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

Q1 This submission was completed by:

Name	**Dr Leroy Chan**

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**

Page 3: Area one: new core recertification programme

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

Area two seems okay but I feel needs working on.

Q5 Is there anything about our proposed core recertification programme you would change?	**Yes,** Please explain.: All of it
Q6 Do you support our proposal to change the recertification cycle to 12 months?	**No,** Please explain.: It doesn't address the policy objectives very well for - assuring the public their oral health practitioners are competent and fit to practise - managing practitioner competence and the prevention of competence decline - identifying at risk or unsafe practitioners In addition, identifying at risk or unsafe practitioners in it's current form, I feel and many people I have talked to is discriminating

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?

Yes,
Please explain.:
I think a short questionnaire about "basic dentistry 101" should be asked and I would recommend a very good quality radiograph with an obvious lesion that is identifiable should be tested rather than an eye test by an optometrist.

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?

Annually,
Please explain.:
I feel that questions should be related to what a practitioner should know as their basic skills. There should be closed ended questions and open ended questions. Opened ended questions should be the same every year so it is like a "broken record" to reinforce to the practitioners what they should know is right!! Too often I have seen practitioners forget their "basic 101" skills. A simple closed ended question could be - "Is it acceptable to leave an overhang?" and "What is used to reduce or eliminate an overhang?" Too often, I have seen so many gross overhangs that it annoys me. A simple open ended question that could show the Dental Council if a practitioner is serious or passionate about their job could be "How would you deal with a new patient that comes into your surgery?"

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

I would like the proposal revoked at and actually scraped.
I would like the CPD to be kept but modified. I feel that CPD should include compulsory attendances to Branch meetings or Structured Peer Group meetings.

In respect to "Area one" - I feel is a waste of time and energy especially if the Dental Council is never going to review it unless there is a complaint. I feel the purpose is not well executed.
I do feel that auditing is a very good way to keep professionals honest. The format of audits needs to be closely looked at and streamlined. I was talking to a patient that is involved with the auditing processes and told me that the amount of dental professionals can be done that won't take that long. Not like the timeframe I was "theoretically" told by a Dental Council Member as this turned into a very heated argument which I was not happy about.
The compulsory requirement for the appropriate Resuscitation levels should stay (not what has been written in the document "emergency care training first aid certificate").

Page 4: Area two: support for new registrants

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

I think "Area two" sounds good but I feel that the Dental Council needs to have been looking at the training of new Graduates in the 1st instance.

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

Yes,
Please explain.:
In regards to "new registrants" there needs to be a clear definition for this and not just a "One Blanket Rule" as this unfairly can single out very competent new registrants that are from another country or a post graduate specialist which has many years experience as a general dentist but had a passion in that specialty. In these circumstances I would be looking at whether a new registrant specialist had "x" amount of years in practice before they did their specialty. This in turn can then have a pro-rata in time for a mentoring programme. The framework needs to be flexible and not prohibitive otherwise there is a risk that these potential new registrants will go to another country or stay in their country!

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

too long ,
Please explain.:
The answers to choose from is restrictive. My answer does not reflect directly on my actual views. As in my explanation above, then the time frame needs to be flexible on the merits of the individuals. Even in cases like a new undergraduate, every individual will vary in their rate of being a better and more competent practitioner. Most new graduates would have an exponential rate of learning and experience in their first 6 to 9 months of starting work (which I would say for every industry). But there would be those individuals that would need to be mentored for longer but I am not sure if compulsory mentoring is a good way to deal with this.

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?

No,
Please explain.:
This question is not well worded to answer a simple Yes or No answer. The last part of the question should not even be there or be in brackets! As I have answered above and given explanations refer to my answer for questions 11 and 12

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

I think that formation of study groups should be made easier to be recognised so both new registrants and non-new registrants can be able get together and share their knowledge, experiences, cases and problem solve etc
This contact should be made easier to record and be recognised as important support to both new and not new registrants

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?

Area three - eye examination every 2 years for over 40 years I do not support. I wear glasses and have my eyes tested at least every year. I think this should be scraped as it is not a good measure of how competent a practitioner is.

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

Yes,

Please explain.:

I know that eye testing does not work to sift out a practitioner that may be lapsing in their abilities. True facts I will share Case 1. A very experienced dental therapist was missing a lot of radiographic lesions, very obvious occlusal caries; she wore glasses. She was sent for an eye examine and she was cleared. I spent at least 3 months, 1 on 1 retraining and monitoring her readings even after that I still had to recheck her readings. Her age at that time was over forty. Case 2. A dental assistant was not preforming very well and I noticed that she struggled to pick up materials with her tweezers and also failed to see in the patients' mouth to be able to suction effectively. I sent her off for an eye test and the optometrist cleared her but said she did have a focusing delay but was fit for work. She still struggles! Her age is was only 18 years!! This proves that eye testing is not reliable. I feel that majority of dentists that have pride in their quality of their work and always strives for that perfection would know if their eye sight is deteriorating and they would do something about it. I know of 1 dentist that continued working with Cataracts while waiting for them to be done as I found out one day at a course where he disclosed to his colleague how much better he can see after his operations - that explained to me why a patient I saw of his had dentistry that was not up his usual standards and I was concerned about. If eye testing is to be implemented then the age should be higher, say age 60 and yearly would be my suggestion but I would question whether a straight eye test would be sufficient from an optometrist. There would need to be evidence based proof of what eye testing examinations would reflect on whether the performance of that practitioner. Sometimes or often things are missed because that practitioner was too busy to closely look at the tooth or a radiograph. This doesn't mean that practitioner's eyesight is a problem!! Sometimes, lesions are missed if radiographs are not exposed properly and with digital radiographs then the contrast could be wrong that will give a false negative or even a false positive. I feel that eye testing is a flawed and unnecessary process especially if you say testing for over 40 years old.

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

I think disclosure of health conditions should be asked such as conditions for registration be included like a drivers licence where "Corrective Lenses" be added. Then a question of "When did you have last have an eye examine carried out? can be asked.
In addition, how about the question of "have you been diagnosed with Cataracts?" Other questions about health should be asked instead of the Closed ended question of "Do you have a medical condition that may affect you working?"

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?

Area four, I do not feel they are not the right actions.

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

Yes,
Please explain.:
In regards to non-compliance, then the question needs to be asked about whether you are talking about recurring non-compliance for the same offence such as infection control or for misdiagnosis for example. If you are saying recurrence for different offences then why the need for recertification. I think that the system has failed that practitioner for support if that practitioner is re-offending or is the practitioner just incompetent and then you would ask the question about whether re-certification is going to help? I think that if the process of auditing that practitioner when they have had a non compliant issue should have had follow ups which supports that practitioner for rehabilitation. They should be help that needs to be instigated before it comes to this point. Area Two, which mentions mentoring should be considered and whether that practitioner needs to be mentored for a set time frame should be considered like 3 months or 6 months or longer. Another action that could be taken is that they be required to attend a course of seminar on that issue and write a report as a suggestion.

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

I feel that this is dependent on the nature of the non-compliant behaviour but the focus needs to be on support and rehabilitation.

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?

In every industry and profession there is always a small number of individuals that will bring down the industry or profession and then we all pay the price for harsher rules and regulations.
However, these harsher rules and regulations make it restrictive for the majority of us that have been complying with the past rules and regulations which in most circumstances would work perfectly fine but only need some tweaking rather than re-inventing the

and regulations which in most circumstances would work perfectly fine but only need some tweaking rather then re-inventing the wheel. The acronym, KISS - Keep It Simple Stupid is a saying I would like the Dental Council to think about.
I feel that the majority of us take pride in our quality and standards and ensure that we are providing to the public a good standard or care if not a high standard of care.
If we are looking at a common goal then the Dental Council needs to support us in continuing to provide a safe environment to be able to work and provide to the public the level of care with respect, dignity and to competent standards.
As I have mentioned, I feel that the majority of us are doing this. The proposals do not help very well to address the 3 objectives outlined (as copied below) as they are restrictive, rigid and harsh.

The policy objectives
- assuring the public their oral health practitioners are competent and fit to practise
- managing practitioner competence and the prevention of competence decline
- identifying at risk or unsafe practitioners

For the 1st objective, I don't see the worthiness in the time and effort of doing a professional development plan if the Dental Council will never look at it unless there is a complaint. The majority of us that would be competent, mean more work, more stress for what?? Those that need to be targeted will be able to complete this and not be identified. To me, this may assure the public their oral health practitioners are competent and fit to practise but it does not do anything to identify those practitioners that are in need to improve there competence.

The 2nd policy objective, the draft proposals are too generalised which leads to the 3rd policy objective which I feel wrongly identifies at risk practitioners especially proposing eye testing from the age of 40 years. Even parameters that have been used to select random audits currently are flawed and can be seen as discriminating.

To ensure the public that oral health practitioners are competent and fit to practise needs the approach of identifying those that are falling short of their competence. In reality, I feel only an audit done by competent auditors will identify that small group of individuals that are letting us down.
As mentioned, the auditing process needs to be looked at and be streamlined. An audit is often highly stressful but for many of us that are practising safely and competently then the can be used as a positive and constructive event if the Dental Council promotes and carries it out in a supportive fashion. I am certain that many practitioners would like to show off their brilliant work as most of us strive for perfection.
I have done audits in the past on many Dental Therapists. It was stressful for both myself and the therapist and I learnt a lot.
I think if audits were streamlined in a way where the audit process is short and simple and costs are minimised, there is a potential it can work.
An idea which many may not be happy about but after my random audit, I was very happy afterwards, especially when I was validated that I was doing things right and even had things that impressed the auditor.
Why does the Dental Council from my understanding only have 1 auditor?
Why is the random audit allocated 2 hours to cover so much? If we are looking at competence and reassuring the public then do we need to audit everything in the practise at that time or should we be looking at looking at the patients' files and selecting a random few? Should it only take 1 hour? We should have more auditors but maybe there should be honorary or voluntary auditors?
Identifying at risk or unsafe practitioners - the questions I ask, "Are we training our graduates sufficiently and have we supported them adequately?". Yes, mentoring is good but how does that solve clinical competency if that Mentor is not working side by side with that practitioner?
In regards to practitioners that are not new registrations then do we need an anonymous hotline to report these practitioners as I am sure if we are working in the same city we often get those patients from another dentist that has had work done which is questionable. But this can lead to reports that may not be genuine in terms another practitioner could be malicious or the public or we saw work done and thought it was from that practitioner but it was from a previous practitioner.

I think we need to look very closely at the reasons why we are doing these changes and how it impacts on the practitioners. I agree that the public needs assurance that the practitioners are competent but the proposals aren't good proposals at GENUINELY giving them peace of mind. As I have mentioned, the majority of practitioners are competent and I feel that only a few would be letting us down. I am all for weeding these practitioners out but not at the stress and harsher regulations that impact on the majority of us that are competent.

I does make me emotional to have patients come in that had work done not to the standards I would expect and I believe that the proposals that have been proposed isn't going make difference for those that need to be weeded out. It just makes it more difficult for the majority of us that are competent and have the best interest of the public to be exposed to more "red tape".

I am passionate about my work but I am sorry I haven't been involved prior to this until now and that is why I have spent the last 4-5 hours on this from about 10pm tonight until 2:30am this morning. I hope that my input into this can be used constructively.
Regards Dr Leroy Chan
P. S. I have not reread all of this as it is now very late at night now.