DENTAL COUNCIL
Te Kaunihera Tiaki Niho

December 2012

NEWS

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Message from the Chair – December 2012

Mark Goodhew, Dental Council Chair

Dental Council has experienced a year of considerable activity, with work continuing on potentially fundamental changes, alongside an increase in business-as-usual matters. There have also been two changes in Council membership. Bede Carran was replaced as a layperson by Dr David Stephens, and Neil Waddell as a technician by John Aarts. During Bede's two years on Council he provided significant expertise to Council's risk mitigation and financial reporting in particular; while Neil has been a valued member of Council since 2005. I wish them both all the best, thank them for their constructive input to Council's governance, and I am looking forward to working with David and John.

A detailed account of the continuing work towards a combined secretariat for all 16 health responsible authorities (RAs) is covered elsewhere in this newsletter but, in short, this has required a great deal of Council and staff energy to make progress, albeit slowly. One of the spin-offs from this work has been a physical move of Council offices to shared office space with five other RAs. This will provide advantages for all those RAs concerned but, for Dental Council, this move, almost contemporaneously with the governance changes reported last year, will result in measurable savings and an increase in efficiency.

Council provided a detailed and considered submission to the initial request from Health Workforce New Zealand for thoughts on possible areas of change and improvement to the Health Practitioners Competence Assurance Act 2003. Amendments to the Act have the potential to make far-reaching changes to the way authorities operate and health services are delivered in New Zealand. A further round of consultation to specific proposals from the Ministry of Health and Health Workforce New Zealand in March 2013 has been signalled; Council will again be prepared to make a submission.

One of the areas seeing an increase in business-as-usual activities has been conduct, with a number of practitioners from a range of scopes of practice referred by Council to professional conduct committees. This work has resulted in an increase in disciplinary levies for technicians, but it is important for public and professional confidence that Council is seen to be active in regulating areas of professional misconduct, such as practising outside a scope of practice. There have also been a number of major working groups established by Council as a way to involve professional expertise at the early stages of policy and code of practice development. Council continues to be aware of the need to manage and further strengthen the relationships Council has with professional associations and other stakeholders.

I am pleased to note Council staff have continued to cope with the changes – as periods of change can be unsettling – and delivered on a heavy workload.

May I take this opportunity, on behalf of Council and Secretariat staff, to wish you all a happy Christmas and a safe and peaceful summer break.

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Budget 2013/14, fees and disciplinary levies consultation

Council is now consulting on its proposed 2013/14 budget, annual practising certificate (APC) fees and disciplinary levies, and other fees.

The APC fees and disciplinary levies are for dental therapists, dental hygienists, orthodontic auxiliaries, dental technicians and clinical dental technicians. The other fees that Council is proposing to prescribe fall into two groups. The first being revised fees for retention on the register, registration and examinations, whilst the second are new fees relating to competence and other individual programmes that Council may order individual practitioners to undertake. It is proposed that the new fees will take effect on 1 April 2013.

Please note that APC fees and the disciplinary levy for dentists and dental specialists will be consulted upon separately in May 2013.

If you wish to have your say on the proposed budget or any of the proposed fees, the full consultation document is available on Council's website at: **www.dcnz.org.nz/dcWhatsNew**. Have your comments to Council by 21 January 2013.

Disciplinary levy for dental technicians and clinical dental technicians

Significant costs have been incurred by Council in prosecuting disciplinary action against a number of dental technicians and clinical dental technicians.

Council has accordingly imposed upon all dental technicians and clinical dental technicians who were practising as at 5 November 2012 a disciplinary levy of $268.78 exclusive of GST.

The disciplinary levy was published in the *New Zealand Gazette* on Thursday 15 November 2012 and will come into effect after 28 days. Invoices will then be issued to practitioners.

Council membership

Michael Bain, **Wendy Tozer**, **Leslea Eilenberg** and **Minnie McGibbon** have been reappointed to Council by the Minister of Health for a further three-year term.

Council farewelled **Neil Waddell** from his role as a member of Council on the expiry of his appointed term of office in November. Neil was appointed to Council in 2005 and, during his tenure, brought a wealth of governance, academic and educationalist experience to Council. He was a member of the Dental Technicians Board from 2005, appointed to the role of Board Chair in 2006, a position he held until the professional boards were disbanded in late 2011. He was also a valued member of Council's Audit and Risk Management Committee, serving on the committee since 2009. Neil's passion and commitment to strive for quality improvement of clinical standards within the dental technology profession is commendable and he will be missed.

Bede Carran resigned from Council, having been appointed to another responsible authority. Bede was appointed to Council in 2010 and, over the past two years, added considerable value to Council discussions with his legal and accounting background. He was actively committed to his role as a lay member of Council to protect the health and safety of members of the public. His considered approach to difficult decisions was greatly valued and his input will be missed.

Council welcomed **Dr David Stephens**, newly appointed Council lay member with effect from 1 October 2012. David has a background in law, biological science, and iwi affairs, with over 20 years' corporate and taxation experience in private legal practice. David has a Doctorate (Canterbury), Master of Science (Hons) (Waikato) and Bachelor of Law (Hons) (Auckland). He currently works part-time as a private consultant in business management and environmental management. David has an interest in critically reflective governance and sits on a number of national and local boards and committees. He is a member of several professional bodies and an associate member of the New Zealand Law Society.

Effective from 2 December 2012, **John Aarts** is the newly appointed dental technician member of Council. He is a senior teaching fellow teaching on the BDentTech programme at the School of Dentistry, University of Otago. His career in dental technology started in 1989 when he studied dental technology at the Central Institute of Technology (CIT) where he gained a Diploma in Dental Technology. After working as a dental technician, he started teaching at CIT in 1995 and, while there, completed a Bachelor of Education and Bachelor of Health Sciences. During his time at CIT, he taught mainly crown and bridge to the final year students. Since starting at the University of Otago in 2001, his focus has been complete dentures and clinical dental technology. He obtained a Postgraduate Diploma in Clinical Dental Technology (2005) and a Master of Health Sciences (2006). He is a registered clinical dental technician and, in addition to teaching, consults patients at the School of Dentistry. He is also one of a few clinical dental technicians in New Zealand to hold the additional scope of practice in implant overdentures. John served as an executive member of the New Zealand Institute of Dental Technologists (NZIDT) for seven years and chaired the NZIDT continuing professional development sub-committee for six years. His involvement with education and the NZIDT has given him a broad understanding of the dental technology profession.

Update on shared secretariat

Previous Council newsletters of March and July 2012 contained updates on the work being undertaken to possibly develop a single secretariat to service the current 16 health responsible authorities (RAs).

It is pleasing to note that all 16 Chairs have recently agreed on a small working party of six people, including Dental Council Chief Executive Officer Marie Warner, to carry out further work towards the development of a detailed business case. The former Health and Disability Commissioner, Ron Paterson, is chairing this group.

Progress has been slower than initially anticipated, but it is important for all 16 Councils and Boards to be satisfied with the business case if any proposal is to be successful. Each of the 16 RAs has a unique professional background, number of registrants and scopes of practice that drive their particular requirements of a secretariat.

Nevertheless, I am confident that sufficient commonality exists between them for a single secretariat to improve on the current model of separate secretariats.

It needs to be emphasised that what is **not** proposed is a merger of all of the Boards and Councils. Dental Council has taken a leading role in the work to date and has recently co-located with five other RAs as a spin-off from this work, but is continuing to maintain an individual identity. I believe it is important for professional confidence in the activities of RAs that each body is seen as having particular knowledge and an understanding of the practice of the professional area it regulates. This is most significant in the area of professional competence and discipline.

However, the fact that one Act regulates the activities of all RAs means that there is a great deal of common process throughout the work of the RAs. A single secretariat is, therefore, capable of major improvements in performance over the status quo without risking loss of the fundamental expertise of individual RAs.

Mark Goodhew
Chair

End of continuing professional development cycle for dentists and dental specialists

The four-year cycle for continuing professional development (CPD) for dentists and dental specialists ends on 31 December 2012. By this time, practitioners are required to have completed a minimum of 80 hours of verifiable CPD and a minimum of 12 peer contact activities, as described in Council's CPD policy. Council's CPD policy is available on its website at **www.dcnz.org.nz/Documents/Policy/DCNZPolicy_CPDActivities.pdf**.

It is important to note that dentists and dental specialists on retention must also meet the CPD requirements. Those practitioners who registered part-way through the CPD cycle were advised at the time of registration of the pro-rated number of CPD hours and peer contact activities they were required to complete.

All registered dentists and dental specialists should have received a recent communication from Dental Council detailing what will be expected from practitioners at the end of the CPD cycle. You are encouraged to carefully review the communication to ensure that you are aware of your obligations before the end of the cycle. This is of particular importance if you still have CPD activities that have not been verified – please submit these for consideration as soon as possible. If for some reason you have not received the letter, a copy is available on the website at **www.dcnz.org.nz/dcWhatsNew**.

Ongoing review of recertification framework

As communicated in the July 2012 Council newsletter, there is a review in progress of the recertification framework for dentists and dental specialists. This project is ongoing and there will be **no immediate changes** made to the CPD requirements for the 2013–16 CPD cycle, as detailed in Council's CPD policy.

Practitioners will have an opportunity to comment on any proposed changes to the recertification framework, including CPD, through a consultation process, before any changes are introduced.

New Recertfication Programme for all dentists/dental specialists commencing 1 January 2013

The Dental Council gives you notice that at its meeting on 3 December 2012 it set a new recertification programme for all registered dentists and dental specialists.

This will commence on 1 January 2013 and finish on 31 December 2016.

The new recertification programme is established pursuant to section 41 of the Health Practitioners Competence Assurance Act 2003, and replaces the programme that comes to an end on 31 December 2012.

Each registered dentist and dental specialists is to undertake and complete 80 hours of verifiable continuing professional development and 12 peer contact activities by 31 December 2016.

Health Practitioners Competence Assurance Act 2003 review

Council submitted its response to the Ministry of Health 2012 review of the Health Practitioners Competence Assurance Act 2003. Council's submission on the review can be found at **www.dcnz.org.nz/dcWhatsNew**.
It is anticipated that the draft findings from the review and proposed recommendations will be published for discussion by the Ministry of Health in March 2013 and the final report released at the end of July 2013.

Specialty of Oral Surgery in New Zealand

Council considered, at its July 2012 meeting, the submissions received from stakeholders on the issue of the future of the specialty of Oral Surgery in New Zealand.

Council received 75 submissions in response to its consultation document. The balance of support received was for Option 2; that is, to retain as two separate scopes of practice – Oral Surgery, and Oral and Maxillofacial Surgery – as dental specialty scopes of practice in New Zealand. Council resolved to proceed with Option 2.

Council determined to seek stakeholders' views on possible amendments to the wording of the scopes of practice for Oral Surgery and Oral and Maxillofacial Surgery. A further consultation document was issued on 7 September 2012, with the closing date for submissions on 2 November 2012. Council will consider the submissions at its December 2012 meeting.

Other Dental Council activities

Consultations

Current consultations

Consultation on proposed prescribed qualifications for the General Dental, Oral and Maxillofacial Surgery and Dental Technology Scopes of Practice.

Dental Council has issued a consultation document on the proposals to approve the following qualifications as prescribed qualifications for the following scopes of practice:

- University of Otago Bachelor of Dental Surgery with Honours as a prescribed qualification for the general dental scope of practice
- University of Otago Bachelor of Dental Technology with Honours as a prescribed qualification for the dental technology scope of practice
- University of Otago Doctor of Clinical Dentistry in Oral and Maxillofacial Surgery as a prescribed qualification for the oral and maxillofacial surgery scope of practice.

Council is seeking comments on the proposals by **11 December 2012**.

Outcome of recent consultations

Follow-up Draft Code of Practice on Advertising

Council's advertising working committee is in the process of considering the individual submission comments on the Follow-up Draft Code of Practice on Advertising. Feedback on the outcome will be communicated as soon as the process is completed.

Codes of practice reviews

Medical Emergency Code Review Working Group

Council has established a Medical Emergency Code Review Working Group with the responsibility to review the two Medical Emergencies in Dental Practice codes of practice and to advise Council on the changes required to the codes.

Working group membership is as follows:

- **Robin Whyman**, Council member, dental specialist (Chair)
- **Darryl Tong**, dentist/dental specialist
- **Rachel Bridgeman**, dental therapist
- **Michelle Enslin**, dental hygienist
- **Steve Russell**, dental technician/clinical dental technician
- **Kevin Nation**, New Zealand Resuscitation Council representative.

The working group had its first meeting at the end of October. Good progress has been made in reviewing the codes to ensure they align with the New Zealand Resuscitation Council Guidelines and in identifying other areas where an update is required.

Dental therapy professional relationship

Council has established a committee of Council members to perform a preliminary review of the Professional Relationship Associated with the Practice of Dental Therapy Code of Practice. The committee will identify any issues that require further investigation with a view to initiate a formal review of the dental therapy code of practice.

Key stakeholders will be requested to become involved in the process, once the initial review has been completed and the committee's recommendations on the scope of the review have been considered by Council.

Expression of interest

Oral Health Therapist Working Group

Council has issued an Expression of Interest for appointment to the Oral Health Therapist Working Group. All interested individuals can find the details on Council's website at **www.dcnz.org.nz/dcWhatsNew**.

The closing date for applications is **25 January 2013**.

Accreditation

Council considered the Australian Dental Council/Dental Council (NZ) accreditation committee's recommendation on the accreditation of the University of Otago MDS/MBChB (Oral and Maxillofacial Surgery) programme at its November 2012 meeting.

Council granted an extension of the accreditation period for the MDS/MBChB (Oral and Maxillofacial Surgery) programme until 31 December 2016 to allow currently enrolled students to complete the programme during the transition period to the DclinDent (Oral and Maxillofacial Surgery) programme.

Updated standing order guidelines

The Ministry of Health *Standing Order Guidelines* was amended in June 2012 to reflect the changes introduced in August 2011 around countersigning the administration or supply of medicines under a standing order. The guidelines were developed to be an informative and user-friendly resource for health professionals issuing standing orders and those working under standing orders. The amended *Standing Order Guidelines* is more prescriptive and incorporate a change in terminology. The guidelines include a standing order template guide and a checklist for use of a standing order, offering a practical resource for health professionals to help their compliance with regulatory requirements when developing and/or reviewing a standing order or when administering and/or supplying under standing orders. The Standing Order Guidelines 2012 is published on the Ministry of Health website: **www.health.govt.nz/publication/standing-order-guidelines.**

Professional conduct and disciplinary matters

Tribunal orders censure, cancellation of registration and costs against dental technician

The Health Practitioners Disciplinary Tribunal expressed strong disapproval for the conduct of a registered dental technician, Mr Daniel George Sutherland, finding his conduct "completely unacceptable". It was established that he had practised without a current practising certificate, practised outside the scope of his practising certificate and inappropriately advertised his services. Accordingly, Mr Sutherland was found guilty of professional misconduct.

Mr Sutherland operated a denture repair service in Whakatane. He advertised his services in making and fitting dentures directly to the public when he knew that such services were outside his scope of practice as a dental technician and/or restricted activities under the Health Practitioners Competence Assurance Act 2003.

The Tribunal noted, as an aggravating factor, Mr Sutherland knowingly provided clinical services he was not permitted to perform and he had "deliberately and cynically" chosen to "ignore the requirements, for personal financial gain". Further aggravating factors included, Mr Sutherland continuing to provide clinical services after being told his conduct was under investigation and, continuing to practise without a practising certificate after repeatedly being advised his certificate had expired. The Tribunal noted it was a fundamental requirement of all health practitioners that they could be trusted. Mr Sutherland's conduct was dishonest and "put members of the public at significant risk of harm". His refusal to engage with the professional conduct committee (PCC) and the Tribunal showed "a significant lack of insight".

The Tribunal ordered the cancellation of Mr Sutherland's registration as a dental technician. He was censured and ordered to pay costs of $38,000 (being 50 percent of the costs and disbursements of the PCC and the Tribunal). The Tribunal noted that the high award of costs might cause hardship, but it was regarded as appropriate. ***Mr Sutherland (481/Dtech11/199P)*** **(www.hpdt.org.nz)**

Dentist convicted of dishonesty offences censured

Dr Ryan Woongki Kim, previously a registered dentist in New Zealand but presently a periodontist practising in New South Wales, Australia, was convicted in New Zealand in 2011 on four charges relating to dishonestly obtaining a student allowance to which he was not entitled. The dishonesty occurred on three occasions over a period of time. Dr Kim received a total overpayment of $23,253.27 of allowances to which he was not entitled. He has since repaid the full overpayment. In the District Court, Dr Kim pleaded guilty to the four charges in question and was sentenced to 100 hours' community work.

As a consequence of those convictions and an application from Dr Kim for registration as a dental specialist, he was referred by Dental Council to a PCC, and a disciplinary charge was then laid before the Tribunal that he had been

convicted of offences that reflect adversely on his fitness to practise. At the time the charge was laid and at the time of the Tribunal hearing, Dr Kim was no longer on the register as a dentist in New Zealand. However, the Tribunal concluded it had jurisdiction to hear the matter. The Tribunal upheld the charge.

It was not open to the Tribunal to cancel or suspend Dr Kim's registration, given that he was no longer registered in New Zealand. However, the Tribunal stated that, had Dr Kim's name been still on the register, it would have ordered suspension for nine months and not cancellation.

The Tribunal ordered, should Dr Kim seek to practise as an oral health practitioner in New Zealand in the future, he do so for a period of 12 months only in accordance with the conditions that: (1) he practise under the supervision of a person approved by the Dental Council for 12 months, such costs to be paid for by Dr Kim; and (2) he provide a certificate of good standing from the environment in which he had been practising before his application for registration and before his commencement of practice, to the satisfaction of the Dental Council, and he deal with such matters as the Dental Council may require concerning his practice in that environment.

The Tribunal ordered that Dr Kim be censured and pay a $10,000 contribution to costs, to be divided equally between the PCC and Tribunal costs incurred in this matter. The Tribunal stated that the censure order was "not a formality but expresses the Tribunal's significant disquiet as to the convictions that have been entered by the courts, the circumstances of those in full and as to detail, and the impact that this has had on Dr Kim's fitness to practise". The Tribunal ordered the publication of a notice concerning this matter in the Dental Council newsletter and on the Council website, and that the appropriate authorities in New South Wales be notified and requested to publish a notice in New South Wales and otherwise in Australia as is appropriate.

Dr Kim (488/Den12/218P) **(www.hpdt.org.nz)**

Guidance from Tribunal decision – Mind your conduct outside work

Dental Council highlights the following statement made by the Tribunal in its decision concerning Dr Kim, which it considers relevant to all oral health practitioners:

"What is required of practitioners in the dental profession is that they act with honesty and integrity not only in their professional lives but also in their personal lives. The dental profession is significantly reliant, as are many other health professions, on the supply of government funding and this funding can only be availed of if there is honesty in application. The system relies heavily on health professionals being honest in their applications for the funding which is provided by the taxpayer."

The Tribunal's view is that members of the public need protection from dishonest practitioners, the dental profession needs to have standards maintained by sanctioning such behaviour, and there is an element of punishment required.

Practitioners are advised to take care to conduct themselves honestly at all times, in and out of work time.

Discipline and competence costs

With an increase in disciplinary cases referred to professional conduct committees and charges laid before the Health Practitioners Disciplinary Tribunal, Council considered it appropriate to provide practitioners with a summary of the third party costs (excluding secretariat overheads) incurred in discipline cases and competence reviews for the period 1 April 2011 to 31 August 2012.

1 April 2011 – 31 August 2012

	Discipline $	Competence review $
Dentists	123,000	54,000
Dental therapists	4,000	-
Dental hygienists	39,000	-
Dental technicians	77,000	2,000
TOTAL	**243,000**	**56,000**

Practitioners' corner[1]

Everyday choices and how they relate to fitness to practise

Kirsty Jennings, Dental Council Professional Advisor – Dental Hygiene

In the days leading up to 31 March of this year registered hygienists, therapists, orthodontic auxiliaries and technicians wishing to continue practising would have signed an application for an annual practising certificate. The application form includes questions relating to your fitness to practise and includes the following.

Question 5

Since you were last issued an APC in New Zealand, have you been subject to any of the following (whether in New Zealand or overseas)?

d. *A police investigation, pending court proceedings, and/or a conviction in any criminal proceedings, punishable by imprisonment for a term of 3 months or longer by any court (including traffic offences involving alcohol and/or drugs)?*

e. *Any personal condition with the potential to affect your fitness to practise in the scopes of practice in which you are registered, such as:*

   i. *Any addictive condition including, but not limited to, a drug and/or alcohol dependency and/or a gambling addiction.*

   ii. *Any mental health condition including, but not limited to, depression, anorexia and/or bipolar disorder.*

   iii. *Any physical condition including, but not limited to, Transmissible Major Viral Infections, injuries as a result of an accident, memory loss and/or any degenerative condition such as Multiple Sclerosis or Motor Neurone Disease.*

   iv. *Any other personal condition that might affect your fitness to practise.*

Understanding the professional implications of an affirmative answer to any of these questions is fundamental and might have been glanced over by some practitioners.

When I shared with a colleague that a dental hygienist was before the Health Practitioners Disciplinary Tribunal their immediate response was – what had they done? What hygiene procedure had they performed that caused such a dire outcome that it led to proceedings? How had they broken a code of practice or breached the law at work? How did they show gross incompetence?

The answer is, the dental hygienist had not made an error at work. The Tribunal proceedings came into play because the practitioner had a conviction for assault. The assault did not take place at work or during work hours but their behaviour, which resulted in the conviction, was held by the Tribunal as reflecting adversely on the practitioner's fitness to practise.

Practitioners must note that 'fitness to practise' does not relate only to a practitioner's clinical ability, we also have an ethical obligation to not break the law. Our lifestyle choices impact on our professional practice.

Section 67 of the Health Practitioners Competence Assurance Act 2003 (the Act) requires a registrar of a court to notify Dental Council if a practitioner is convicted of an offence punishable by imprisonment for a term of three months or longer[2]. Section 68(2) of the Act dictates that when Council is notified by a court registrar of a practitioner receiving a conviction, it **must** refer the practitioner to an independent professional conduct committee (PCC) for investigation. A PCC has a number of options available to it, one of which is to lay a charge against the practitioner before the Health Practitioners Disciplinary Tribunal.

The decisions you make in your personal life that can lead to a criminal offence directly influence and impact on your work life, and your ability to work, if they are serious enough. In addition, you expose yourself to disciplinary proceedings that will likely cause you considerable anguish and expense.

I want to highlight this issue to my colleagues because I do not feel there is a high-enough level of awareness within our profession regarding this. The decision to do any number of things that could lead to a criminal conviction – perhaps you choose to drive after too many drinks and get caught – will impact on your ability to practise your profession. It's that simple!

Whatever issues we face in our day-to-day life, and how we react to them, are matters that will inevitably come up in our practising life. That we are competent to practise is very different to being 'fit to practise'. The onus of professional responsibility is on us – the registered practitioner – at work and outside of work. It is clear from the decisions of the Tribunal that a registered practitioner has obligations to behave in a way that is appropriate – ethical and honest – and does not break the law. Failure to do so may reflect adversely on their fitness to practise.

Mind how you go!

1 The opinions expressed in the Practitioners' corner articles are the opinions of the authors and do not necessarily reflect Council's position or view.
2 This catches a raft of offences, including driving while under the influence of alcohol or drugs.

Body and mental stressing – a problem amongst dental therapists?

Marijke van der Leij Conway, Dental Council Professional Advisor – Dental Therapy

In 2006, the Government initiated a reinvestment programme in oral health services for children and adolescents with the launch of the Good Oral Health for All, for Life strategic vision. The reinvestment programme was the result of several reviews of the School Dental Service, including the District Health Boards in New Zealand School Dental Service Review and the Review of Maori Child Oral Health Services.

District Health Boards (DHBs) saw the review as an opportunity to develop and reconfigure a service that had basically been operating in the same way since it was established in 1921. The DHBs reported that many clinics were outdated in design, were in poor repair and in many cases did not comply with practice standards and guidelines. Many were staffed for only part of the year, often by part-time staff, were in isolated areas and patients frequently had to travel to a different clinic for treatment. There was also a lack of collegial and professional support available for staff. It was not cost effective to rebuild and upgrade clinics and equipment, and an alternative solution was recommended. A new 'hub and spoke' model was developed – centralised clinics combined with mobile outreach services. The new model was intended, among other things, to improve efficiency, improve access, improve collegial and professional support, make better use of clinic sites and reduce arrears.

Over the past few years throughout New Zealand, this new model of service delivery has taken shape with minor variations in some areas. Many dental therapists now practise with their colleagues in modern, insulated, air-conditioned community clinics with state-of-the-art equipment. Mobile vans are driven onto school grounds where children are examined directly from class with treatment completed at centralised clinics (hubs). The Ministry of Health funding for this service is based on a regional population based formula with a focus on preventative services. As a result of the government's reinvestment into the school dental service, DHBs are expected to achieve efficiencies and improvements, for example, reducing arrears.

To respond, a number of DHBs have set 'targets' for dental therapists to achieve to help meet this expectation. Result? Access has improved, efficiency has improved, collegial support has improved, arrears are reducing and, today, more children are receiving an annual examination on time.

However, this reorientation of the service and drive for efficiency has introduced major changes to the way dental therapists work. It is timely to consider the impact of change on practitioners such as any physical consequences, for example, repetitive strain injury, aching backs, necks, shoulders, hands and wrists, or any stress-related issues, such as early 'burn out'. The Health and Safety in Employment Act 1992 offers robust guidance on the importance of managing hazards in the workplace. With the nature of the changes in place we need to be sure that we maintain a safe and healthy work environment.

Mechanisms of harm specified in the Health and Safety in Employment Act include 'Body Stressing' (muscular stress, repetitive movement) and 'Mental Stressing' (exposure to mental stress factors). Anecdotal and documented evidence shows 'body and mental stressing' is a problem for some dental therapists. DHBs, through their occupational health departments, have policies and guidelines in place to help dental therapists to reduce and manage their symptoms. Jennifer King, Occupational Health Nurse at Hutt Valley DHB, has stated:

"Occupational related discomfort, pain and injury may affect many aspects of health and wellbeing. It may impact on non-work and social aspects of life to an equal or greater degree than that of the work itself. So in providing evidence based, employee (patient) centred, holistic nursing care to employees, the following strategies may help minimise the impact of a problem.

- Report discomfort, pain and injury early. Early intervention generally results in a shorter road to recovery and a lesser loss of ability.
- Maintain communication with team leaders and managers. They are knowledgeable and/or experienced and hold a toolbox of strategies that can support the journey.
- Nurture yourself and foster your wellbeing. Looking after yourself enables you to do a great job at educating and looking after others or providing the support to those who do.
- Seek assessment, treatment, diagnosis and support from health providers. The health workforce is not bullet proof to day to day health issues present in our communities."

The Accident Compensation Corporation discomfort, pain and injury prevention programme reveals seven groups of contributing factors that may lead to discomfort, pain and injury. Check out the information to help yourself at **www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/guide/pi00237.pdf** or visit their interactive educational tool promoting self-help and problem solving for preventing and managing discomfort, pain and injury at **www.habitatwork.co.nz**.

The government's drive for efficiency and cost effectiveness is understandable. However, it is equally important to closely monitor the physical and mental wellbeing of dental therapists amidst the reorientation of service delivery. We need to be mindful of, and nurture, the most important resource of the model of service – our practitioners.

The importance of relationships

Dexter Bambery, Dental Council Professional Advisor – Dentistry

Dental Council is receiving an increasing number of referrals under section 34 of the Health Practitioners Competence Assurance Act 2003 (the Act). This includes complaints or concerns forwarded by the Health and Disability Commissioner as well as from employers of dentists whose competency has been of concern or has led to their dismissal or resignation.

Some referrals are coming from other practitioners who are concerned about the standard of treatment being provided by an oral health practitioner. Third parties such as the Accident Compensation Corporation or DHBs are also referring when concerns arise about the standard of care being provided by an individual practitioner.

Section 34 referrals require Council to undertake inquiries under section 36 of the Act. My personal experience over the past few years has led me to the following two conclusions:

1. Practitioners referred to Council, and those around them, find this a very stressful time. It can have a huge impact on the enjoyment of life both in dentistry and at home.
2. Most often there is a communication issue or a breakdown in the dentist–patient relationship.

Even if it is found that the practitioner's standard of competence was not deficient, the consequences of the initial complaint may be detrimental to a practitioner's reputation. Increasingly, patients have access to You Tube, Facebook, Twitter, Blogs and so on, and critical comments can take time, effort and expense to correct or remove from some internet sites, if possible at all.

On occasion, the referral from a patient or another practitioner can be vexatious and the inquiry process requires specific consideration of this possibility. Although the referral can be vindictive, at the same time, there may be concerns about clinical or professional competence as well.

Complaints frequently come from patients where there has been no mistake or clinical error. They often occur as a result of a breakdown in communication between the patient and healthcare professional team. As practitioners, we need to be aware of the importance of understanding and meeting patients' realistic expectations. We also need to address any unrealistic or difficult-to-meet expectations. This is an increasing source of complaint, perhaps due to the growing demand for 'cosmetic' procedures or more advanced (and expensive) treatments such as implant dentistry. The outcomes from endodontic treatment are one of the most common causes for complaint.

One of the most common catalysts for patients to complain is comment made by a second treating dentist. Handling questions from patients who are looking to complain about other practitioners requires careful managing. Patients want to be told the truth but without speculation on errors or mistakes by previous practitioners. If you are unsure, it pays to seek advice from senior experienced colleagues or the New Zealand Dental Association.

Developing positive and trusting relationships with patients can reduce the risk of litigation or complaint. Paying attention to our communication style and skills is fundamental to this.

When things go wrong, having a rehearsed and carefully considered strategy to deal with patients is very helpful. On these occasions it can be difficult to concentrate on solutions and the best outcomes. Having a check list to follow will enable increased confidence that you have done everything possible to minimise the chances of patients taking a complaint against you.

From time to time we have challenging interactions with patients. It is easy to label patients as 'difficult' without being aware of other contributing factors in tricky situations. Again, having a clear strategy in these circumstances can reduce the likelihood of patients taking action against you.

Dental Protection Limited offers a number of educational and practical workshops in the area of communication skills and risk management. These workshops are based on sound research and offer clear strategies for reducing our risk of complaint and litigation.

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