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Sent via post & email

This submission was completed by: David Crum

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Making this survey on behalf of: NZDA Executive/Board/Association Members

Sector that submission survey represents Registered Dentists with membership (voluntary) being approximately 98% of practising dentists from private and public, generalist and specialist practice throughout New Zealand.

Dental Council Consultation on Recertification

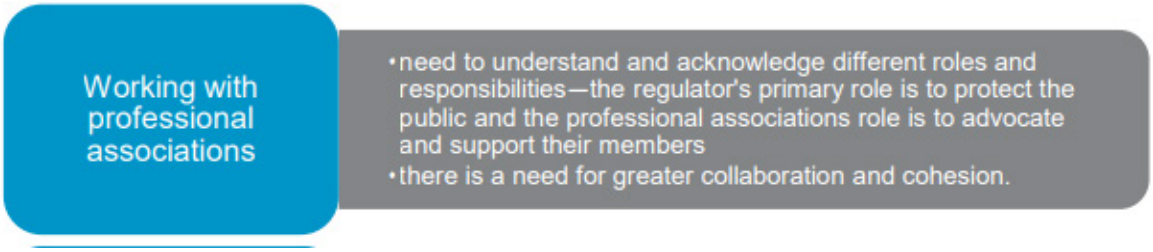
The Association thanks the Council for the opportunity to make a submission on Recertification.

General comments

The Association's view is summarised as:

1. Dental Council, particularly the staff who prepared the background documents and Council members who invested considerable time to make presentations throughout New Zealand are to be congratulated. Recertification is an area that is best explored through direct discussion and gradual idea development. The process to date is encouraging.
2. The 'survey' format for feedback is not well suited to a submission from NZDA – it is focussed on the individual. We have answered some of the feedback questionnaire (Attachment 1) but, in the interests of more fully and productively providing feedback, opinion and constructive ideas we provide this written submission and encourage Council members to give it their consideration.
3. There is a clear lack of a unified or proven singular direction regarding what form (if any) of recertification produces demonstrable beneficial outcomes for patients.
4. A pragmatic cautious approach and incremental change, based on evidence, is required.

5. The comprehensive and detailed material presented by the Council, contained conclusions (actual and implied) that are not supported by robust data or evidence. We can discuss this further if Council believes that is useful.
6. Recertification is a system to ascertain compliance and confirm practitioners are competent to practice. Compliance and competence are two different things and it is difficult to keep equal emphasis on both within the discussion.
7. The philosophy of being a 'right-touch risk-based regulator' is a good one if the Council follows through on the philosophy of 'response proportionate to the risk or problem' and having a 'transparent and user-friendly system, which is fairly and consistently implemented'. We would add, this needs to be 'fiscally responsible' and as such there are significant limitations as to the depth and breadth of process achievable with any programme. There is a clear need to be pragmatic regarding limitations and significant focus on utilising limited resource where most needed and productive. That is the reality.
8. 'Wholesale' or significant immediate change in the current system of recertification is not required, desirable or indicated by the material presented or discussion to date.
9. The Association believes the following statement from within the documents is an insufficient, poor and misinterpreted representation our Association's role.



The Association has over one hundred years of managing the dual aspects of practitioner welfare and protection of the public (weal). The Association has a long history of patient welfare and protection and manages both roles with the application of considerable resource and expertise and, a high degree of success.

10. Therefore, it is important to realise the Association's purpose is not distant from the Dental Council's role:
    - Whilst Council is mandated with the purpose of 'protecting the public', the Association's mission is to promote the art and science of dentistry and this is inclusive of promoting oral health and 'good' dentistry for the benefit of our patients, the public. (*NZDA – for the common good since 1905 – To Represent, Advance, Inform and Support*). Therefore, it is central and important to realise, believe and acknowledge that, in this sense, the Association and the Council both move through this discussion with the aim of developing effective recertification process because we have similar desired, patient centred, outcomes.
    - Such acknowledgement and understanding by Dental Council will assist in improving the 'greater collaboration and cohesion' that they (and the Association) desire.
11. We can present and participate fully in partnership with the Council (if allowed) to place Council in a stronger position to improve recertification in a evidenced based constructive manner. We have information and expertise from which the Council could benefit; some ideas are outlined below.

The Association's positive value set – its relevance to better recertification outcomes.

The Association's active emphasis may be different to that of the Council in terms that our first position is of promoting positive values, rather than emphasis on rules and regulation, compliance and recertification.

Our view is based on our professional 'being' and our interactions with our patients. We know at each and every practitioner / patient interaction that Trust is, and will always be, at the centre of an effective healthcare delivery by a practitioner and that you cannot regulate TRUST.

Within the discussion of recertification (and any revised recertification process) we request the Dental Council gives active and full consideration to supporting our emphasis on promoting positive values and our provision of membership services that enhance these values including:

- Recent graduate programme, the Mentorship Programme (now with 208 participants, the largest in New Zealand), nationwide multiple complaint resolution services, the NZDA/ DPL Scheme of Cooperation (complaint resolution, free counselling support services), provision of a huge array of continuing professional development activities, the Benevolent fund and its support role, peer and collegial activities locally and nationally, considerable funding to allow a participation of members in volunteer work, provision of oral health promotion, free dental care and research and, most recently, the NZDA Wellness Initiative.

The Association requests further discussion with Council regarding means by which Council could assist in placing participation in the above listed Association programmes and activities as integral components to better, more proactive and positive engagement by practitioners with the recertification process.

In essence, we are hoping that when developing thoughts around the need for a revised recertification process, the Dental Council carefully considers the social contract practitioners have with patients and incorporates inclusion of participation in programmes that create and sustain the want to deliver our positive value set.

An example:

> We can anecdotally state the existence of, but cannot quantify the group of practitioners who within their value set:
>
> - have poor insight, 'over grown' feelings of entitlement, or who place the patients interests second to their own.
> - exhibit poor balance between the business and professional motives, whose focus is on being the 'best business' rather than 'best dentist' – '*all is well if business is going well*'.
>
> These are identifiable features and it is very questionable whether the HPCA Act and Dental Council have had any impact on these practitioners, because the deficiency is within their value set and not directly amenable to rules or regulations. Again, this presents an argument for the Council becoming more actively supportive of the Association's positive value set and engaging in partnership with us on these value concepts.

Data and better engagement

Within the documents distributed there was helpful disclosure of data held by the Dental Council.

It is the Associations view that:

1. Dental Council is considering development of a risk pyramid / matrix model but has not demonstrated sufficient detailed data to allow the development of a robust, reliable model.
2. Natural justice requires that robust evidence supports any system that profiles and targets practitioners.
3. We believe Council is deficient in data collection and that is a significant problem. We agree recertification should include risk targeting and adding more support to at-risk groups. (Again it is the Association's view that effective recertification outcomes are not just about measuring compliance but about strongly encouraging activities that support the positive value set). We cannot think of a legitimate way to build a risk pyramid / matrix, at this time, without compelling evidence.
4. In essence, the data presented is 'notifications' and do not disclose the concluded position of those notifications. Notifications in themselves are a poor measure and the evidence is not robust. A 'notification' does not, in every instance, equal a significant compliance or competence issue. Additionally, the number of notifications to Council (123 dentist notifications in 12 years) is extremely low, particularly when compared to the 50 million plus dental visits during the period.
5. It could be concluded that the Dental Council has not presented any compelling evidence that there is a problem with the existing competence levels and performance of practitioners or the recertification system. In fact, it could be argued the data and evidence presented suggests that currently there are absolutely minimal competence issues within the profession. Alternatively, the extremely low notification rate could be related to a perceived lack of need or desire for practitioners / public to seek engagement with Council. The above is not a criticism, just that collectively we do not know – the data is not substantive, robust, or particularly useful.
6. Within the NZDA/ DPL work exists much greater information regarding patient / dentist issues than that presented by Council and we have staff with (in our view) extensive experience in patient / practitioner interactions, complaints and issues.
7. It would be beneficial for the Council to engage positively with the Association in a project to ascertain what information should be collected over time, so that jointly we can develop a better risk pyramid/matrix to explain the types and levels of risk and corresponding regulatory responses.
8. Dental Council should reconsider / re-interpret its policy of not allowing NZDA staff to be placed on Dental Council working groups and actively engage with our DPL / NZDA staff and others in a project regarding appropriate and useful data design and collection.
9. Given the current level of data Dental Council has presented, the constructive and useful direction required, is to fully explore and determine what data we could have in (say) 10 years' time.

The following (examples only) are provided to support the need for better data;

1. There is a changing demographic and significant emerging diversity of registrants within our profession. Whilst the data presented is very limited and of questionable robustness, what was presented has suggested there is a much higher (perhaps multiples higher) notification rate with respect to overseas trained dentists, and that this appears even higher in the NZDREX registration cohort. We do raise the concern, as we have in the past, as to whether a single-point-in-time (NZDREX) assessment can adequately gauge a dentist's competence, and whether that assessment can truly be correlated to the statement - NZDREX accurately determines equivalence to the competence and knowledge of a graduating Otago student (whose

assessment for registration = graduation from a continual 4-year assessment at Dental School). The reason we raise this is that there could well be the need to amend the registration process to consider provisional registration followed by particular requirements e.g. ongoing assessment and most importantly formalised support during transition to New Zealand practise. Again, we stress the importance of needing robust data prior to travelling such a path, but if that data is substantiated then participation in support 'programmes' could become a productive part of a revised recertification programme.

2. Given the almost 100% pass rate within the Otago BDS course we would suggest that consideration be given, over time, to better data collection and cross correlating 'notifications' with previous individual performance profiles whilst at dental school. Anecdotally, there is the view that there are students graduating who simply may be long term difficult prospects for the Dental Council in terms of recertification. It may be constructive for Dental Council to explore this collaboratively with the Faculty.

3. There is information (but is it robust?) in the background documents supporting the position that the clear majority of dentists exceed or sit at the acceptable standard and that those who hover around the margin, do so in a way that creates low risk infringements of patient safety. David Crum has stated (20 years of DPL / NZDA work) it is his view and experience that in fact individual practitioners do not complete their lifecycle of practice with a uniformity of competence throughout the journey. Periods of Illness, alcohol dependency, relationship breakdown (marriage in particular), financial pressures, work conflict, family issues, bereavements - can and in his reported view reasonably often, alter interest in and ability to maintain levels of competent care for various periods of time. Exploring these aspects and assisting to support practitioners is fundamental. Performance and how this is affected by distractors or poor value sets leading to poor treatment decisions and patient outcomes, mean a practitioner may well pass competency assessments and yet perform poorly day to day. Poor performance is probably a greater risk to patient safety than incompetence.
   Again, as initiatives develop out of the Association's Wellness programme there may be opportunity for Dental Council to incorporate aspects into requirements of a recertification programme.

Continuing professional development

The Association strongly supports CPD as an integral part of recertification because the:

- CPD and the collegiality derived from it are, in our view, a significant contributor to practitioner wellness and part of the foundation of protecting the public.
- environment and emphasis the Association has placed on providing CPD has assisted in creating a dozen years of newly graduated dentists who have entered an environment of CPD that is entirely different to previous generations.
- CPD interaction
    a. through and then after these initial 'transition to practice' programmes (mentorship and recent graduate programmes) that exposes individuals constantly to the value sets of others (especially other cohorts).
    b. maintains not just learning but collegiality.
    c. assists assimilating the large numbers of overseas-trained registrants entering our workforce.

All oral health practitioners

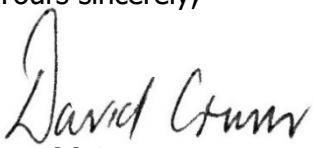
Our view is that recertification does not necessarily need to contain the same process or elements across all oral health practitioner groups. The various professions have different demographics, different risks, different scopes, different work environments. So, in our view we don't believe the Dental Council needs to have the same system for all groups. Some flexibility in this is probably desirable.

Regulatory complexity

The reality is, there are a huge range of dental practices and the huge variation in what is collectively described as the public and the diversity is growing. The regulatory complexity (DCNZ, Health and Safety, Employment law, ACC, staff checks) is getting ahead of what dentists can effectively do within the constraints of care delivery to a diverse public with an increasing array of expectations and needs, all of which is almost entirely provided within a small business environment.

With this regulation burden and complexity there is reason to support a continuation of some broad-brush recertification measures but, if additional measures are required then with diversity appreciated, carefully targeted interventions are required. Reliance on good evidence with respect to accurately determining risk groups and appropriate levels of targeted recertification interventions is fundamental to whatever revised system is enacted.

Yours sincerely,



David Crum
Chief Executive Officer
New Zealand Dental Association

Encl. *Additional Comments*