INQUIRY INTO THE COMPLAINTS MECHANISM ADMINISTERED UNDER THE HEALTH PRACTITIONER REGULATION NATIONAL LAW

❖ *Topic: Complaints to AHPRA about Dentists*

SUMMARY

Terms of reference addressed:

B. The existing regulatory framework contains inadequate provision for addressing:

1. Complaints about infection control at dental practices
2. Emergent risks associated with dental scope of practice and 'Dr' title
3. Statutory offences related to dental advertising

C. Complaints about dentists increased by 33.8% in 2015/16 (Dental Board, 2016). While the dental 'profession' is likely to have reputational and legal concerns, patients have concerns about the impartiality of AHPRA's peer-review complaints process - in which few dentists have been disciplined (see AHPRA, 2016a).

D. There were 196 complaints to AHPRA about possible dental-related statutory offences in 2015/16 (Dental Board, 2016); with just 13 completed by June 2016 (AHPRA 2016b, p.23). This indicates inadequacies in monitoring such offences and/or the interpretation and application of *National Law*.

F. The following actions are needed to improve the AHPRA complaints process:

1. Address behaviour around legal indemnity
2. Make AHPRA complaint bodies accountable for their decisions
3. Encourage less reliance on the dentist's 'clean' clinical records
4. Demand greater transparency on decision-making processes
5. Conduct an independent analysis of de-identified complaint data
6. Review AHPRA's 'management' of the dental Register of Practitioners
7. Develop National Guidelines on Dental Treatment & Pricing

B Whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints

- ***Infection Control - risks of self-regulation by dentists***

Under the existing framework, the self-regulation of infection control by dentists is inadequate. The Dental Council NSW (2013) reported that infection control was a *common complaint* they received about dentists. However by 2014 the media reported that patients at Sydney clinics were being advised to get tested for possible exposure to HIV, and that there are no regulated inspections or random audits of dental hygiene practices (Carroll, 2014). Both NSW Health (2016) and QLD Health (Moore, 2016) have found further cases of hygiene breaches; recently closing clinics and advising dental patients to undergo health tests.

The Dental Board have responded to this issue with a 'Self-Audit Checklist' for dentists and futile 'Tips for Patients' such as; 'Does the surgery look clean and tidy?' (although viruses are invisible). Dentists also simply keep a logbook of their Continuing Professional Development (CPD) activities (Dental Board, 2015b).

- ***Scope of practice – emergent risks and the "Dr" dentist title***

Grey areas are emerging in dentists' scope of practice. Dentists with limited experience offer orthodontic treatments (Bite Magazine, 2016) while others perform conscious sedation or sleep dentistry without an anaesthetist (e.g. see Cauchi, 2010). This is now an endorsed area in which dentists 'may be audited for compliance'. Other dentists give Botox and dermal filler injections which are usually performed or supervised by a doctor (e.g. Skates, 2014; Smith 2011) while some reportedly perform breast surgery (see Davey, 2013).

This situation is confounded by the dentists' use of the title "Doctor" in advertising and on the AHPRA Register of Practitioners - despite having a basic three year undergraduate degree in dentistry (many graduating despite a high failure rate; see Jensen, 2011a).

However the Dental Board (2010) argues that there are no provisions under *National Law* that specifically prohibit a dental practitioner from using the title 'doctor'. Nevertheless, the 'Dr' title is a courtesy title, *not a professional title*, and its use can mislead patients about the *medical expertise* of dentists.

The "Doctor" title also carries an implied trust in ethical patient-centred scientific diagnosis - when it is well known that patients can go to multiple dentists and receive completely conflicting diagnoses and quotes. This situation is exacerbated by the absence of national guidelines on dental diagnosis, treatment and pricing (Choice, 2013). However it also demonstrates a lack of scientific reliability and/or the dominance of the business-model of dentistry.

- ***Advertising: dental-related statutory offences***

In 2015/16 there were 196 complaints to AHPRA about possible dental-related statutory offences (Dental Board, 2016); with just 13 completed by June 2016 (see AHPRA 2016b, p.23). This indicates inadequacies in monitoring such offences and/or weaknesses in the interpretation of *National Law.*

There has been a rapid growth in dental marketing via websites containing stock photographs (not the dentists' own work). Such advertising can create *an unreasonable expectation of beneficial treatment [National Law]* and misrepresent the skills of individual dentists. Clinical work can fail to meet such advertising claims.

Advertising also contravenes *National Law* [*s133 1(d)*] when it *fails to disclose the health risks of a clinical procedure*. However disclosure of known risks with white fillings, or prolonged anaesthesia from nerve blocks is largely ignored by private sector dentists.[1] This paternalism is at odds with the right to informed consent.

Further, AHPRA (2014) have interpreted *National Law s133 1 (c) on testimonials* to exclude positive statements about non-clinical issues. Consequently, dentists have signed up to web sites such as Whitecoat; in which they can opt to preview non-clinical patient reviews to check for 'inappropriate' comments - before they are published (thus accumulating a skewed volume of positive comments). However positive statements (testimonials) and stock photographs (e.g. of models) can distort patient judgement about the dentist's clinical skills and experience.

C. The roles of AHPRA, the National Boards and professional organisations, such as the various Colleges, in addressing concerns within the medical profession with the complaints process

- Since the introduction of AHPRA, there have been a high number of complaints about dentists (e.g. Colyer, 2012; Dental Council NSW, 2013; Jensen, 2011b; Jensen, 2011c).[2]
- Notifications (complaints) to AHPRA about dentists increased by 33.8% in 2015/16 (Dental Board, 2016).
- Dental Board tribunal decisions from 2014 to 2016 show that five dentists have been disciplined (see AHPRA, 2016a).
- There were 196 complaints to AHPRA about possible dental-related statutory offences in 2015/16 (Dental Board, 2016); but only 13 were "completed" by June 2016 (see AHPRA 2016b, p.23).
- Complaints about dentists relate to clinical treatment; poor communication; infection control; and unprofessional behaviour (Dental Council NSW, 2013).

[1] Written treatment consent forms are used in the public sector (e.g. Queensland Health, 2011).
[2] This excludes complaints to the OHO Qld and the Australian Dental Association.

- ***Reputational and legal concerns within the profession***

The Dental Council NSW (2013) said they were "deeply concerned about the reputational risk of the dental profession with regard to the number of notifications flooding into headquarters."

Within the profession/industry, there are also likely to be legal concerns with the complaint process. For example, the Australian Dental Association QLD has membership professional indemnity insurance arrangements (e.g. see ADAQ, 2016). Any refunds to patients who complain occur via a signed 'deed of release'. The Dental Care Assessment Committee (NSW) reportedly negotiated such legal indemnity for a dentist it was meant to be investigating (see Jensen, 2011b). This prevents the patient from recovering damages and the cost of repairing faulty work.

- ***Impartiality?***

The most common patient complaint about dentists is dissatisfaction with clinical treatment (British Dental Journal, 2013; Dental Council NSW, 2013). Hence such complaints are unlikely to be vexatious or frivolous. Rather, after being repeatedly ignored by dentists, patients may complain to AHPRA as a last resort in having their grievance 'heard'.

As AHPRA do not have the power to enforce financial redress, patients who paid for faulty dental work, also pay to get it fixed. Any suggestion that patients lodge a fee with their complaint is thus misguided.

Further, patients who have lodged a complaint with Australian dental councils and committees perceive that such panels protect dentists, not patients, with only a small number of dentists being disciplined (Jensen, 2011b). This is supported by Dental Board statistics (see AHPRA, 2016a). Hence the impartiality of the AHPRA peer-review system has often been questioned by patients (e.g. State of Victoria, 2014).

D. The adequacy of the relationships between those bodies responsible for handling complaints

The relationship between Dental Board complaint bodies and state Statutory Offences Units appears to be inadequate. This is reflected in AHPRA statistics:

- In 2015/16 there were 196 complaints to AHPRA about possible dental-related statutory offences (Dental Board, 2016); with just 13 completed by June 2016 (see AHPRA 2016b, p.23).

F. Other improvements that could assist in a fairer, quicker and more effective medical complaints process

1. Address covert behaviour around legal indemnity

Many dentists omit errors from clinical records and either ignore patient complaints, or may use a Deed of Release (so-called "goodwill gesture") in an attempt to settle patient grievances and deny the existence of faulty treatment.[3] Either way, patients pay to have the faulty dental work corrected. The Dental Care Assessment Committee (NSW) reportedly negotiated such legal indemnity for a dentist it was meant to be investigating (see Jensen, 2011a). Under shared professional indemnity arrangements; peer members avoid acknowledging the faulty work because their comments and actions are important in any settlement of grievances (e.g. see Dennett, 2016). These practices may be at odds with *Australian Consumer Law.*

2. Accountability for decisions

One way that AHPRA bodies can dismiss patient complaints is to deem them to be "*lacking in substance*" [*s151 National Law*]. The main source of evidence to show 'substance' is the clinical record. However, most dentists do not make notations of errors, adverse actions, or complaints on the patient's clinical record. The Dental Board's *Guidelines on Dental Records 2010 do not* require dentists to note these errors/adverse actions. This should be amended. Conversely, AHPRA bodies accept feeble practitioner excuses for inadequate clinical records.

Dental Board bodies can also ignore their own published guidelines. They may avoid asking the dental practitioner for information to support the patient claims [show substance] and which they agree forms part of the dental record (as per the *Dental Board Guidelines on Dental Records*). They instead suggest that the patient contact the Office of the Australian Information Commissioner (thus burdening other government agencies).

3. Less reliance on the dentist's 'clean' clinical records

It is unfair to the patient for Dental Board bodies to rely on the dentist's 'clean' clinical records because these are largely treated as a legal document – so that errors and adverse actions are omitted. When mistakes are made, dentists seem reluctant to provide patient access to their full unedited records - sometimes utilising their receptionists as gatekeepers. Patient requests for correction of incomplete information (as per their rights under *the Privacy Act 1988 (Cth); see* OAIC, 2015) may also be ignored. However the electronic *My Health Record* may potentially put patients back in control of their records via the ability to upload information and corrections [*My Health Records Act 2012:73B*].

[3] Refunds to private health insurers via HICAPS for dental items may thus be negligible.

4. Greater transparency on decision-making processes

In their first written response to the patient (notifier), AHPRA state that they are very limited in what they can tell them, including "the reasons for the Board's decisions", and that they will be unable to provide "full details". For the system to be considered fair, AHPRA's decision-making processes should be fully disclosed, not top secret.

For example, AHPRA should advise patients if practitioner and community members of Dental Board committees have an equal say in deciding cases. The Dental Board should also disclose their compliance with the *Privacy Act 1988* and *Australian Privacy Principles* (APPs) in conducting investigations; and whether they access dental patient (notifier) data from third party dentists.

It is also notable that the Dental Board have imposed conditions on very few dentists; yet required one to "maintain membership with an approved professional association or body for three years" (2013). Peer practitioner members of AHPRA bodies should thus disclose any membership-related conflicts of interest, including in negotiating legal indemnity for dentists (see Jensen, 2011a).

AHPRA's assumed (unmeasured) 'expertise' in a wide range of clinical matters creates a power imbalance because of the asymmetry of technical knowledge. In my experience, QRNC decisions on expert matters relating to their peers can be in contradiction to known standard practice, yet deemed by them to be "reasonable and appropriate in the circumstances." Independent non-affiliated experts should thus be utilised to facilitate transparency.

5. Independent analysis of de-identified complaint data

Dental Board statistical data is obscured by its dispersal into separate tables and documents. Their annual reports do not reveal their reasons for dismissing patient complaints [*s151 National Law*; *'frivolous', 'vexatious', 'misconceived',* or *'lacking in substance'*].To show 'the bigger picture', de-identified data needs to be collated into *one table* to show a comparison of how many complaints about dentists AHPRA have: (i) received; (ii) dismissed (showing reasons); and (iii) made adverse findings against. Independent analysis of AHPRA data is needed to facilitate transparency.

6. Review AHPRA's 'management' of the Register of Practitioners

Publicised dentist convictions (e.g. see Jensen, 2011c; Jensen 2011d) and findings of professional misconduct are missing from the Register of Practitioners (e.g. see AHPRA 2016a: *Health Practitioner Court and Tribunal Case Summaries*; 15 Oct 2012, p.3). A Google search is often more revealing. 'Conditions' (e.g. psychiatric care, drug screening), and gaps in practice, are also not shown on the register. The latter may be determined via a search of the Australian Business Register. The current register thus gives the public a false sense of security.

7. ***Develop National Guidelines on Dental Treatment, Diagnosis & Pricing***

The predominance of patient complaints about clinical treatment (Dental Council NSW, 2013) may be attributed to the absence of national guidelines on clinical diagnosis, treatment, and pricing (Choice, 2013).

To address this, *national guidelines on dental treatment* and a *recommended dental fee schedule* should be developed by an independent non-commercial body[4] - in line with those published by the Australian Medical Association and the Australian Psychological Society.

These best practice guidelines should include the requirement for written patient consent and full disclosure of treatment risks[5] and materials used. These measures may reduce the public risk posed by dentists who use cheap [potentially toxic] imported dental products (e.g. see Burke, 2009; Clare, 2011). Patients are currently assigned a passive decision-making role in their treatment (Chapple et al., 2003).

Without a dental fee schedule, access to dentistry is unnecessarily inequitable; as industry sources cite greed as the reason for Australia's high dental fees (SBS, 2008). Hence under the current private sector monopoly, dentists continue to earn more than medical specialists and doctors (MJA, 2011; Hartley & Rowley, 2016) – while many Australians cannot afford basic dental care.

Most dentists cluster in wealthier populated suburbs; forcing rural patients to turn to their GP's for dental care (Serkan, 2015). Consequently, there is "an adequate supply of dentists only in the major cities for those who can afford private dental care" (Russell, 2014, p. 641).

The *Dental Relocation and Infrastructure Support Scheme* (Dept. of Health, 2016) may help to redistribute the dental workforce into rural areas by 2019, but without a *recommended dental fee schedule* it may not facilitate workforce retention.

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[4] See Department of Health 'Average Dental Charges 2015'; Private Health Insurance Ombudsman: http://www.privatehealth.gov.au/healthinsurance/whatiscovered/averagedental.htm

[5] There is a lack of national data and reporting requirements on treatment failure (e.g. nerve damage)
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- **Increasing complaints about clinical treatment may be attributable to the predominance of the business model of dentistry**

Most complaints to AHPRA about dentists relate to clinical treatment (Dental Council NSW, 2013). While a health-care 'profession' should be focused on public service - dentistry has increasingly moved toward the business model (Trathen & Gallagher, 2009) and is largely self-regulated.

Profit-driven [vs minimal intervention and preventative] dentistry is unnecessarily excessive, often fails to meet advertising claims, and potentially causes the patient new dental, emotional, and financial problems.

Many dentists also focus on profitable cosmetic work such as tooth whitening, rather than functionality and dental occlusion. They can also make misleading claims about their skills in 'cosmetic dentistry' to enter the profitable cosmetic market.[6]

On the other hand, scientific diagnostic 'technology' in dental occlusion (bite) has not progressed beyond basic articulating paper (*circa* 1923).

Overtreatment such as unnecessary and excessive fillings can cause the patient new problems which such tools can never correct. These profit-driven dentists heavily "drill and fill", and thus ruin healthy teeth.

Overtreatment can occur when dental businesses obtain the patient's private health insurance status/balance prior *to* devising a treatment plan. In some cases, there can be a subsequent focus on maximising the patient's health insurance benefits (unnecessary fillings, adding extraneous items).

Medicare has similarly identified 626 dentists for *overuse* of the Chronic Disease Dental Scheme (Jensen, 2011e), with other dentists preying on vulnerable patients to extract the maximum from such schemes (see Bradley, 2014; Gardiner & Bibby, 2015; Hoffman, 2015; Smith, 2012).

- In light of this obvious shift toward the business model of dentistry, Australia needs a two-tier (public-private) dental system - with the public sector dental workforce (including therapists-hygienists) greatly expanded to provide *basic* patient-centred preventative care for all Australians.

[6] The term 'cosmetic dentistry' is nebulous – many dentists simply perceive this to be the use of white composite resin.

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