on, the dentist under section 15(1)(e), 18(1) or 21(2); and	Retain and expand to read "failure to comply with an order or determination of the Board, or with a condition of registration";
New section	failure to comply with a direction of the Board to provide information with respect to a complaint against the provider	This will assist the Board in dealing with complaints;
5(d)	carrying on the practice of dentistry under a name other than the dentists own name except where the name os that of the incorporated practice of which the dentist is a director, or while the dentist is acting as a duly appointed locum tenens of another dentist;	Delete;
5(e)	allowing the use of his or her name in connection with the practice of dentistry at premises at which he or she, or a duly appointed locum tenens, is not in regular attendance for the purposes of practice and supervision during the hours in which the premises are open for the practice of dentistry;	Delete;
5(f)	for fee, salary or other reward, being employed by or associating with, in carrying on the practice of dentistry, a person (within the meaning of subsection (4)) who is not a dentist.	Delete;
5(g)	Being a habitual drunkard or being addicted to any deleterious drug	Delete. More appropriate as a grounds of complaint
NEW	any other improper or unethical conduct relating to the practice of dentistry.	To be added

ENDNOTES

[1] Dental Board of NSW, Annual Report for year ending 30 September 1999, page 4.

[2] while it is difficult to obtain data in this area to enable the calculation of reliable figures, this estimate is based on data collected by the Australian Bureau of Statistics *"National Health Survey : Summary of Results"*, Cat No. 4376, (1995) and the 1996 schedule of fees issued by Australian Dental Association (note however, that the ADA no longer produces fee schedules for reference by members)

[3] Dental technicians construct dentures, crowns and orthodontic appliances using specifications obtained by a dentist or dental prosthetist. Dental Prosthetists are dental technicians who through additional training, are able to provide advice to patients and to fit, construct, insert and repair or renew dentures. As at 30 June 2000 there were 629 registered dental technicians and 390 registered dental prosthetists in NSW**;** NSW Dental Technicians Registration Board, Annual Report for The Year Ending 30 June 2000 page.5.

[4] while it is difficult to obtain reliable figures, these estimates are based on a figure of 71,000 consultations per annum [see Australian Bureau of Statistics, *"National Health Survey : Summary of Results"* Cat No.4376, (1995)] costed by reference to the schedule of fees referred to in note 2 above.

[5] Dental therapists conduct school dental clinics that provide basic dental services including fillings, basic extractions, and examinations. There are 180 dental therapists operating in NSW the value of the services they provide has been estimated at $4.6 million

[6] .As at September 1998, there were 159 dental hygienists enrolled by the Dental Board of NSW Correspondence from the Dental Board of NSW (16/04/1999), and in the financial year 1998-1999, the Board added an additional 22 persons to the dental hygienist list; Dental Board of NSW, Annual Report for year ending 30 September 1999, page 5.

[7] Clause 3 of Schedule 1 of the Dentists Act;

[8] Section 5 defines "professional misconduct as :

(*a) any conduct that demonstrates a lack of adequate knowledge experience skill, judgment or care by the dentist in the practice of dentistry; and*

(b) the dentist's contravening (whether by act or omission) a provision of this Act or the regulations; and

(c) practising dentistry contrary to a requirement made of, or condition imposed on, the dentist under section 15(1)(e), 18(1) or 21(2); and

(d) carrying on the practice of dentistry under a name other than the dentists own name except where the name os that of the incorporated practice of which the dentist is a director, or while the dentist is acting as a duly appointed locum tenens of another dentist; and

(e) allowing the use of his/her name in connection with the practice of dentistry at premises at which he or she, or a duly appointed locum tenens, is not in regular attendance for the purposes of practice and supervision during the hours in which the premises are open for the practice of dentistry; and

(f) for fee, salary or other reward, being employed by or associating with, in carrying on the practice of dentistry, a person (within the meaning of subsection (4)) who is not a dentist.

(g) being a habitual drunkard or being addicted to any deleterious drug

[9] Dental Board of NSW Information Bulletin (October 1997) page5

[10] . ibid; Dental Board of NSW : Record of Decisions 1988-1993 (ed) John Dale; Minister's Second Reading Speech on the Dentists Bill 1989 in the Legislative Assembly 2/8/1989, Parliamentary Debates (Hansard) pages 9149-9152.

[11] Under section 41, the Committee is to have regard to :

(i) the time occupied in performing and the nature of the dental treatment rendered;

(ii) the distance between the consulting room or residence of the dentist and the place at which the dentist rendered the dental treatment;

(iii) the hours of the day or night at which the dental treatment was rendered;

(iv) the degree of skill, knowledge or experience required or given in rendering the dental treatment;

(v) whether the dentist rendered the dental treatment in the capacity of specialist, consultant or dentist in ordinary practice;

(vi) what amount, if any, was paid by the dentist to any other person in respect of any dental prosthesis used in the dental treatment;

(vii) any other matter which appears relevant to the Committee.

[12] See section 10AB, Part 2A Public Health Act 1991.

[13] Submission from the Dental Board of NSW, page 1

[14] Submission from the Australian Dental Association (NSW Branch) page14

[15] For example, the Submission from the Dental Board of NSW

[16] based on the table set out at page23 Victorian Government, Discussion Paper on the Review of the Dentists Act 1972 and Dental Technicians Act 1972, (December 1997)

[17] See for example, the Submissions from the HCF, Dental Board of NSW, ADA, Health Funds Association,

[18] Submission from the Health Care Complaints Commission, page 5;

[19] Submission from the Australian Society of Orthodontics Submission, page 2;

[20] Submission from the Hospital Contribution Fund of Australia (HCF), page 4;

[21] Submission from the Dental Board of NSW, page 2;

[22] Submission from the Health Care Complaints Commission, page 5;

[23] See for example the submissions from the Dental Hygienists Association of Australia, Australian Society of Orthodontists, the Dental Board of NSW, the ADA (NSW Branch) and the NSW Health Funds Association

[24] Submission from the Australian Dental Association (NSW Branch) page 16

[25] Submission from the Dental Board of NSW, page 3

[26] Submission from the Dental Hygienists Association of Australia, page 7

[27] See Report on the Review of the Dentists Act 1972 and Dental Technicians Act 1972 Victorian Government, pages13-14

[28] As are the dental technicians and dental prosthetists, who have a title protection under the Dental Technicians Act 1978

[29] Report on the Review of the Dentists Act 1972 and Dental Technicians Act 1972 Victorian Government, page 14. This theme was also pursued in at least one submission (from Dr Peter Etcell, Dr David Jones and Dr David Moffet) which drew attention to the role of dental assistants, suggesting there were also a range of tasks these professionals could safely perform under the supervision of a dentist.

[30] *Radiation Guideline 6 : Registration requirements and industry best practice for ionising radiation apparatus used in diagnostic imaging; Part 3 – Dentistry (Including maxillofacial)* NSW Environmental Protection Authority, August 1999.

[31] Clause 22 states :
(1) A dentist must not carry out any procedure forming part of the practice of dentistry on a patient to whom a general anaesthetic has been administered unless the general anaesthetic has been administered by a registered medical practitioner who:

(a) is a specialist in anaesthesia, or
(b) is accredited for the purposes of administering any general anaesthetic at a public or private hospital where surgery may lawfully be carried out.

Maximum penalty: 5 penalty units.
(2) A dentist must not administer simple sedation by the intravenous route unless the dentist:

(a) has received appropriate training in techniques of intravenous sedation and resuscitation, as approved by the Board, and
(b) is assisted by another person who is either:
(i) a registered nurse (within the meaning of the Nurses Act 1991) who has received training in intensive care or anaesthesia, or
(ii) a dentist.

Maximum penalty: 5 penalty units.

(3) In this clause

general anaesthetic means any drug or substance which when administered to a patient will render the patient:
(a) unaware of the patient's surroundings, and
(b) unable to retain reflex control of the airway, and
(c) incapable of understanding and obeying a spoken command.

simple sedation means a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, and in which:
(a) verbal contact with the patient is maintained throughout the period of sedation, and (b) the drugs and techniques used have a margin of safety wide enough to render unintended loss of consciousness unlikely.

[32] see the definition of "invasive procedures" as per clause 1 of Schedule 2 to the Dentists (General) Regulation 1996

[33] page 1, *Recommended Infection Control Practices for Dentistry,* CDC (Centre for Disease Control), May 28, 1993/42(RR-8.

[34] CDC, *"Update : investigations of patients who have been treated by HIV-infected health-care workers* MMWR 1992;41:344-6; Siew C, Chang B, Gruninger SE, Verrusio AC, Neidle EA. *"Self-reported percutaneous injuries in dentists : implications for HBV, HIV transmission risk"* J Am Dent Assoc 1992;123:37-44; Ahtone J, Goodman RA. *"Hepatitis B and dental personnel: transmission to patients and prevention issues"* J Am Dent Assoc 1983;106:219-22.

[35] details of these incidents are referenced in *Recommended Infection Control Practices for Dentistry,* CDC (Centre for Disease Control), May 28, 1993/42(RR-8).

[36] CDC. *Investigations of patients who have been treated by HIV-infected health-care workers – United States* MMWR 1987;36:132-3

[37] ibid;

[38] currently reflected in the *Infection Control Policy*, NSW Department of Health Circular 99/87

[39] Budtz-Jorgensen & Evjind *"Epidemiology: Dental and Prosthetic status of older adults"*, pages 1-18 Textbook of Prosthodontics for the Elderly. Diagnosis and Treatment" Lori Bateman (ed), Quintessence Publishing Co, Inc. Illinios, 1999

[40] Katz RV, Neely AL, & Morse DE *"The epidemiology of oral diseases in older adults"*, pp 263-301 in Textbook of Geriatric Dentistry. (2nd Ed), Holm-Pedersen, P.& Loe H (eds), Copenhagen. Munksgaard, 1996.

[41] Seymour R, *"Dental pharmacology problems for the elderly"* pp 42-50, in Textbook of Gerodontology, Barnes I & Walls A (eds) Cambus Litho Ltd, Glasgow, 1994.

[42] Submission from the HCF, page 6

[43] Submission of the Dental Board of NSW, pages 5-6

[44] Submission from Dr Ken Marshall, Orthodontist, page 2

[45] Submission from the Dental Therapists Organisation, page 7

[46] Submission from Dental Therapists Organisation (Supplementary), page 2

[47] Both in it's initial and supplementary submissions, which included copies of submissions made on dental therapy to the Victorian and Queensland legislation reviews.

[48] Submission from the Victorian Dental Therapists Association, page xi

[49] Submission from Dental Therapists Organisation (Supplementary), page 2

[50] A point noted by the Submission of the NSW Council of Social Services (NCOSS), at page 1.

[51] ibid

[52] Submission from Dental Therapists Organisation (Supplementary), page 3.

[53] "The changing role of dental auxiliaries : a literature review" Baltutis L, Morgan M, Aust Dent J 1998;43: (5) 354, refering to Spencer AJ, Brennan DS, Szuster FS. Changing provision of restorative services in Australia J Dent 1994;22:136-40 and Johnson PM. Dental hygiene practice : international profile and future directions. Int Dent J 1992;42:451-9

[54] Submission of the NSW Council of Social Services (NCOSS), page 2, quoting the Senate Community Affairs Reference Committee, *Report on public dental services,* May 1998

[55] Submission from the Australian Dental Association (NSW Branch), p18

[56] In 1998 the University of Queensland introduced a Bachelor of Oral Health, in Victoria training is through the Diploma of Oral Health Therapy, a 2 year course run by the University of Melbourne.

[57] in addition, the submission from NCOSS argued for removal of restrictions page3

[58] Submission from the NSW Dental Therapists Association, page 10

[59] ibid

[60] Submission of the NSW Council of Social Services (NCOSS), page 3

[61] See, for example, the submissions from the HCF, the Dental Board of NSW, and the Australian Dental Association (NSW Branch)

[62] Submission from the Dental Hygienists Association, page 11

[63] Submission from the Australian Society of Orthodontists (NSW Branch) page 4

[64] Submission from the NSW Health Funds Association, page 5

[65] id, page 11

[66] Submission from the NSW Dental Therapists Association, page 10

[67] Supplementary Submission from the NSW Dental Therapists Association,page 4

[68] id., page 6

[69] id., page 4

[70] Submission from the Dental Therapists Organisation, page 5

[71] id., page 1

[72] Submission of the NSW Council of Social Services (NCOSS), page 3

[73] Submission from the Australian Dental Association (NSW Branch), pages 17-18.

[74] Submission from the Australian Society of Orthodontists (NSW Branch), page 5.

[75] Submission from Dr A. A. Mills, p 9.

[76] Submission from the HCF, page 3; the NSW Health Funds Association echoed this view, stating that the "scope of practice of dental therapists requires retention of supervision in the public interest, (submission from the NSW Health Funds Association page 5).

[77] Final Report of Vic Review , page 23

[78] See clauses 20(3) and (4), Dentists (General) Regulation 1996

[79] Issues Paper at page 31

[80] Submission from the Health Care Complaints Commission, page 7, quoting Mahoney JA in *Bannister v Walton* (NSW SC/CA, unreported, 30/4/1992)

[81] Other than those registered in New Zealand, who can obtain automatic registration via the Trans-Tasman Mutual Recognition Agreement.

[82] Child Protection (Prohibited Employment) Act 1998

[83] Submission from the HCF, page 7.

[84] At the time of going to print, this includes the Psychologists Bill 2000

[85] Submission from the Australian Dental Association (NSW Branch) page 20

[86] Submission from the Continuing Education Committee of the Faculty of Dentistry, University of Sydney page1

[87] Submission from the Health Care Complaints Commission, page 10

[88] Review of the Medical Practice Act, Issues Paper, September 1998, pages 39-41

[89] Review of the Medical Practice Act, Final Report, December 1998, page 29

[90] Submission from the Health Care Complaints Commission, page 10

[91] See for example, the submissions from the Australian Dental Association (NSW Branch), and the HCF

[92] the Submission from the Health Care Complaints Commission at page 10-11, being a notable exception

[93] For details of this case, see the summary at page 39 of the Issues Paper

[94] 1998 Report of the Ministerial Committee of Inquiry into Impotency Treatment Services in NSW, page 18

[95] Information provided by Dental Board, 9 November 2000, showed the following breakdown:

Organisation	Location of clinic	initial approval
Hospital Contribution Fund (6)	Sydney CBD Parramatta Hurstville Chatswood Bankstown Hills District Bondi Junction*	September 1988 October 1995 June 1996 December 1996 July 1997 July 1997 November 1999
Australian Health Management Group [formerly Government Employees Health Fund] (3)	Sydney CBD Wagga Wagga Parramatta	May 1983 September 1985 October 1991
NIB Health Fund (2)	Newcastle Sydney CBD*	August 1996 August 1996
Western District Health Fund (2)	Lithgow Penrith*	October 1988 August 1998
Broken Hill Mines Dental Clinic (1)	Broken Hill	July 1986
UNESA Dental Clinic Armidale (1) Southern Cross University [formerly University of New England] (1)	Armidale Armidale	July 1976 May 1993

* approval granted, but clinic not yet operational

[96] Court of Appeal, Supreme Court of NSW (Unreported) 30 May 1996

[97] Issues Paper, page 42

[98] see, for example, the Medical Practice Regulation 1998 and the Dental Technicians Registration Regulation 1998

[99] Indeed, the ADA has discontinued producing a schedule of fees.

[100] As noted in the Issues Paper, DCAC is made up of three dentists and a consumer representative, and provides the Board with a mechanism through which complaints can be investigated and/or conciliated. Where a matter cannot be resolved by the DCAC with the consent of the parties involved or there are issues which DCAC considers should be brought to the attention of the Board, the Committee can refer

the matter back to the Board with a recommendation for action. The Board receives around 80 complaints a year, and about 80% of these are referred to the DCAC for consideration

[101] The submissions from the HCF and NSW Health Funds Association

[102] Submission from the HCF, page 10

[103] As at 30 June 1999 there were approximately 20,000 medical practitioners in NSW, and 90,000 nurses,

[104] See, for example, the Psychologists Bill 2000

[105] Although it is likely that the principles of natural justice would intervene in the latter case, and require a registrant facing removal or suspension from the register to be entitled to be heard and supported by legal representation.

[106] . ibid; Dental Board of NSW : Record of Decisions 1988-1993 (ed) John Dale; Minister's Second Reading Speech on the Dentists Bill 1989 in the Legislative Assembly 2/8/1989, Parliamentary Debates (Hansard) pages 9149-9152.

[107] Submission from the NSW Dental Board, page 9

[108] *Final Report* Review of the Health Care Complaints Act, December 1997, page 33-34

[109] Support for this proposal came from a number of submissions, including that of the NSW Dental Board, and a private submission from Associate Professor Hawkins

[110] Submission from the Health Care Complaints Commission, page 17

[111] id, at page 20

[112] Submission from the Australian Dental Association, page 26

[113] Submission from the NSW Dental Board, page 11

[114] Submission of the NSW Dental Therapists Association, page 14

[115] *Breen v Williams* (1996) 70 AJJR 772

[116] Submission from the Health Care Complaints Commission, page 21

[117] Submission of the NSW Health Funds Association page10

[118] See Submissions from the Australian Dental Association (NSW Branch), Oral Health Branch of the Department of Health, and that of the Health Funds Association

[119] see for example, Report of the Review of the Chiropractors and Osteopaths Act at page 86.

[120] see in particular the submissions from the Academy of Australian and New Zealand Prosthodontists and the Australian Society of Orthodontists

[121] Submission from the AUSt NZ Academy – page ??

[122] Orthodontists Sub, page ??

[123] cite – orthos and I think some private ones

[124] for example, the NSW Health Funds Association suggested that there should be a representative from a health fund on the Board, given their role in providing dental services to members.

[125] Submission from the Health Care Complaints Commission

[126] see for example, the provisions for Board appointments as set out in the Psychologists Bill 2000, currently before Parliament