22/10/2018

New Zealand Dental Council
Email: recertification@dcnz.org.nz

Re: Proposed recertification changes submission

To whom it may concern,

Here are some concerns that I have regarding the proposed recertification changes.

What is the evidence that conforming with increased compliance will increase competency? For example, if a procedure has the risks explained but the recipient doesn't like the final outcome for whatever reason, they may complain, and does a complaint mean that the dentist is incompetent?

It has been noted that the number of hours and form (eg lecture or conference) of CPD is not relevant to competency. So how will a professional development activity (PDA) be any better? The annual time frame for recertification may be too short for dentists who are sick or work part time.

Who will guarantee the quality of a course and that it is of a high enough standard for competence? There are courses that are run to market and increase the sales of a product eg Fast Braces, Bo-tox injections, and other short courses, that skim the surface of the specialist knowledge required and do not provide enough teaching for comprehensive treatment planning. Dentists may be attracted to easy profits, as running a business requires the dentist to cover their initial start up and ongoing costs, and be able to save for their retirement.

And if things go wrong, shouldn't it be a specialist practitioner/body that make recommendations about competency as it is in the patient's interest that they receive the appropriate treatment in the first place? The patient should have been given the option to see a specialist at the consenting process.

Theoretical knowledge is not necessarily the same as practical skill(s). Graduate dentists leave Dental School as competent practitioners but graduates are not taught the reality of working in the private sector. There is a difference between confidence and competence. Shortcuts may be made for financial reasons. New products are marketed to practitioners and the risks are not always explained. Yes we have a scope of practice but who is really checking? It is generally left up to the practitioners knowledge and experience on whether they use a new product or procedure. Mistakes will be made as part of their learning experience. Maybe the Dental School should have the support to review new products and techniques and give updates on or extra practical learning or online learning opportunities as a PDA.

How do we choose a peer? A peer may have a conflict of interest or bias. What happens if your peer retires, moves, passes away, hates your guts or is too good of a friend to admit that you are incompetent? Can you have more than one peer? Should a specialist peer be a non-specialist? What responsibility (if any) of 'attestation' does a peer have regarding their colleague's standard of competence? We all have different quality of standards, so what would be the minimum acceptable standard? The financial stressors of running a business may not be something a practitioner would want to tell a peer especially if in the same town.

What is the cost/benefit analysis of having these extra compliance tasks?
We already have processes in place for:

- complaints like, peer review, the Dental Council, Health and Disability Act, local dental association,
- social and extra learning opportunities at conferences and courses with the mandatory CPD,
- welfare through officers at local dental branch associations,
- specialist practitioners have their own associations,
- new dental graduates have the NZDA mentoring system
- the huge variation in experience and competency of overseas trained dentists are already screened through the NZDREX examinations to be competent

Do we need to add another layer of 'compliance' to being a dentist? Local branch associations already have a hard time keeping members interested in coming to branch meetings, does the Dental Council not want to support dentists to be involved with their local branch association?

Is this model likely to better identify risky practitioners than what we have already?

Is it suitable for all oral health disciplines (ie GDP, Specialists, Hygiene, SDT, Clin dent tech, etc) to undergo the same recertification process?

Who will administer the changes, be responsible for assessing competency, and overseeing those deemed incompetent? I assume it will necessitate more paperwork and time in which we will end up bearing the extra cost thus increasing our patient fees or driving more shortcuts for dentists who are already in business.

Yours sincerely,

Mark Kum