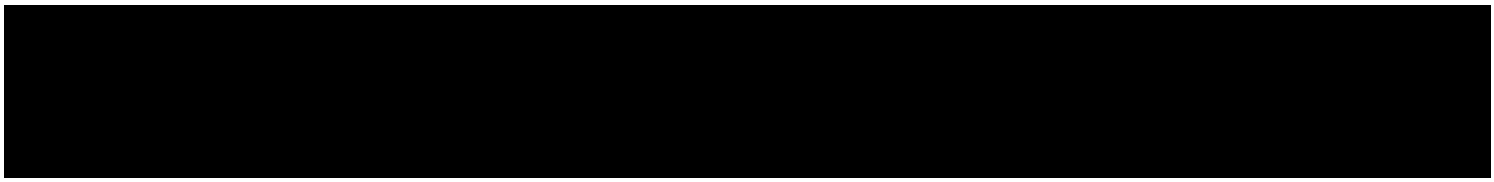
Page 2: Information about the person or organisation completing this submission

Q1 This submission was completed by:

Name	**Andrea Shepperson**



Q2 Are you making this submission	**as a registered practitioner**
Q3 Please tell us which part of the sector your submission represents	**a registered dentist or dental specialist** , **an education provider,** **a company/organisation**

Page 3: Area one: new core recertification programme

Q4 What, if anything, do you like about our proposed core recertification programme?

1. Annual recertification but not recertification in the way the Council has identified in the document.
2. Eye checks for over 40's and ultimately health related competence. However I am not in support of cognitive decline assessment. I have not seen medical evidence to support a testing methodology and feel this is fraught with potential for prejudice and subjective interpretation.
3. Mentoring for new practitioners and new registrants. As an educator in dentistry I see a significant need for overseas dentists/new registrants to engage in cultural and supportive clinical guidance in new jurisdictions. A requirement for mentoring is likely to incur cost to the practitioner however. I prefer the term 'collegial support' rather than 'formal 2 year mentoring'.

Q5 Is there anything about our proposed core recertification programme you would change?

Yes,

Please explain.:

My comments relate to dentists, and to a limited degree to hygienists. I have no direct experience of employing a therapist who practices as a therapy. The fact that we run a largely self-regulated profession is a privilege in NZ. We lack litigation and a 'no blame' insurer (ACC) protects NZ dentists from punitive damages and both public and peer complaint that is vexatious. The system seems 'about right' and it is not clear why it needs to change now. Peer against peer complaint is active in countries like Australia

and the collegiality, that is so strong in New Zealand, has been lost through competitive behaviour. In the UK even the GDC incited the public to complain about their dentist in a full page ad in the Guardian some years ago. For many years a system for recertification has worked on the basis of professional declaration, personal responsibility from a highly motivated, responsible and educated professional, and accumulation of documented CPD hours over a fixed term. Dr Whyman was asked in a webinar if there is evidence of greater practitioner competence and improved patient outcomes from programmes in other countries operating the recertification programme as proposed. He stated in response to a webinar question that " It is hard to get to the point of improved outcomes for patients. The professional development literature that we read that it is related to a change in practitioners transition of their knowledge to actual practice." He openly acknowledged that this is a complex area to research to suggest a change in practitioner competence and implied that there was no clear evidence to support the proposal. When asked about the motivation for change in relation to public complaints that are upheld, Dr Whyman stated "We receive at Council between 3 and 5 notifications per month. A number of these go no further and require no further activity. We have 25-30 practitioners currently being managed in terms of through formal programmes of various activities around their competence or recertification". He referred to Marie Bismark who identified 3% of medical practitioners in Australia drive 49% of concerns and complaints. This is highly skewed towards a very small number. That means 51% of complaints fall across the remaining 97% of practitioners and it is hard to determine where and how they fall. He felt a base programme is needed for every practitioner and we need to be proportionate about it. I feel the newly proposed regime is far from proportionate, particularly in the area of peer attestation. Please note that I am a dentist but also an education provider who conducts formal mentoring education for a fee. Theoretically I stand to profit from the changes. However I prefer to use a carrot rather than a stick and these changes seem to be moving away from informal self-assessment to formal documentation which has to be attested by colleagues. It is time consuming for the average practitioner and onerous in terms of documentation as proposed. We are a small dental community with high levels of familiarity, particularly for graduates of Otago University. Within the growing number of overseas trained colleagues there is still a high level of collegiality. Peer contact opportunities are plentiful. I also support self-directed learning, where practitioners recognise voids in their current knowledge, skill, or attitude in order to direct relevant subsequent learning and professional development. This is reflective activity, away from peers or in consultation with peers in an informal setting. I believe most practitioners are able to make an

appropriate choice of learning activity and choose areas of improvement and direction to one’s professional learning without peer attestation. There is some value in recording this, and reflecting on it later, so I support a PDP. The peer role is very poorly thought out. Most dentists are disinclined to act as peers, will not have time to undertake peer activities and are not going to be remunerated for them in the current system. A peer will become a mate who will sign off another mates capability. Far from acting as a professional peer, clinicians have strongly indicated they will resist providing the Council with a level of assurance that the clinician is following their learning plan and satisfying the competency obligations of their registration. I would not accept responsibility as a peer, and I am a formal provider of dental education. The relationship is too close, with no formal way to monitor colleague activity, particularly where practitioners do not work in the same office, While the relationship is designed to be a supportive, planned and purposeful one, it becomes an obligatory one with scope for abuse or indifference. There is strength in peer contact but not in a master/servant relationship with the potential to 'report on' or 'sign off' another colleague. Currently the identification of close working peers with competency issues is done by colleagues in the same practice, through kind and sensitive observation and encouragement. The conversation is discrete and private to avoid shame and humiliation. Peer identification also occurs indirectly in team meetings, in safe ways with team-based language to encourage behaviour change. Within the Lumino group it is also done in a sensitive way, by Clinical Advisor guidance and awareness raising. Reflective activity occursalready for many practitioners, without formal reporting and 'writing down'. They occur while commuting, over a coffee in the lunchroom, with colleagues at a course over lunch, in the garden, and while out running. Most dentists carry the burden of service and delivery on their shoulders everyday. To couch these in terms that require a dentist to write them down, asking what went well and what didn't, where areas for improvement can occur and other self-awareness dissections is demeaning. It infers that dentists are like high school students, lacking the frontal lobe development to have this level of awareness anyway. I do support the concept of targeted learning however, and individual documentation of an annual plan to direct oneself to education that is directed and provides value. In my view a curriculum based learning activity, with self-assessment components is more valuable than a peer overseen journal/plan. The role of a peer in providing assurance to the Council, or attestation, is burdensome even if it doesn't carry liability. It will become a "you attest mine and I'll attest yours" relationship.

Q6 Do you support our proposal to change the recertification cycle to 12 months?

Yes,
Please explain.:
Yes and No. I am not in support of a written PDP which is peer attested. I believe it will be written cursorily or retrospectively, and peer attested, when a dentist is required to produce it on demand from the DCNZ in a random audit. Practitioners are busy and burdened with compliance. This adds another layer of compliance and most practitioners engage above the requirements of their 4 year cycle at present. However I am in support of annual reporting of recorded and documented verifiable CPD attendance and professional development activity. I agree that it does not meet the intent of Section 29 of the Act to have a 4 year cycle. Mandated continuing education (CE) and course attendance still carries considerable value to practitioners, and an annual cycle would force clinicians to engage more frequently with educators and colleagues. This in turn ensures more frequent peer contact. I understand that it may be seen as an isolated vehicle for ensuring competence and for that reason I like the idea of a PDP. My preference is that dentists are given a workbook with PDP guidelines and the consider their own plan and direction. Many will naturally compare with their peers, but to add formal peer planning and oversight is unnecessary.

Q7 Do you think our proposed core recertification programme should include a requirement for practitioners to complete an online open-book assessment of their technical and clinical knowledge and skills?

No,
Please explain.:
I think this could applied to practitioners who are identified as at risk of competency issues. It should not be applied across the board.

Q8 If a proposal about an online open-book assessment of a practitioner's technical and clinical skills and knowledge is supported, how often should practitioners be required to complete an assessment?

Every five years ,
Please explain.:
Not needed more frequently amongst the majority of practitioners.

Q9 Do you have other proposals about our proposed core recertification programme you would like us to consider? Please explain.

I prefer a curriculum based commitment for practitioners. This would be a series of educational activities by a course provider, in small mentored workshops with colleagues. Engaging in focused and consistent learning along a clinical pathway would benefit many practitioners and hold more value than a simple one day course attendance. The cost of curriculum based learning would negate annual engagement but once every 4 year cycle would be reasonable.

Page 4: Area two: support for new registrants

Q10 What, if anything, do you like about our draft proposals for supporting new registrants?

I favour mentoring for new practitioners and new registrants. As an educator in dentistry I see a significant need for overseas dentists/new registrants to engage in cultural and supportive clinical guidance in a new jurisdiction. A requirement for mentoring is likely to incur cost to the practitioner however. I prefer the term 'collegial support' rather than 'formal 2 year mentoring'.

Q11 Is there anything about the draft proposals for supporting new registrants you would change?

Yes,
Please explain.:
I have run 5 cohorts of a best practice curriculum training programme for Lumino The Dentists and Maven Dental Group in Australia. The programme runs over 8 x 2 day workshops, over 2 years, and has been conducted in Auckland (x3), Sydney and Brisbane. It is called Lumino/Maven GO. The subject matter covers clinical practice, best practice guidelines, patient communication and complaints, and involves small group mentoring, hands-on training, problem solving, group exercises and discussion, peer feedback and self-reflection and evidence based didactic teaching. I have utilised dental specialists and Prime Practice to contribute to the programme. The purpose is to provide a safe, collegial learning environment that inspires additional knowledge acquisition. There is a clear distinction in the cultural understanding, clinical best practice standards and problem solving aptitude from dentists who are not trained in NZ. The GO programme assists those dentists with integration. Without a formal training programme they struggle to form strong relationships with patients, often hold several part-time roles so lose continuity of in-house mentorship and are not always well supported by NZ trained colleagues.

Q12 Do you think the proposed two year minimum period for the mentoring relationship is:

just right

Q13 Do you think all new registrants should participate in a mentoring programme, or are there some new registrants who should not be required to participate in a mentoring programme?

Yes,
Please explain.:
Countries with closely aligned values and education to NZ may be exempt.

Q14 Do you have other proposals about supporting new registrants you would like us to consider? Please explain.

No

Page 5: Area three: addressing health-related competence decline concerns

Q15 What, if anything, do you like about our draft proposals for addressing health-related competence decline concerns?

Issues around cognitive decline are challenging and need more definition. I see practitioners struggling with stress, long hours, patient expectation and depression. These lead to a general decline in standard of care - a 'get in and out and go home' approach to dentistry. This is a health-related competency issue which may impact a practitioner who is isolated. Maintaining informal peer contact is a way to re-calibrate in the presence of more optimistic peers and creating an environment where stress is openly discussed should be encouraged. I think we under-estimate the impact of mental health related competence decline in our profession. It is not age related. You can't enforce or audit this without shutting down disclosure. I would prefer the Council takes this off the table and instead has a "John Kirwan" style campaign of opening up about mental health and stress.

Q16 Is there anything about the draft proposals for addressing health-related competence decline concerns you would change?

Yes,
Please explain.:
See notes above. Eye checks should be annually after 50.

Q17 Do you have other proposals for addressing health-related competence decline concerns you would like us to consider? Please explain.

No

Page 6: Area four: addressing recurring non-compliant practitioner behaviours

Q18 What, if anything, do you like about our draft proposals for addressing recurring non-compliant practitioner behaviours?

I'm concerned about how the DCNZ is going to identify non-compliance in its true and meaningful form. Dentist mates will cover up for other dentist mates and unless a complaint is received (as happens now), the Council will be none the wiser. Once DCNZ knows about non-compliance I don't have a major issue.

Q19 Is there anything about the draft proposals for addressing recurring non-compliant practitioner behaviours you would change?

No

Q20 Do you have other proposals for addressing recurring non-compliant practitioner behaviours you would like us to consider? Please explain.

No.

Page 7: Final thoughts and comments

Q21 Do you have any other comments, suggestions or information you want to share with us about the draft proposals for improving our approach to recertification?

Respondent skipped this question