Submission Regarding Legislative Change in Dental Regulation

Presenting the Dental Council's views on the changes necessary to protect the public now and into the future in a rapidly evolving dental profession

Dental Council
An Comhairle Fiaclóireachta

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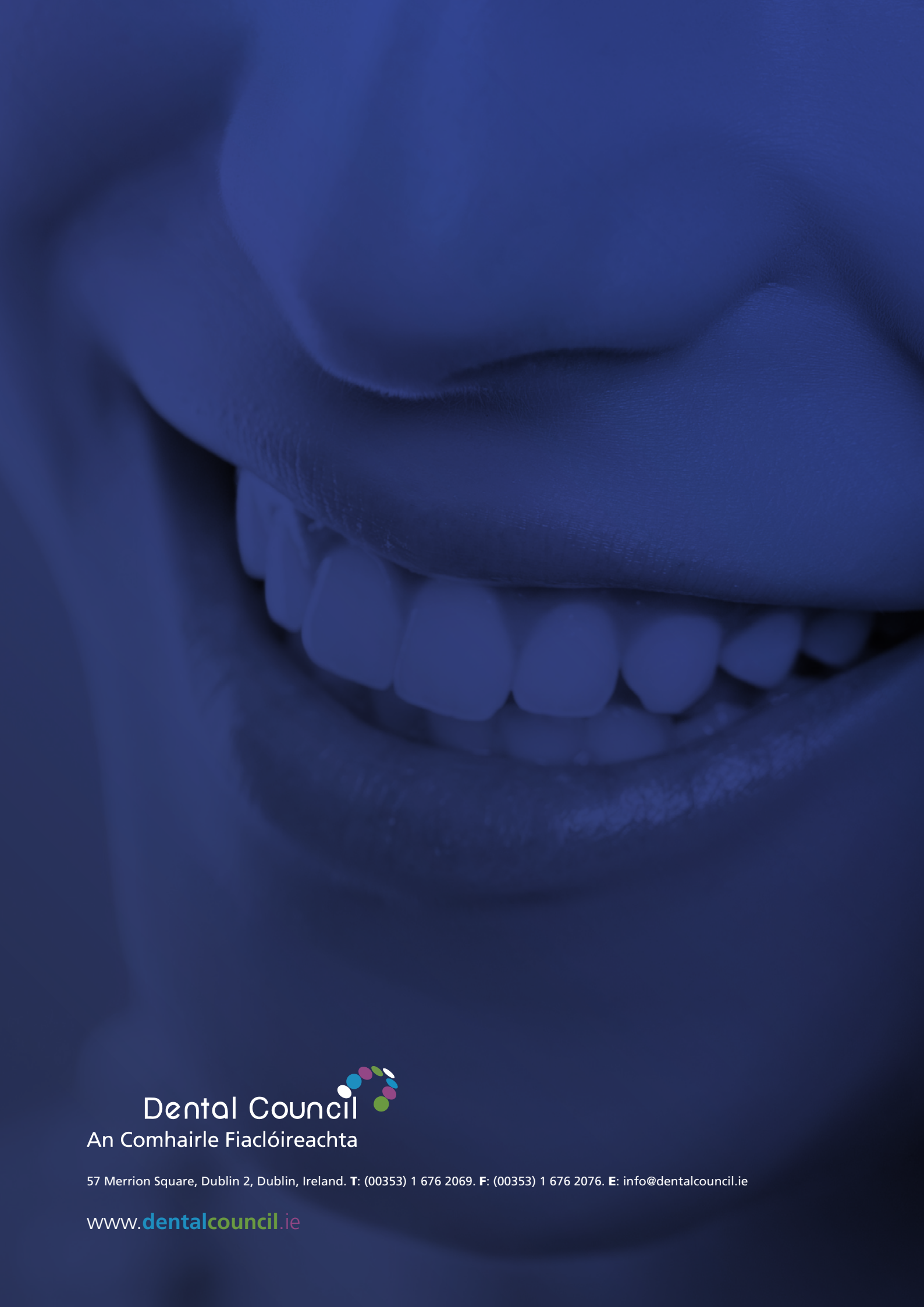

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1. EXECUTIVE SUMMARY

The Dental Council is making this submission to the Minister for Health under the provisions of Section 66(1) of the Dentists Act, 1985. Under this section the council is obliged to advise the minister on all matters relating to the functions assigned to it under the Act.

The Long Title of the Act obliges the Dental Council to: *'provide for the registration and control of persons engaged in the practice of dentistry'.* Section 6(1) states that: *'the general concern of [the council] shall be to promote high standards of professional education and professional conduct among dentists'.* For almost fifteen years, the Dental Council has advised the minister that, because of both omissions and weaknesses with the 1985 Act, the council is not able to adequately meet these obligations.

There are two gaps in the present Act that pose a significant risk to public safety: the failure to oblige registrants to maintain their ongoing competence and the failure to regulate dental practices. Patient safety cannot be assured and patients have been harmed because of this failure to regulate.

The Dental Council advises that the changes it is proposing are necessary to implement some of the objectives of the national oral health policy, *'Smile agus Sláinte'.* Indeed, the policy itself confirms that updating the Dentists Act is a priority. In this submission, the Dental Council identifies five main policy themes that in its view require change to ensure that dental regulation is fit-for-purpose.

To Address Omissions from the Act	Education, Training and Continuing Competence Dental Practise Regulation and Other Public Safety Measures Independent Practice for Allied Dental Healthcare Professionals
To Address Weaknesses with the Act	Consistent Registration Systems Enhanced Fitness to Practise Provisions

The Dental Council has identified the measures that are required to address each of these omissions and weaknesses. All of the measures it is recommending already exist in other areas of regulation in Ireland. The only novel proposals, which are a variation on existing public policy, are in Chapter 10 *Policy Theme - Enhanced Fitness to Practise Provisions*. Here, the recommendations reflect the distinctive nature of dentistry as a healthcare profession and the Dental Council's unique structure. The Dental Council has always had a different governance model to the other healthcare regulators.

The Dental Council advises that the policy changes it is recommending are a series of integrated proposals predicated on the council being responsible for each part. Should the minister determine an alternative policy, then a number of the proposals made in this document will need to be significantly revised. Because of our concerns, the council is willing to explore methods to implement the most critical patient protection policies by means other than a new Dental Act. It looks forward to engaging with the minister and the department to agree these policies at an early stage.

2. INTRODUCTION

The dental profession is presently regulated under the provisions of the Dentists Act, 1985 (the Act). This Act was the third of three pieces of primary legislation enacted to regulate the medical, nursing, and dental professions. The Act is broadly similar to the Medical Practitioners Act, 1978 and the Nurses Act, 1985 which regulated the medical and nursing professions respectively. The purpose of each piece of legislation was primarily to enhance the ability of the existing regulatory bodies to regulate across the main domains of registration, education, and fitness to practise. The Acts established properly resourced independent regulators and sought to harmonise professional healthcare regulation.

There was one noteworthy difference in the Dentists Act, 1985 from the other legislation. The regulatory models for medicine and nursing were largely self-regulation, where under the legislation a significant majority of council or board members had to be either elected or nominated registrants. The model introduced for dentistry was more analogous to a co-regulation model. Only one third of the members of the Dental Council must be dentists.

New Acts were enacted in 2007 and 2011 for the medical and nursing and midwifery professions which significantly enhanced their regulatory powers. In particular, the new legislation enshrined ongoing competence as a statutory obligation. These Acts also significantly changed the registration, education, and fitness to practise functions, although not all the changes were ultimately beneficial. A significant driver for this change was the healthcare scandal concerning Dr Neary. Dr Neary was a consultant obstetrician/gynaecologist who was erased from the Medical Council register for professional misconduct. A subsequent judicial inquiry found that he had performed almost 200 peripartum hysterectomies (which was found to be 30-40 times the number most gynaecologists would perform in a career). The case only came to light following a disclosure from a whistle-blower. Three peers of Dr Neary had been asked previously to review cases and recommended he be allowed to continue to practise. Even though this review was not conducted by the Medical Council, this, and the culture in the hospital where Dr Neary worked, cast doubts on the capability of the medical profession to self-regulate.

The underpinning legislation for regulating the dental profession is now almost forty years old, and while many of its provisions remain robust, some elements of the Act are no longer fit for purpose. There are also some significant gaps that pose a substantial risk to patient safety. The Dental Council has been calling for a new Dental Act for almost fifteen years to allow the system of regulation to adapt to the systemic changes in dentistry since 1985. Dentistry has evolved, and a fundamentally different profession now exists. The way the profession delivers dental healthcare and the range and complexity of treatments routinely available in general practice has changed significantly and continues to do so. Specialist-level dentistry and the four auxiliary professions (see Table 2 on page 35) are also now regulated under the Act, albeit imperfectly. This evolution has challenged the regulatory framework, exposing risks to patient safety and potentially undermining public confidence in the profession. Dentistry, like many other healthcare professions, is now a global and very mobile profession; this mobility is not well supported by the Act. The present Act is also not sufficient to support the implementation of many elements of '*Smile agus Sláinte*,' the new National Oral Health Policy (NOHP).

The purpose of this submission is to:
• Present the council's views on the changes necessary to protect the public now and into the future in a rapidly evolving dental profession
• Identify the changes required to allow the council to meet its obligations under the NOHP.

3. THE DENTAL COUNCIL'S JOURNEY 1985 - 2021

Dental Council 1985 to 2008

The Dental Council was established in November 1985 when it took on the responsibilities of the former Dental Board. The Dental Board was established under a 1928 Act, and it assumed the responsibilities previously held by the General Dental Council in the United Kingdom (UK). There were three staff in 1985 and for much of the period until the late 2000's. At its establishment, there was only one register, the Register of Dentists, and there were fewer than 1,000 registrants. Almost all the new registrants were graduates of the two Irish programmes or dentists from the UK. There were virtually no European Union or non-European applicants for registration. The Dental Council accredited only two educational programmes, and during the period from 1985 to 2008 it held only eight fitness to practise inquiries.

Dental Council 2008 to 2021

The Dental Council now regulates almost 4,500 registrants across seven statutory registers. Irish-trained applicants for registration must have completed a Dental Council accredited programme and the council now accredits 21 programmes and several institutions. Each programme is accredited every five years and the accreditation process involves a detailed review of both the institution and the training. The Dental Council registered over 240 dentists in 2017. This was approximately 20% higher than the numbers registered in 2016 and it was the largest number ever registered in a single year. Similarly high numbers were registered each subsequent year until the COVID-19 pandemic, which virtually halted international movement. Now that the restrictions on international travel are being relaxed, the number applying for registration is starting to climb again. Two thirds of the dentists registering annually are trained outside of Ireland. Most are European Union-qualified dentists. The registration process is becoming increasingly complex as the typical registrant tends to have practised and/or been registered in more than one country.

The Dental Council runs an examination for non-European Union trained dentists wishing to work in Ireland. The numbers seeking to sit this have been gradually increasing over the last five years. For the first time ever, the 2018 examination was oversubscribed, and it was oversubscribed again in 2019 (the examination was not run in 2020 due to the pandemic restrictions). Our examination process is regularly challenged and the rules supporting it have become increasingly complex as a result. The Dental Council took over some of the responsibilities of the former Postgraduate Medical and Dental Training Board in 2010. The Dental Council published a guidance document on continued professional development for dentists in 2012, which was revised again in 2019. While registrants are ethically obliged to maintain an ongoing competence, this is not underpinned by legislation. This means that the council can only guide registrants on maintaining competence but it cannot regulate or check how registrants achieve this.

The Dental Council has held 22 fitness to practise inquiries since 2008. In common with the experiences of the other healthcare regulators, the cases have become increasingly complex in recent years, and they tend to be defended more rigorously than previously. Two recent cases were jointly the longest inquires ever held by the council. Each year, approximately 150-200 people contact the Dental Council seeking advice and guidance on concerns they have following dental treatment. The Dental Council's fitness to practise caseload is, however, significantly lower than in the other healthcare regulators. There is some evidence that this may be beginning to increase as dentists start to provide increasingly more complex treatment in general practice, but it is too early to determine that this is definitively the case. It is important, however, that the fitness to practise provisions are robust and allow the council to take appropriate action to protect the public, and to provide for a range of regulatory measures that are proportionate to the concern in question.

4. Significant Gaps in the Current Regulatory Framework

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4. SIGNIFICANT GAPS IN THE CURRENT REGULATORY FRAMEWORK

There are two gaps in the present Act that pose a significant risk to public safety: the failure to oblige registrants to maintain their competence on an ongoing basis in line with a statutory scheme and the failure to regulate dental practices. These are important because the majority of registrants are in private practices. Best practice in comparable professional regulation in Ireland is that the regulator has the appropriate powers to regulate in both these areas.

These gaps were of limited concern when the Act was first introduced as the range of treatments available, by today's standards, were minor and mostly confined to simple procedures or preventative work. As practices were comparably smaller and less complex, a proportionate regulatory balance between professional autonomy and patient protection was achieved by registering and advising dentists. Because of the significant changes in the structure of dentistry over the intervening period, the Dental Council's ability to ensure that patients are properly protected can no longer be adequately assured.

4.1 Ongoing Competence

There are two fundamental changes in the dental profession since the Act was introduced where the absence of a statutory competence scheme has increased the potential risk to public safety. The first is that the range of treatments routinely provided in general dental practice has become more varied and significantly more complex. Treatments such as orthodontics and implants, that were previously only provided in a specialist practice, are now routinely available in general practice. There have also been significant advances in the technology in dentistry, both in terms of the materials utilised and in terms of the diagnostic and records management systems used.

In addition to the usual progression that occurs in the practice of many professions over time, there have been at least five advances in dentistry since the early 1980's that have been more revolutionary than evolutionary. These have resulted in fundamental shifts in the way that dentistry is practised. As the research continues, change in each area is continual and accelerating:

- Adhesive dentistry and bonding, which is a complex treatment modality that resulted in significant changes in the way treatment is planned.
- The range and complexity of dental materials used in practice (for example in the use of ceramics and true multi-substrate adhesion materials).
- Implant dentistry in terms of treatment concepts, materials, and complex treatment planning.
- Significant infection prevention and control advances with the increasing knowledge of how pathogens are transmitted in dental and other healthcare settings (40 years ago, instruments were boiled, and dentists did not routinely wear gloves performing surgery).
- Digital technology, especially in endodontic treatment, radiography, and scanning.

The undergraduate dental programmes of forty years ago were unable to predict these changes to equip dentists for the rapid changes that occurred post-graduation. The profession changed and evolved safely because of the voluntary commitment of the profession to ongoing continuing education but there is no mechanism to proactively check this. Dentistry, along with other medical professions and disciplines, will change rapidly in the coming years as information processing capabilities improve and with the rapid advancement in robotics.

The second fundamental change is the internationalisation of the profession. The founding principles of the European Union (EU) underpinning the free movement of people, services and capital has created an international workforce in all areas of society, and especially in healthcare. Two thirds of the dentists registering annually trained outside of Ireland. While there is a minimum duration and subject-set for all dental programmes in the EU, in reality, the undergraduate training programmes do vary significantly across the union and are generally focused on local or national needs. While there are certain minimum standards that apply in dentistry, the range of treatments routinely provided varies significantly from country to country. There are also important differences in national healthcare systems and patient/disease demographics.

A properly functioning ongoing competence scheme serves two important functions: it allows professionals to both maintain and improve their skills base and to develop their practice as their patients' needs evolve. It also provides a structure to ensure that the profession remains informed and trained to best international practice. It is generally accepted that ongoing competence is an essential feature of the liberal professions, and this is generally underpinned by statutory obligations. Dentistry is out of step with both the other healthcare professions in Ireland and with dentistry internationally in not having a mandatory scheme.

4.2 Dental Practice Regulation

Dental practices have grown in scale since 1985 and it is commonplace to have a number of dentists and a range of auxiliary dental workers practising from one location. A dental practice operating at the standards applicable in 1985 would be dangerous by present standards. In addition, many dentists providing specialised treatments practise in several different locations. Dental practice ownership now includes corporate entities (of varying scale, and many not controlled by dentists), dentists in partnership and sole practitioners. As practices have increased in size and with the changes in the ownership structures, the question of where the responsibility rests between the professional and the dental practice for implementing appropriate standards has become increasingly unclear. The potential risk to patients has correspondingly increased.

Even though Section 52 of the Dentists Act, 1985 prohibits the practice of dentistry by bodies corporate, the interpretation of employment law for tax purposes and contractual workarounds have effectively circumvented this prohibition and made it largely symbolic. Increasingly, dental professionals are being regarded as employees rather than self-employed contractors for employment and taxation purposes. Many practice principals have created limited companies to manage the business side of their dental practice. Under this model, the practice principal provides a professional service as a dentist to the limited company they control through a contract for service: in effect, dentists are contracting to provide dental services to themselves. There are also a growing number of corporate bodies that own or control multiple dental practices. This means that increasingly, dentists are effectively employees of large corporate chains. This in turn creates a tension – and possible conflict – between a company's obligation to maximise shareholder return, an employee's obligation to act on the direction of their employer, and a professional's obligation to act in an ethical manner.

The Dental Council notes that it is government policy to remove the statutory prohibition on the practice of dentistry by body corporates. This was one of the twelve recommendations made by the Competition Authority (as it was known then) in its 2007 study of the dental profession. In this report, recommendation 10 stated that the Act should 'explicitly permit corporate dental bodies'. The Dental Council recognises that corporate dentistry can significantly benefit both the dental professional and their patients, but the ineffectiveness of the regulation of dental practices is providing an opportunity for risky, unscrupulous, and occasionally criminal behaviour. The Dental Council is aware of cases where the public have been exposed to significant risk and harm. Set out below are some examples where the council has received information highlighting significant public risk and where the council was powerless to intervene:

- A practice was opened by a dentist who was erased in two other European countries. He did not seek to register in Ireland, and a number of European Union-qualified dentists were brought to work in this practice. These dentists were registered properly with the Dental Council but tended to stay in Ireland for only a short period of time. It was not uncommon for a patient undergoing orthodontic treatment to have been seen by a number of different dentists over a short period of

time. Patients were encouraged to pay for their treatment upfront, and when the practice folded, many patients were left abandoned mid-treatment and out of pocket for many thousand euros.

- The council is aware of a number of practices where there are probably unregistered dentists practising, but it has no power to properly investigate these matters. One of these practices has closed and reopened under a number of different corporate entities, making it difficult for patients to seek a remedy for problems with treatment. There was also a significant turnover in the registered dentists working in this practice, making it almost impossible to attach a clinical responsibility to an individual dentist for deficiencies with treatments. Some of these practices cater to a mainly immigrant population who are a vulnerable cohort.

- The council receives a regular stream of concerning information from patients. These concerns frequently indicate that there may be significant failures in infection prevention and control standards and other patient safety standards. Generally, this information either concerns failings at a practice level rather than with a registrant, or it falls below the threshold required to prove an allegation against a registrant at a fitness to practise inquiry. There is no statutory or regulatory mechanism to address deficiencies with dental practices.

- The Dental Council is aware of the appointment of non-registrants into quasi-clinical positions (for example, treatment co-ordinators with no dental training whose role is effectively to 'sell' complex dental treatment to patients). The Dental Council is concerned that measures like this potentially skew the balance away from the delivery of safe and appropriate clinical care towards a requirement to achieve a certain financial return. Dentists need to be supported to make clinical decisions in their patient's best interests. Regulation is required to ensure that the correct balance between safe and ethical clinical practice and business objectives is achieved.

The Dental Council had no statutory power to act in any of these cases. In similar circumstances, the Veterinary Council of Ireland, the Pharmaceutical Society of Ireland, the Legal Services Regulatory Authority and the Irish Accounting and Auditing Supervisory Authority have the appropriate statutory powers to act.

5. Structure of Submission

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5. STRUCTURE OF SUBMISSION

5.1 Omissions and Weaknesses in Dentists Act, 1985

This submission is structured in the following way. The Dental Council has identified five broad policy themes that, in its view, requires legislative attention. The council's submission on each theme is set out in the following five chapters of this submission.

The themes fall into two categories: Omissions and Weaknesses, and Regulatory Enhancements. These are summarised in Table 1 below. The themes listed in the Omissions and Weaknesses section are matters that the council views as requiring urgent attention to ensure public safety. The themes listed in the Regulatory Enhancements section are matters that would enhance the current regulatory framework and the efficiency of the Dental Council as a regulator.

Omissions and Weaknesses in Dentists Act, 1985
Policy Theme – Education, Training and Continuing Development • Statutory scheme of ongoing competence • Replace Education and Training sections of Act with provisions that are fit for purpose • Code of conduct for mentoring new registrants
Policy Theme – Dental Practice Regulation and Other Public Safety Measures • Allow Dental Council to establish a register of dental practices, to regulate dental practice conduct and activities, and to inspect dental practices • Provide a statutory basis for inter-agency co-operation and enforcement between Dental Council and other agencies • Ensure professionals and practices are adequately insured and/or indemnified
Policy Theme – Independent Practice for Allied Dental Healthcare Professionals • Amend definition of practice of dentistry and remove the 'blocking' provisions in the Act • Provide for the Dental Council to establish a statutory scheme(s) for independent practice, to include a code of conduct, and to set education requirements and standards • Provide for a proper system of registration, ongoing competence, and fitness to practise
Regulatory Enhancements to Dentists Act, 1985
Policy Theme – Consistent Registration Systems • Ensure broadly similar registration processes across all registers • Enhance the council's powers at the point of registration • Revise the structure of the statutory committees
Policy Theme – Enhanced Fitness to Practise Provisions • Splitting the functions of the present fitness to practise committee between two committees, one dealing with preliminary matters and the other to hear inquiries • Add additional grounds for an inquiry • Amend the sanctions available to the council

Table 1

These proposals are critical to strengthen and enhance the regulatory system. Some of the provisions of the existing Act, especially those for education and training, are obsolete and no longer fit for purpose. The most significant gap is that no dental healthcare professional is lawfully obliged to maintain their competence, closely followed by the failure to regulate the corporate structures around dentistry (the first two policy themes listed in table 1). These omissions are a very significant public safety risk.

Currently the council has no statutory basis to either compel improvements in, or in serious cases, to withdraw recognition from registerable programmes of training where the programmes are failing to produce safe and competent professionals. This applies across the full range of programmes registerable by the Dental Council, but especially with the auxiliary and specialist training programmes. While the Dental Council is satisfied that the programmes it presently accredits are fit for purpose, the council notes the importance attached to undergraduate and post graduate education in the NOHP. It further notes the expanding roles envisioned in the plan for auxiliaries and specialists, and the likely expansion in the number of auxiliary programmes and changes in training modality, such as moving towards apprenticeship models for some disciplines. Having an appropriate accreditation process to regulate training underpins all regulation. Education is the key to safe practice.

The council's proposals for registration, education and training, and fitness to practise are to ensure that there is a broadly similar regulatory framework for all registrants. The proposals also aim to ensure that the council as an organisation is fit for purpose and appropriately resourced and constituted in a way that allows it to effectively regulate the profession, while maintaining public confidence and providing a structure that will allow the council to fulfil its role under the NOHP.

As the council anticipates that there will be a regular and ongoing engagement between the Department of Health and the council's executive as the new legislation is being prepared, this submission primarily identifies the significant changes required based on the council's knowledge of operating the current Act, the powers of comparable regulators and the requirements of the NOHP. It anticipates that much of the detail will be worked out during further engagements.

It is critically important to note that the proposals made in this submission are part of an integrated approach to Dental Regulation. In this submission, the council has set out its reasons why it is appropriate and practical for it to regulate dental practices. If, for example, a decision was made to designate a body other than the Dental Council to regulate dental practices, this will fundamentally undermine the council's policy themes concerning education and training (in particular, the proposals regarding ongoing competence and mentoring) and independent practice for allied dental healthcare professionals. Further, it will impact the way the council regulates dentistry in the future. The council asserts that this is the first key decision to be made and that it should be negotiated and agreed before agreeing or implementing any other policy.

The council also recognises that the State is required under European Union law to examine new or significantly amended regulation to ensure that the regulation is proportionate and fair, and to consider if the same policy aims can be achieved by alternate means. This may mean that some of the existing regulation in dentistry, mainly concerning the auxiliary dental professions, may require re-examination should the policy proposals concerning dental practice regulation in this submission be accepted.

5.2 Legislative Process

A new Act remains the Dental Council's key objective. The Dental Council notes that updating the Act is also a priority action for the Government in the NOHP (Action 28). At a meeting with the Department of Health in May 2021, the council was informed that the new Dental Act has *de facto* been deprioritised in the department's legislative agenda. The Dental Council is profoundly disappointed by this. New legislation is urgently required as public safety is at risk under the present legislation. From the council's perspective, it has seemed that the essential changes required in dental regulation have never had a high priority and it is deeply frustrating to consider that a new Act has been deprioritised even further.

The Dental Council recognises that it has a statutory obligation under the Dentists Act, 1985 to advise the Minister for Health on all matters relating to its functions under the Act and it welcomes the opportunity to make this submission. This submission primarily offers the council's opinion on the important policy issues that are necessary to ensure that the public are adequately protected in a dental environment that has changed significantly in the last thirty-six years, and to ensure the council is positioned to provide the appropriate regulatory structure to support the implementation of the NOHP.

The Dental Council has real and substantial concerns that the weaknesses and omissions in the Act identified in this submission require urgent and immediate attention. While the Dental Council's preference is for a new Dental Act, its overriding concern is that the gaps in the present regulatory framework are addressed as urgently as possible by whatever legislative means are necessary.

The council's proposals under *Policy Theme - Education, Training and Continuing Development and Policy Theme – Dental Practice Regulation and Other Public Safety Measures* are the urgent matters requiring attention to ensure public safety. The other matters are to address public access to dental treatment, to underpin the objectives set out in *'Smile agus Sláinte',* and to enhance the Dental Council's regulatory efficacy. The Dental Council wishes to again impress on the minister the urgency of this submission and again reiterates its view that dental regulation is out of step with best regulatory practice in Ireland in some key areas, and that patient safety is being compromised as a result.

The Dental Council appreciates that while a new Dental Act is not imminent, there may be scope to address some of the major shortfalls by bringing forward amending legislation. At a recent meeting, the Chief Dental Officer (CDO) opened a dialogue on whether, in the period until a new Dental Act was introduced, it might be possible to move ahead with some of the more urgent policy matters. The CDO wished to ascertain the council's views in this regard.

While the Dental Council acknowledges that it has no role in advising on legislative procedures, it submits that it would be best to implement change by way of amending legislation for each of the policy themes identified by the Dental Council above rather than approaching change in a piece-meal manner. The council recognises that one of the advantages of this approach is that it will allow the council to continue to apply the parts of the Act that are still fit-for-purpose (the Act proved resilient in allowing the Dental Council to address the challenges posed during the pandemic). It should be noted that amending existing legislation can make the regulatory framework complex and may expose the council to more legal challenge, but this is a necessary price for ensuring the important patient safety protections are brought forward at the earliest opportunity.

The council submits that the first and most important step is to agree the main areas requiring change. It looks forward to engaging with the minister and the department to agree the policies at an early stage. The council would like to re-iterate its views that the policy changes it is recommending are a series of integrated proposals predicated on the council being responsible for each part. Should the minister determine an alternative policy, then a number of the proposals made in this document will need to be significantly revised. The Dental Council submits that the policy objectives be agreed and signed off in its 2022 Performance Delivery Agreement with the Department of Health.

6. Policy Theme
Education, Training and Continuing Development

Policy Proposals Concerning:

6.1 Ongoing Professional Competence

6.2 Education and Training

6.3 Post-Registration Mentoring

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6. POLICY THEME: EDUCATION, TRAINING AND CONTINUING DEVELOPMENT

6.1 Ongoing Professional Competence

POLICY PROPOSAL – Introduce a statutory obligation for all dental professionals to maintain their competence and empower the Dental Council to develop an appropriate scheme.

Rationale – Dentistry is out of step with all other regulated healthcare professions in not having a statutory continued professional development scheme. Implementing this is also necessary to ensure the NOHP can be implemented.

The provisions of Sections 87 to 91 of the Nurses and Midwives Act, 2011 are a useful reference point. The main features of the 2011 Act are that it obliges the regulator to establish an ongoing competence scheme, it creates a statutory obligation for the professional to maintain competence, and it obliges employers to facilitate this. This will be a crucially important provision in the context of practice regulation. This proposal is consistent with Action 25 of the NOHP.

No dental healthcare professional is statutorily obliged to maintain their competence to practise. The Dental Council has no authority to establish an ongoing professional competence scheme, and there is no obligation on any dental healthcare professional to demonstrate the steps they are taking to maintain competence. Matters concerning competence can only come to the council's attention during a fitness to practise matter. In the council's view, this is a failure of regulation as patient safety cannot be protected retrospectively. For the profession and the integrity of dentistry, this is the single biggest weakness in the present Act.

Dentists routinely prescribe a range of medications, perform complex, invasive/surgical and expensive treatments, use ionising radiation, manufacture and insert prostheses, implant medical devices into tissue, administer anaesthesia and sedation, manage medical emergencies, and provide dental and healthcare advice to patients. There is no system to assess that a registrant is competent to perform these treatments. In common law jurisdictions, the remedy for patients when something goes wrong is generally through the legal system, and for this reason most competence cases are litigated as negligence cases in the courts. A properly functioning competence scheme is a proactive 'upstream' measure that aims to reduce the chances of a patient suffering harm from negligence, poor practice based on out-of-date knowledge and techniques, or professional misconduct.

It is also important for the auxiliary professions to be competent to practise safely. Clinical dental technicians practice independently and autonomously. Dental hygienists and orthodontic therapists are highly skilled practitioners, and they must be familiar with the ongoing clinical and theoretical developments in their respective fields. Dentists routinely delegate practice-wide responsibility for infection prevention and control to their dental nurses (many of whom are also trained to take x-rays under prescription). Some dental nurses also are trained to assist dentists providing treatment to patients under sedation and general anaesthesia. All members of the dental team are expected to be competent to manage or assist with medical emergencies.

By law, Ireland obliges all healthcare professionals except dentists to be competent to practise. While registrants with the Dental Council have an ethical obligation to be competent, it is impossible for the council to evaluate what steps a registrant is taking. The Dental Council's only role at present is to determine if there was professional misconduct when something goes wrong. Even then, it is generally not possible to perform a 'look-back' on the dentist's continuing professional development. Often a patient who suffers harm does not wish to make a formal allegation of professional misconduct.

It is generally accepted that all professionals, healthcare and otherwise, need to maintain their competence to practise and the Dental Council is out of step with almost all other statutory professional regulators in not having a legislative basis for introducing a competence scheme. Dentistry in Ireland is also out of step with good practice in Europe and world-wide. The Dental Council is not aware of any jurisdiction where the obligation on a dental registrant to remain competent to practise is as inadequate as the Irish system. Public safety is being compromised by not having a statutory competence scheme.

The Dental Council's vision is that all registrants should be competent to work in their chosen area of practice. The Dental Council will have to ensure that any statutory scheme it brings forward is equally amenable to all registrants regardless of their area of practice. This will mean the scheme will need to be nuanced. The scheme must apply equally to a dentist who works whole-time in policy or administration, an oral surgeon, a high-street dentist offering implants and orthodontics, or a recently qualified dental nurse. Best practice in healthcare regulation in Ireland is to provide that registrants are legally obliged to maintain competence and to provide for the regulator to establish a scheme of continuing professional competence.

Developing the rules for an ongoing competence scheme will take time as the scheme needs to sufficiently balance the obligations on the registrant, their area(s) of practice, previous training, career lifecycle and the obligations on employers. It needs to be relevant, apply equally to all registrants and it must be realistic. For this reason, the present Dental Council guidelines are not fit for purpose as a statutory scheme. Because the key obligation will be on the registrant to be competent, the scheme, and how the Dental Council monitors it, needs to be supportive and not punitive. A key component would be the registrant's personal reflection on their own knowledge gaps and the steps being taken to address these deficiencies.

One of the core goals in the NOHP is matching the treatment needs of the population to the skills base of the dental profession, with the gaps to be filled by appropriate training and development (Action 25). This has been identified as a priority action and the lack of a statutory scheme will hinder the implementation of the NOHP.

6.2 Education and Training

POLICY PROPOSAL – Grant the Dental Council the explicit power to evaluate all registerable programmes of training, including the power to attach conditions to programmes and ultimately, the power to remove recognition from a programme of training.

Rationale – the Dental Council should have power to evaluate all registerable programmes of training and the training bodies, including the power to attach conditions to programmes, and ultimately, the power to remove recognition of a programme of training. This is consistent with the NOHP and with best practice in healthcare regulation in Ireland and internationally. The council suggests replacing Sections 34 to 36 of the Dentists Act, 1985 with provisions similar to Sections 85 and 86 of the Nurses and Midwives Act, 2011. The Dental Council also wishes to continue to recognise qualifications from outside the EU for the purposes of registration.

Regulating the education and training of registerable programmes has become increasingly complex both in Ireland and internationally. All education programmes are subject to a significant amount of oversight within the education sector to ensure quality in the education process. The regulator has a 'gatekeeper' role, and it is responsible for ensuring that the requirements and standards for training are sufficient to equip graduates to practise safely and to ensure that the education providers are meeting these standards.

The legal provisions for the regulation of dental training in Ireland does not allow the Dental Council to attach statutory conditions to a programme of training or to remove the recognition of a programme for registration purposes. The powers the council does have are significantly different depending on whether the programme is an undergraduate dental programme, an auxiliary programme, or a specialist programme. The Dental Council submits that the accreditation provisions should be sufficiently robust and broadly similar for all dental programmes.

All healthcare regulators have developed robust systems to ensure that the graduates of registerable programmes are adequately trained to practise safely on graduation. The Dental Council lacks many of the powers open to other healthcare regulators. The quality and content of dental education is central to the implementation of the NOHP (Actions 19, 21 and 27 and all three are identified in the policy as priority actions). The provisions of Sections 34, 35 and 36 of the Act are not sufficiently robust enough to ensure that the Dental Council can properly regulate dental education or to meet its obligations under the NOHP.

6.3 Post Registration Mentoring

POLICY PROPOSAL – Create a statutory obligation on employers to provide an appropriate mentoring programme for new registrants, and oblige the Dental Council to issue guidance and, ultimately, to bring forward a statutory code of conduct for mentoring rew registrants.

Rationale – this measure is being proposed to ensure that new registrants (both new graduates and those new to practice in Ireland) are appropriately inducted into the Irish healthcare system. This proposal is consistent with the NOHP (Action 24 and, partially, Action 25).

The Dental Council supports an objective of the NOHP to ensure that postgraduate mentoring and supervisory networks are in place to support dentists in their professional career (Action 24). A key part of this is ensuring that those professionals who are new to practice in Ireland – be it those who have recently qualified or those who have recently registered and are practising in Ireland for the first time – are supported during their introduction to Irish dentistry. The policy notes that almost 40% of dentists hold qualifications from outside of Ireland and the United Kingdom, and that two thirds of those applying for registration as a dentist each year are not Irish-trained.

The Dental Council notes that for this reason, this support can only practically occur post-registration and not as part of the programme of education. The Dental Council will only be able to formulate a more detailed proposal on how this might be implemented after it has been confirmed that the intention of Action 24 is broader than just recently qualified Irish dentists. In the Dental Council's view, all new members of the dental team should be appropriately mentored post-registration. It would be helpful for the department to clarify this at an early stage.

The proposals set out in the *Policy Theme – Dental Practice Regulation and Other Public Safety Measures* section are framed under the assumption that this mentorship and support will occur post-registration and that the Dental Council will have the power to regulate and inspect dental practices. It is the Dental Council's view that there is an ethical obligation on the new registrant, their employer, and the State to ensure that those new to practice in Ireland are appropriately supported and mentored. The Dental Council recommends that these obligations be underpinned in the Dentists Act. Ensuring that this obligation is fairly and appropriately balanced will require further detailed consideration.

It is important that the mentoring scheme is seen as supportive of both the dental practice and registrant, and that it is regarded as a safety-focused initiative to support the transition into dentistry in Ireland. The Dental Council recommends that this should be underpinned in the Act by obliging the Dental Council to create a statutory code of conduct that sets out the obligations on both the professional and the practice that are balanced, graduated, proportionate, and reflect the nature and circumstances of the dental practice and the new registrant's post-qualification clinical experience, competence, and knowledge of the Irish healthcare systems.

As this is a new concept in dentistry, the Dental Council proposes that in the first instance, it should issue guidance to employers and new registrants on mentoring. This could then be replaced by the statutory code of conduct, possibly in tandem with commencing the scheme of dental practice regulation.

7. Policy Theme

Dental Practice Regulation and Other Public Safety Measures

Policy Proposals Concerning:

7.1 Regulating Dental Practices

7.2 Inter-agency Co-operation

7.3 Insurance and Indemnity Cover

Dental Council

An Comhairle Fiaclóireachta

7. POLICY THEME: DENTAL PRACTICE REGULATION AND OTHER PUBLIC SAFETY MEASURES

7.1 Regulating Dental Practices

POLICY PROPOSAL – Establish a register of dental practices and revoke the provisions of Section 52 of the Dentists Act, 1985 regarding the prohibition on practice by corporate bodies. The council submits that there should be a statutory obligation to register:

- **sufficient information about the controlling entity to ensure that it, and the persons controlling it, are fit and proper to control a dental practice or a group of practices**
- **a principal practitioner in each location controlled by the controlling entity**
- **an owner representative (a suitably qualified practitioner) with a group-wide remit.**

Rationale – there are a significant number of similarities in the ways the business of dentistry and the business of pharmacy are organised. The registration and offences provisions for retail pharmacies allow for the regulation of different classes of corporate ownership and ensure that there is a nominated supervising pharmacist in every pharmacy. This is an important public safety measure. The council recommends using the model for regulating retail pharmacies as a starting point for regulating dental practices.

The register will enhance public safety and confidence and the information contained therein will be important for implementing the NOHP. Both the owners and controlling corporate entities must be fit and proper to own and manage a dental practice or a group of dental practices, and that the criteria to establish this be set in rules made by the Dental Council.

There is no direct accountability for dental practices under the Dentists Act, 1985 and this is a significant omission in the regulatory framework. When the Act was introduced in 1985 most dentists practiced individually or in a small partnership with one or two other dentists. Dental practices were comparably smaller and less complex and a proportionate regulatory balance between professional autonomy and patient protection was achieved by regulating the dentist and prohibiting the practise of dentistry by bodies corporate. Dentistry has also become more complex in the intervening thirty-six years. In this time, the council has introduced a specialist register with two divisions, and registers for four auxiliary dental professions. Dentistry has become a very integrated profession since 1985.

It is now becoming more commonplace for corporate entities to own or manage the dental practice and to employ dental professionals either as independent contractors or, increasingly, as employees. Even though Section 52 of the Act prohibits the practise of dentistry by bodies corporate, the interpretation of employment law for tax purposes and contractual workarounds have effectively circumvented this prohibition and made it largely irrelevant. On occasion, a dentist may not even be involved in the controlling corporate entity. With these changes, the question of where the responsibility for implementing appropriate standards rests between the registrant providing treatment and the dental practice has become increasingly blurred. In addition, it is also becoming increasingly commonplace for dental professionals to provide treatment in multiple dental practices, especially those providing specialised services. The potential risk to patients has correspondingly increased.

It is intended that any place where dentistry is practiced would fall within the scope of these provisions, with the exception of dentistry practiced in hospitals. This would include, general practice, specialist practices, independently practicing allied dental healthcare professionals, and practices only offering dental appliances. This includes settings in both the public and private sector, and cohort-specific dental practices such as dental services provided by employers, in the prison service, and possibly the armed forces.

The Dental Council made its case for dental practice regulation eight years ago, and the failure to implement any system of control has resulted in significant patient harm. In one of the cases cited in the introduction, the Dental Council is aware of at least twenty-five patients who were left with incomplete or ineffective treatment and who were out of pocket for significant sums of money. In some cases, patients had paid a five-figure sum to the dental practice and also had to fund the resultant corrective work at significant expense. The council is concerned that clinical safety is being potentially compromised in other dental practices also. No statutory body has the express authority to investigate these clinical concerns and there is little redress open to patients.

Failures of care can also happen at the practice level, and this has led to other cases where patients were exposed to harm and/or significant financial loss through failures of care where the root cause was at practice level. The ability to set standards, inspect, and oblige improvements at a dental practice level are the cornerstone of a system that will allow the council regulate dentistry in an appropriate, risk-based manner, and is consistent with the regulation of other comparable professions. Below are the three strands necessary to properly regulate dental practices and the business of dentistry. These are the minimum necessary to ensure that there is an effective range of enforcement and compliance tools in place to protect the public and underpin confidence in the profession:

- An appropriate registration framework
- Statutory Code of Conduct for dental practices and those with designated accountability
- Investigation, inspection, compliance, and enforcement

The Dental Council is aware that an argument could be made that dental practices are already open to potentially multiple inspections. The following organisations have statutory powers to routinely inspect any business or entity (and not just in dentistry or healthcare) falling under the relevant statutory purview:

- Employee terms and conditions and payroll (Workplace Relations Commission)
- Health and safety (Health and Safety Authority)
- Waste management activities (Environmental Protection Agency and/or local authorities)
- Radiation protection (Health Information and Quality Authority and Environmental Protection Agency)
- Regulated medicines and medical devices (Health Products Regulatory Authority)

In addition, dentists applying for contracts under the Dental Treatment Services Scheme (DTSS) are visited to assess their suitability to provide services on behalf of the State, albeit without an express statutory provision. It is important to note that this is a commercial inspection rather than a regulatory inspection and the only sanction open is to have a contract refused or terminated. The Dental Council understands that these visits are by invitation of the contracting dentist.

None of the agencies listed above has a statutory role to ensure that the clinical governance, treatment standards, patient safety and protection, and practice management systems are adequate at a dental practice level for the safe delivery of dental care to the public.

POLICY PROPOSAL – Provide an appropriate system of inspection and enforcement by the Dental Council.

Rationale – The lack of a system of dental practice regulation has caused both harm and financial loss to patients.

There are several similarly worded provisions to provide for statutory inspections in healthcare regulation already (The Health Act, 2007 for HIQA, the Pharmacy Act, 2007 for the Pharmaceutical Society of Ireland and the Food Safety Authority of Ireland [FSAI] Act, 1998). The most relevant model for dentistry is the one provided for in the FSAI Act. The FSAI provisions allow for a graduated system of control that starts with the issue of improvement notices and escalating to improvement orders (via the District Court) and closure orders (by their nature, these are rare and based on significant risk to public safety. Because of the urgency, these are temporary and injunctive in nature and are signed by the CEO of the FSAI).

All these systems provide for an authorised inspector to enter, inspect, and take and remove evidence where appropriate. The provisions should allow for council officers to examine patient records and to interview witnesses where appropriate. The registrar should have the power to take whatever action is deemed necessary and appropriate on foot of an inspection report, including making a complaint under fitness to practise concerning a registrant, applying to the courts for an improvement order or, in exceptional circumstances, issuing a temporary closure order when urgently required in the public interest.

The Dental Council should also have the power to apply to the courts to permanently close a practice and to levy fines on the controlling entity for breaching the code of conduct. The Dental Council recommends that fines be set on a sliding scale based on a percentage of turnover. The council submits that this is a more appropriate way to levy a fine and properly reflects differences in the commercial scale of the controlling entity.

The Dental Council notes section 9.3.1 of *Smile agus Sláinte* on updating the Dentists Act, 1985. This identifies some of the key areas requiring legislative attention in order to meet the policy's objectives. The policy recognises the importance of regulating and enforcing standards in dental practices to assure and protect the public:

> *Another aspect of providing assurance for the public is the need for regulation to enforce standards for dental practice premises in line with Dental Council policies, ethics and recommendations. The protection of the public and ensuring high oral healthcare standards will be the central focus of the new legislation.*

The Dental Council also notes section 6.5 of the Competition Authority's 2007 study of the dental profession where the authority accepted that the council is severely restricted in its ability to regulate the dental profession because it does not have the power to inspect dental practices:

> *There are no regular checks on the standard of dental services provided by dentists. The Dental Council cannot promote high standards of dental treatment through regular inspections. Rather, the Council must wait until damage is done to a patient before it can act against a dentist.*

Best practice in comparable Irish professional regulation, where that profession is practised predominantly in the private sector, grants the regulatory body the power to register and inspect premises and investigate. Regulators who maintain registers and have the power to inspect include:

- Pharmaceutical Society of Ireland
- Veterinary Council of Ireland
- Legal Services Regulatory Authority
- Irish Auditing & Accounting Supervisory Council

These are comparable professions because they predominantly practise in the private sector and the business models are comparable to those in dentistry. The regulatory model in accountancy is only partially comparable because its regulatory

structure is a mix of a statutory body and non-statutory professional organisations. But the statutory regulator has the power to regulate auditing practices and to investigate.

In healthcare, the organisation of dentistry is more akin to the pharmacy profession than it is to medicine or nursing and midwifery. The medicine, nursing and midwifery professions are practised mainly in the public sector or public hospitals. HIQA regulates the large multidisciplinary healthcare providers and the nursing home sector, and so it is not necessary for the professional regulation legislation to include an inspection regime.

A comparison with veterinary services is relevant. Like dentistry, it is a statutorily regulated profession that operates primarily in the private sector and veterinary practices are potentially subject to the same range of inspections listed above (including the HIQA inspections for radiation protection). But the Veterinary Council maintains a register of practices, has the power to set the standards within practices, and it has the power to inspect practices and determine suitability. Presently, the State seems to offer a better protection to animals in a veterinary practice than it does to human patients in a dental practice.

For the comparable professional regulators mentioned above, the practice regulation and inspection regimes are fully integrated with their professional regulation. This integration is essential to ensure that professional practise is delivered appropriately. The learnings from competence schemes, education accreditation, patient communications, fitness to practise, liaison with the profession and Irish and international regulatory experiences will all inform the dental practice regulation framework. The practice regulation framework in turn informs the development in the education system, enhancements to the ongoing competence schemes, and revised guidance to professionals and standards of practice.

The Dental Council is aware that there are three possible working options for inspecting dental practices. The HSE already has a small team visiting practices albeit with no legislative basis. Because the HSE is the biggest single provider of dental services in Ireland (and would be regulated under these provisions) and because it has commercial arrangements with over half the private practices in the country, the HSE is compromised in having any role in the regulation of the profession. The Dental Council or HIQA would need to develop additional resources to create an appropriately structured inspectorate.

Disconnecting the inspection role, or even the entirety of dental practice regulation, from the professional regulator will not strengthen patient safety. In regulatory terms, a practice inspection is akin to the function of a wrist on an arm: it allows the regulator act with agility and precision and to change direction as the circumstances warrant it. There is no logical argument that can be made towards the position that having one organisation regulate the professional and another regulating the practice or premises strengthens the regulatory landscape. At best, the protection can only be the same, but in practice, it will be significantly worse because the agility to act when required is lost if it requires two organisations to co-ordinate action. For example, it is almost certain that a decision to close a dental practice on public safety grounds will also lead to the Dental Council to applying to the High Court to suspend one or more practitioners on the same public safety grounds. It would be difficult for this to happen if responsibility for regulating the dental practice was separate from the professional regulator.

A key power held by the regulators listed above is the power to initiate an investigation based on information received or on the regulator's own initiative. This power is crucial because it allows the regulator to assess the risk of harm based on multiple sources of information such as patient communication with the Dental Council, complaints received that do not reach the threshold for a fitness to practise inquiry, the ongoing competence scheme, other agencies, media and social media, mentorship programmes, and information from the profession generally.

Introducing a register of dental practices will also enable the registers to be a source of information to aid the implementation of the NOHP. The policy places primary care at its heart and one of the stated goals is to increase access to care and to ensure the provision of dental services adequately matches dental need. At present, there is no unified source of information regarding dental practices.

POLICY PROPOSAL – Provide for the Dental Council to set standards for dental practices and to regulate the duties of practice owners, registered principals, and registered owner representatives.

Rationale – this proposal is necessary to ensure that the Dental Council can establish the appropriate regulation to set standards for dental practices and to guide inspections. These standards will copper-fasten the practice owners' responsibilities in a range of areas such as:

- Ongoing professional competence
- Mentoring schemes for new graduates and registrants
- Supporting auxiliary dental workers to practise in a safe manner
- Ensuring appropriate patient protections are in place (for example, appropriate referral pathways, clinical audit policy, risk management, 'cooling-off' periods etc.)
- Robust complaint management
- Ensuring that practices and professionals are adequately insured or indemnified
- Enforcing infection prevention and control standards
- Regulating practice-wide record keeping
- Other relevant public health matters

In the Dental Council's view, it is essential that the dental practice regulations include a requirement for owners to register the name of a suitably qualified principal registrant for each practice location. Where the owner operates dental practices in multiple locations, they must also nominate a suitably qualified registrant to be the registered owner representative (this person would be effectively managing standards across a group of practices). Both the owners and controlling corporate entities must be fit and proper to own and manage a dental practice or a group of dental practices, and the criteria to establish this should be set in rules made by the Dental Council. The Dental Council submits that the registration and inspection strands of dental practice regulation should be underpinned by a statutory code of conduct that is binding on practice owners. The council envisages that this code would be centred on patient safety and there should be a governance framework that promotes accountability, clinical audit, risk management and adverse event management.

Dental practice ownership is likely to include a combination of corporate bodies (of varying scale and structure), dentists in partnership, and sole practitioners. All regulation must be fair, proportionate, and reasonable. Any code of conduct will need to balance patient safety, the nature and the scale of the entities controlling dental practices, and risk. The dental practice regulation provisions will also allow the Dental Council to support ongoing competence and mentoring schemes, and it will assist in establishing a framework for auxiliary professionals working independently to practise safely.

How a dental practice is defined for the purposes of regulation will be critically important. The definition will need to properly reflect the variety of circumstances in which dental services, including dental appliances, are offered to a patient, how dental services should be organised to ensure the registrant's ethical responsibilities to their patients are protected, and the general corporate fitness of both the entity and its owners.

7.2 Inter-agency Co-operation

POLICY PROPOSAL – The new Dental Act should allow for the Dental Council to enter into agreements with other bodies for the purposes of avoiding duplication of activities, to provide for the exchange of information, and to allow for joint investigations or studies.

Rationale – To avoid duplication of effort and reduce the regulatory burden on the regulated persons and entities. Section 16 of the Nursing and Midwifery Act, 2011 provides for the Nursing and Midwifery Board to enter arrangements with other bodies. While the provision in this Act is a useful starting point, the arrangements will need to be more robust, possibly to the point of a regulatory body being able to delegate some of its enforcement powers to another entity or allowing the council to enforce on behalf of another regulator (or vice versa), or to provide for joint action.

Inter-agency co-operation and action will almost certainly become increasingly important for all regulatory and enforcement bodies over the coming years. Changes in technology and the developments in artificial intelligence will mean that the boundaries of dentistry will become more blurred. Some care and treatment that is the practice of dentistry at present will almost certainly be delivered in other ways in the future because of developments in technologies and information processing.

The Dental Council supports the appropriate use of technology to provide safe care and treatment, and it accepts that over time, treatments that can now only be safely provided by a dentist may ultimately be able to be safely provided by other means. As the technology progresses, public safety is of paramount importance. It is probable that the regulatory responsibility will either fall across several agencies or may not fit comfortably into the role of any one agency. The underpinning legislation for Dental Council should allow it enter arrangements with other regulatory bodies to allow for flexible and focused regulatory action.

Inter-agency co-operation is already a feature of the Dental Council's work. The Act does not prohibit this, but because there are no express provisions to allow it, the extent of this co-operation is limited. The new Act should facilitate this work by allowing for the council to enter into agreements to avoid duplication of effort, to exchange information and to allow for effective regulation in the public interest. Currently, the Dental Council engages with the Health Products Regulatory Authority, Health Information and Quality Authority, the Environmental Protection Agency and education institutions. The Dental Council submits that this provision, along with its proposals concerning practice regulation, will assist it in ensuring that patients are appropriately protected as digital technology develops to ensure that devices such as orthodontic appliances and dentures are provided to the public in a safe manner.

7.3 Insurance and Indemnity Cover

POLICY PROPOSAL – The new Act should mandate that all registrants, including dental practices, are appropriately indemnified or insured in a manner similar to the system in place for medical practitioners.

Rationale – This is a significant omission from the present regulatory system in dentistry and it is leaving patients exposed by not having an adequate recourse for shoddy or negligent treatment. Common law is clear that these matters, when disputed, are appropriately litigated in the courts. Consequently, it is in the public interest to ensure that registrants are appropriately indemnified against failures in care. This provision should go a step further and place an active obligation on dental practices to ensure that their employed registrants carry appropriate indemnity for the entire time that they are practising and to ensure that the practice is appropriately insured/indemnified.

The Dental Council receives regular correspondence from solicitors acting on behalf of patients either seeking information concerning the treating dentist's indemnity (as the dentist has failed to provide this information) or claiming that the dentist

does not have indemnity. The council has significant concerns that there are dentists practising who have either inadequate insurance or no insurance. There is no statutory provision obliging registrants to hold indemnity or provide this information to the Dental Council. Failing to hold appropriate insurance or failing to provide this information to a patient's legal representative is not in the public interest and potentially exposes patients to significant expense and stress. While dentists have an ethical obligation to hold insurance, in practice, it is impossible for the Dental Council to prove beyond reasonable doubt that a dentist does not hold indemnity.

The Medical Council has a system of regulation in place to ensure medical practitioners are appropriately indemnified/insured (Medical Practitioner (Amendment) Act, 2017). The Medical Council, on the recommendation of the State Claims Agency, has set the conditions for cover for over fifty different classes of medical practitioner. This Act sets out a statutory scheme obliging all medical practitioners to hold appropriate indemnity and provides for a proper system of regulating this. Subject to the State Claims Agency consenting to this, the Dental Council submits that similar provisions should apply in dentistry.

It is important also to ensure that the entity controlling the practice is also appropriately insured and indemnified. This requirement will need to have regard for the different ownership models in dentistry. The Dental Council is aware of a recent case in the United Kingdom High Court (which, while not creating case law in Ireland, would be influential) where a practice owner was found to be vicariously liable for failures in treatment by an appropriately indemnified associate in his practice. The presently understood legal model where the registrant carries the insurance risk for treatment would seem to be breaking down. The council is aware of instances where corporate entities have paid the cost of restorative work where the treatment provided by a former employee or associate has failed.

8. Policy Theme

Independent Practice for Allied Dental Healthcare Professionals

Policy Proposals Concerning:

8.1 Auxiliary Dental Workers

8.2 Dentures and Dental Technology

8.3 European Union Proportionality Test

Dental Council

An Comhairle Fiaclóireachta

8. POLICY THEME: INDEPENDENT PRACTICE FOR ALLIED DENTAL HEALTHCARE PROFESSIONALS

8.1 Auxiliary Dental Workers

POLICY PROPOSAL – Remove the statutory provision prohibiting independent practice, and direct access by the public to auxiliary dental workers.

Rationale – Removing the statutory prohibition on auxiliary dental workers practising independently is a priority in the NOHP (Action 19) and this cannot be achieved without amending or revoking Section 54 of the Act. This can only be done safely in conjunction with the other measures set out in this submission regarding registration, education, ongoing competence, and fitness to practise. The council submits that using statutory rule rather than primary legislation to regulate the different classes of allied health professional is the optimal way to regulate for independent practice. It will also allow the professions evolve with changes and improvements in technology and clinical practice *(see Policy Theme – Consistent Registration Systems)*.

POLICY PROPOSAL – That auxiliary dental workers be known as allied dental healthcare professionals and that the term 'registered allied dental healthcare professional' be defined in the 'Interpretation' section of the Act

Rationale – The NOHP proposes to significantly widen the scope of practice of the allied dental healthcare professions, including where appropriate and safe, the introduction of independent practice for some classes. A level of independent practice implies that these professionals are not auxiliary to registered dentists but work collaboratively with dentists. The term 'auxiliary' does not presently reflect the scope of practice of clinical dental technicians and conflicts with the intent and scope of the NOHP.

Independent practice requires strong registration and education provisions (covered in more detail under *Policy Theme – Dental Practice Regulation and Other Public Safety Measures* of this submission) to ensure public safety, but the Interpretation section should define 'registered allied dental healthcare professionals' as meaning a person whose name is registered in a register of a division of dental healthcare professional.

Section 54 of the Dentists Act, 1985 is the only legislative bar on allowing patients to access auxiliary dental workers directly. This section is a significant blockage to implementing the NOHP which identifies enabling direct access to auxiliary dental workers as a priority (Action 19). The Dental Council submits that removing this provision should only be done in the context of establishing a proper regulatory system. This includes systems for registering auxiliary professionals, accrediting registerable programmes, and ongoing professional competence. It should also provide accountability (especially for those registrants providing either direct access or practising independently) through fitness to practise, and to allow for a proper statutory scheme to regulate professional activity. Removing Section 54 alone and without the other measures would not be in the public interest.

The Dentists Act, 1985 was enacted at a time when dental assistant was the only auxiliary profession in dentistry in Ireland. There was no register and no obligatory minimum education standards. In 1985, Part 7 of the Act envisaged that different classes of auxiliary dental professions might in time evolve, and it provided for the creation of auxiliary professions by way of

statutory scheme. But it failed to provide for a proper and robust regulatory framework to control access to and removal from the register or to allow the council set appropriate standards of education and competence. This is only clear in retrospect now that new professions have evolved, and the new registers have been established. Patient safety is compromised by this failure.

There is no mechanism for removing an auxiliary dental worker from the register for a reason other than the failure to pay the annual retention fee. This means that, for example, a clinical dental technician who is convicted of a serious crime or who has endangered patient safety in a practice setting can remain on the register and continue to treat patients. In common with dentistry, there is also no statutory provision for an auxiliary dental worker to maintain their competence.

There is no statutory provision to allow the council to properly accredit auxiliary training programmes, or, if necessary for public safety reasons, to remove the accreditation of a programme for registration purposes. While the Dental Council would be willing to defend this point on patient safety grounds should it be challenged, the lack of a statutory basis for removing approval means that it is questionable if the council could successfully defend a challenge.

It is important to note that the Dental Council is satisfied that the programmes it presently accredits are fit for purpose. The council notes the importance attached to undergraduate and post graduate education in the NOHP (Actions 24 and 25). It further notes the expanding roles envisioned for auxiliary dental workers in the plan (Action 19) which will result in the number of auxiliary programmes expanding and possible changes in training modality, such as moving towards an apprenticeship model for some classes of auxiliary dental workers. The Dental Council's priority in all instances is that the training pathways develop safe graduates.

The Dental Council anticipates that the movement towards independent practice will be gradual. Independent practice means that the allied dental health professional would attend to and treat a patient without a dentist first examining the patient and then prescribing and supervising the course of treatment. There are different models for this, but council anticipates that most treatment will continue to occur in a general dental practice and that it will provide for direct access to dental hygienists in the first instance. It is important to note, however, that the training programmes will have to be expanded to allow for any form of safe independent practice. The expanded programmes will at a minimum, have to include training on managing medical emergencies, clinical diagnosis, treatment planning, referral pathways, and an enhanced clinical component. The regulatory structure providing for independent practice will also have to be mindful of the possible consequences of independent practice, such as the provision of other non-dental treatments and services such as non-surgical cosmetic procedures.

The Dental Council further notes that it may, in time, be desirable to regulate for dental therapists. Internationally, dental therapists tend to practise with a significant level of clinical autonomy. Proposals to strengthen the registers and the associated protection of title requirements are addressed in the *Policy Theme – Consistent Systems of Registration section of this submission*. Proposals to make all registrants amenable to fitness to practise are addressed in the Policy Theme – Enhanced Fitness to Practise section of this submission.

8.2 Dentures and Dental Technology

POLICY PROPOSAL – Remove the reference to artificial teeth in the definition of the practice of dentistry.

Rationale – One of the aims of the NOHP is to ensure the supply of dentures is sufficient to meet demand. In addition, and in a proposal that is compatible with this aim, the Dental Council would like to open a register of dental technicians. The existing definition for the practice of dentistry has put the profession of dental technician beyond the scope of dental regulation and it also potentially conflicts with Section 54(3) of the existing Act, which is the section enabling the practice of clinical dental technicians.

The definitions within the Act seeking to demarcate the fabrication of dentures and the supply of dentures to the public would be better addressed by way of regulation rather than within primary legislation. In making this proposal, the Dental Council is seeking to ensure that the public has appropriate and safe access to care. The Dental Council suggests that to address this anomaly, and subject to legal advice, the definition of the practice of dentistry could be shortened to:

*'The performance of any operation and the giving of any treatment, advice, opinion or attendance which is usually performed or given by a dentist.' **

** Legal advice may be required as to whether this is necessary to cover auxiliaries practising independently in the definition of dentistry.*

The Dental Council views the manufacture of dentures and dental devices as an intrinsic part of dentistry. Dental technology is a profession that exists only to provide prosthetic and dental devices to the dental profession. Although the number is diminishing, historically, many dentists manufactured dentures and crowns for their own patients. The manufacture of a device is a collaborative process between the prescribing dentist and the dental technician, but the definition of dentistry in the Dentists Act, 1985 has put this key part of the profession outside of the legal definition of dentistry. The effect of this means that the Dental Council can only partially regulate the practice of clinical dental technicians and it cannot regulate dental technology.

The Dental Council notes that one of the aims of the NOHP is to ensure that patients have access to appropriate care, including in the supply of dentures. There are capacity and access issues in the profession that mean that there are only a small number of clinical dental technicians practising in Ireland. This profession is unlikely to ever achieve a sufficiently large critical mass of professionals to be self-sustaining, and its small size means that there is little geographic coverage to ensure reasonable public access to the profession. At present, there is only one approved and accredited programme of training for clinical dental technicians in Ireland. Because of an anomaly created by the definition of dentistry in the Act, entry to this programme is pitched at an academic level that puts it beyond the reasonable aspiration of many who might ordinarily consider entering the programme.

There is a demand for denture services and while much of this demand is being met by dentists and clinical dental technicians, it is also being met by the many dental technicians illegally providing dentures to the public. The Dental Council is a prescribed organisation under Section 71 of the Consumer Protection Act, 2007, which allows it to apply to the courts for an order prohibiting a trader or person from committing or engaging in an act or practice prohibited under the legislation. While this is a potentially useful power, the circumstances in which the council can use it are limited. The main problem is that the provisions of the Dentists Act, 1985 are insufficient for the council to take any meaningful action.

The council notes that the NOHP proposes reviewing the roles of dental technicians and clinical dental technicians (Action 21) and to assess how dentures services are provided to the public. The policy identifies this as a priority action. The NOHP implicitly recognises that the present low numbers of clinical dental technicians are insufficient to meet the demand for denture services and it proposes possibly expanding the scope of what a dental technician is permitted to do. The Dental

Council submits that amending the definition of dentistry and allowing the council to regulate the roles of clinical dental technician and dental technician through statutory schemes is the optimal way of ensuring that public safety is ensured as both professions evolve.

8.3 European Union Proportionality Test

Under European Union law, Ireland is required to examine new or significantly amended regulation to ensure that it is proportionate and fair, and to consider if the same policy aims can be achieved by alternate means. With healthcare regulation the risk of harm is key to this assessment. The purpose of the proportionality test is to ensure that the regulatory burden on a professional activity is minimised so that barriers to trade and excessive or unnecessary regulation is avoided.

The Dental Council is aware that the Department of Health has recently received a commissioned report from the Health Research Board of its literature review on the approaches to regulating healthcare professions among a small number of OECD members. The council notes that one of the main topics of this review concerned the thresholds to be considered when deciding whether to regulate for a new profession. The council notes that while a number of new healthcare professions have been considered for statutory regulation internationally, very few new professions have been regulated since 2015.

The review found that some countries have risk-focused procedures to assess proposals to regulate for new professions. These include assessing under criteria such as the complexity of the intervention, environmental contexts (for example, does the intervention occur in the patient's home or in a designated healthcare centre), the agency or vulnerability of the patient, the size of the profession and patient cohort, and whether there are other means of assurance available to manage the risk, such as working under the supervision of a regulated professional or other employer controls. There are examples internationally where the risk of harm is considered to be mitigated by means short of full professional registration, such as voluntary registers, protection of title and minimum standards.

As a principle, the Dental Council favours a full regulatory regime for all members of the dental healthcare team to ensure that the profession evolves in a manner that allows new and evolving treatment and technology be incorporated into practice in a safe manner, and that reflects the professionalism of the dental team. The council notes that the Health Research Board review found that most dental professions were fully regulated in the majority of the jurisdictions surveyed. The council notes that this is not necessarily the case in other European Union countries not reviewed by the HRB. The council is not aware of any instances internationally where a dental healthcare profession has been deregulated.

Most of the dental team currently practises under the supervision of a dentist and the level of complaints against allied dental healthcare professionals is very low. New policies such as introducing independent practice for some of the allied dental healthcare team and regulating dental practices are significant changes. The council acknowledges that if accepted, the policies proposed in this document will require it to fundamentally re-examine the case for full professional regulation for all the allied dental healthcare professions, and especially those who will remain practising under the supervision of a dentist. The council appreciates that it cannot be automatically assumed that additional powers granted to the Dental Council will simply be 'added on' to the existing range of regulation.

9. Policy Theme
Consistent Registration Systems

Policy Proposals Concerning:

9.1 Professional registration
9.2 Temporary registration
9.3 Other Registration Matters
9.4 Restrictions on the Practice of Dentistry
9.5 Specialist Dentistry
9.6 Revised Committee Structure

Dental Council
An Comhairle Fiaclóireachta

9. POLICY THEME: **CONSISTENT REGISTRATION SYSTEMS**

9.1 Professional Registration

POLICY PROPOSAL – Provide for three statutory professional registers for:

- **Allied dental healthcare professionals**
- **Dentists**
- **Dental Specialists**

And allow for different divisions be established within each register by rule/scheme, subject to the Minister's consent.

Rationale – to simplify the registration provisions within the Act. Presently, there are three widely different registration provisions. The NOHP envisages a significant role for both the allied professions and specialists, and it is in the public interest to have broadly similar registration processes.

The nature and complexity of the registration process has increased significantly since the Act was introduced in 1985, mainly arising from the movement of European Union citizens under the provisions of the Recognition of Professional Qualifications directives. In addition, implementing the NOHP (Action 25) will require the council to collate and to hold a significant amount of additional information on its registers than heretofore. Establishing the detail of the register by way of rule will facilitate this.

POLICY PROPOSAL – Insert a provision to allow the Dental Council to set out by way of rule or scheme: the qualifications recognised for registration, the registration process, the content of the register and how the register will be published. Delete Section 26(7) regarding publishing the register and Section 31 regarding additional qualifications.

Rationale – Controlling the classes in each register and the detail of the registration process by way of rule is an efficient way of organising the statutory registers in a way that allows the registration process and structure of the registers to evolve in an organic way. The Nursing and Midwifery registers are regulated in a similar manner. The Dental Council intends that only registerable qualifications be recorded in the registers.

The information the Dental Council may decide to hold as part of a dentist's registration is likely to evolve over time, especially as the NOHP is implemented. At present, there is no legislative or regulatory basis setting out what information the council may retain and for this reason, the council has traditionally only recorded the minimum information necessary to register a dentist. Other than changes of address, very little post-registration information is recorded. Using statutory rules to set out the application process, including when to close an application, the structure and content of the register and how it is published is appropriate and commonplace with the other regulators.

The Dental Council submits that the new or revised Act should establish three statutory registers for dental professionals, each with broadly similar legislative provisions. The divisions of each register should be established by rule or scheme.

- Register of Allied Dental Healthcare Professions (with divisions for dental nursing, orthodontic therapy, clinical dental technician, and dental hygienist – notations to the register will indicate those practising independently)
- Register of Dentists (with divisions for full registration, two divisions for temporary registration and a division for visiting

dentists – those entitled to provide temporary and occasional service under the EU's Professional Qualifications Directives)

- Register of Dental Specialists (with divisions for each specialty recognised by the Minister for Health)

Table 2 below summarises the current and proposed registers:

CURRENT REGISTERS	PROPOSED REGISTERS
Clinical Dental Technician	**Allied Dental Healthcare Professional** DIVISIONS: Clinical Dental Technician Dental Hygienist Dental Nursing Dental Technician* Orthodontic Therapist
Dental Hygienist	
Dental Nursing	
Orthodontic Therapist	**Dentist** DIVISIONS: Dentist Temporary Registration -Education Temporary Registration -Service Visiting EEA Dentist
Dentist	
Specialist DIVISIONS: Oral Surgery Orthodontics Others approved by the Minister for Health	**Specialist** DIVISIONS: Oral Surgery Orthodontics Others approved by the Minister for Health

**Proposed new division*

Table 2

As set out previously, the Dental Council views the profession of dental technician as being integral in dentistry and it would seek to establish this as a class of allied dental healthcare profession in due course by way of statutory scheme under the Act. The Dental Council notes that a class of dental therapist may also be introduced to assist with implementing the NOHP. Under these proposals, both classes could ultimately be divisions on the register of allied dental healthcare professionals.

The council recognises that the State is obliged to examine new or significant amending regulation under the European Union's proportionality test and that it may therefore be necessary to re-evaluate the basis for statutory registration for some classes of dental professional.

The Dental Council submits that new classes of allied dental healthcare professionals and specialists should be introduced by way of a rule or scheme made by the Dental Council with the consent of the Minister. This should set out all matters pertaining to the required education and training, establishment and entry on the register, the qualifications recognised for registration, regulations concerning practice (including supervision of registrants, if appropriate) as well as information concerning the application process and the content of the registers. This will also allow the Dental Council flexibility in its actions in ensuring its rules are consistent with the European Union's Professional Qualifications Directives into the future. It is important to note that no change in legislation is required to introduce any new specialist divisions envisaged under the NOHP. These can be brought forward under the present Act.

The Dental Council considered whether it would be appropriate to establish a register for dental students. This was a proposal made by the council in a previous submission. As maintaining competence is a post-registration obligation and as dental students cannot be amenable to the council's fitness to practise requirements, the only purpose of such a register is to foster

a sense of professionalism and ethical conduct as the students' progress towards registration. The Dental Council has completed two comprehensive reviews of the undergraduate dental programmes since it made this proposal. On both occasions, the council specifically reviewed how professionalism and ethics are taught and it is satisfied that both are appropriately covered in the undergraduate programmes. The council further considers that this is the appropriate way of introducing students to their post-registration professional obligations. The council therefore is not now seeking to establish a register of dental students.

9.2 Temporary Registration

Temporary registration causes the Dental Council a disproportionate amount of administrative burden and difficulty given the very small numbers of registrants involved. Temporary registration is a facility to register a person who is not ordinarily entitled to full registration for a period of up to five years. This is primarily a medical construct and is only used in dentistry for postgraduate education and to facilitate the recruitment of a very small number of non-EEA nationals to maxillofacial units. The temporary registration system is an appropriate way to allow trainees to treat patients while following a dental council approved programme of postgraduate training. It is unclear why maxillofacial units are recruiting dentists who are not entitled to registration as opposed to dentists who are registerable. The Dental Council has limited options in determining how such registrants are supervised, which is important given that these are dentists who are not otherwise entitled to register with the Dental Council.

Under this proposal, the Dental Council intends to create two separate divisions of the register of dentists for temporary registration by way of rule/scheme. These divisions are for education purposes and for service purposes (see Table 2). The Dental Council functionally treats these as two separate divisions at present, and it would wish to formalise this under new legislation. The temporary education registration should be subject to the applicant being enrolled on a programme approved by the Dental Council and it should be available for the duration of the applicant's registration on the education programme. The temporary service registration should only be available for a short period of time (one to two years) and be subject to the Dental Council being satisfied that there is not a suitably qualified registered or registerable dentist who could fill the position.

In addition, the Dental Council would also create a division for visiting dentists. These are dentists entitled have their credentials recognised for the purpose of delivering temporary and occasional service under the provisions of the European Union's Professional Qualifications Directives. A significant difference between this class and the two classes of temporary registration referred to previously is that these registrants are entitled to full registration. Under the EU regulation they may have their entitlement to practise in another EU country recognised in Ireland in a process short of full registration. This is on the basis that their practice in Ireland is of a temporary and occasional nature. The criteria on assessing temporary and occasional service are set out in the regulation transposing the directive. This proposal is in line with the arrangements for other healthcare professions in Ireland.

9.3 Other Registration Matters

POLICY PROPOSAL – To allow the Dental Council attach conditions to a registrant's name on the register at the point of registration, subject to a similar confirmatory and appeals process as set out in Part 5 of the Act.

Rationale – this change will allow the Dental Council act in a manner that is both fair to the dentist and in the public interest. This is best practice in healthcare regulation in Ireland and the Medical Council, the Nursing and Midwifery Board and CORU have the power to attach conditions at the point of registration. This proposal is also consistent with the spirit of the Regulated Professions (Health and Social Care)(Amendment) Act, 2020.

There is one significant gap in the current registration process. The decision to register a dentist is a binary decision: to register or not to register. The Dental Council always seeks to exercise its authority in a proportionate, fair, and reasonable way. There are occasions when this would be best served by attaching conditions or accepting undertakings at the point of registration, rather than the council refusing to register. Any conditions attached should be subject to a similar confirmation and appeals process as with a fitness to practise case. These cases do not arise often but may arise in different circumstances, for example:

- A graduating (and therefore registerable) student who has had an issue during training that would ordinarily mean a registrant would be subject to a fitness to practise case. Typically, these are health or addiction issues.
- Conditions attached to an applicants practice in another jurisdiction. The scope of the Regulated Professions (Health and Social Care)(Amendment) Act, 2020, is limited only to existing registrants. The council should have the power to deal with applicants for registration in the same manner at the point of registration.
- The circumstances leading to a dentist voluntary removing themselves or being erased from the register.

POLICY PROPOSAL – To allow information contained on an application for registration be released to another regulator or for the council to request information from another regulator if the registrar is satisfied that it is in the public interest to do so.

Rationale – this will allow other regulators process disciplinary matters that arose in another country. The proposal is consistent with the intent of the Regulated Professions (Health and Social Care)(Amendment) Act and is in the public interest. A statutory basis is required to release this information under the European Union's General Data Protection Regulations. It will also assist the Dental Council in processing applications for registration.

Under the Regulated Professions (Health and Social Care)(Amendment) Act, the Dental Council can release information to other regulators concerning fitness to practise proceedings held by the council. This information can be released to any regulator within Ireland and worldwide. The Dental Council periodically receives a request for information about a dentist who is not the subject of proceedings in Ireland but where the registrant may be subject to proceedings in another jurisdiction, or where there may be questions concerning the registrant's bona fides. There may be relevant information contained in the application for registration and there should be a statutory provision to allow this information to be released in limited circumstances. Also, from time to time, the Dental Council may require information from another regulator to allow it to fully assess an application for registration. It is necessary for regulators internationally to be able to share information in order to regulate effectively in a world where the dental workforce is highly mobile. This is a necessary provision that is in the interests of dental patients both in Ireland and internationally.

POLICY PROPOSAL – To place an obligation on the registrant to inform the Dental Council of any errors, omissions, or changes in circumstances relevant to their registration with the council.

Rationale – The proposal is consistent with the intent of the Regulated Professions (Health and Social Care)(Amendment) Act and is in the public interest. Registrants with CORU have a similar obligation.

The Dental Council notes that the Health and Social Care Professionals Act, 2005 places an active obligation on the registrant to inform the regulator of any errors, omissions, or changes in circumstances (for example, changes in registered address or being granted registration with another body inside or outside of the State). In the Dental Council's view, this obligation copper-fastens the registrant's obligations under the Regulated Professions (Health and Social Care)(Amendment) Act, 2020 and the council submits the Dentists Act should contain a similar provision.

9.4 Restrictions on the Practice of Dentistry

POLICY PROPOSAL – Expand the statutory protections under Part Six of the Act to include the allied dental healthcare professions and specialist dentistry.

Rationale – the present statutory provisions are not fit for purpose and do not offer sufficient protection to the public. The proposals also are consistent with the aims/objectives of the NOHP.

POLICY PROPOSAL – Grant the council power to apply to the Courts for an order prohibiting a person holding themselves out as a registrant or practising dentistry while not registered.

Rationale – at present, there is no legislative provision to stop a person who is not registered from practising dentistry. The only statutory power open to the council is to prosecute. The sanctions are either a fine or imprisonment, and so the offence can be repeated. A prohibition order of this nature is consistent with and complimentary to the council's proposals on regulation generally.

POLICY PROPOSAL – Oblige registrants to use their registration number on all prescriptions, documents and records relevant to the registrant's practice.

Rationale – This is a relatively simple obligation that will enhance public safety and confidence in the profession. Medical practitioners are obliged to do this under Section 43(8) of the Medical Practitioners Act, 2007.

The Register of Dentists is the only register where there is a clear statutory obligation to register if a person wishes to practise dentistry. This protection should be extended to the allied dental healthcare professionals (where appropriate) and to those on the specialist registers also. Patients have the right to check that they are being treated by a well-educated and appropriately trained dental healthcare professional. The conditions for registration on all three registers should be in accordance with rules made by the Dental Council.

Under Section 53 of the Act, in order to show that a person holding themselves out as an auxiliary dental worker is practising illegally, the council must effectively prove that the person does not hold the required qualification. In practice, this is almost impossible to prove, and the appropriate regulatory requirement should be for the council only to establish that the person is not registered.

At present, there is no statutory bar on a dentist claiming they are a specialist, especially in the areas of specialist dentistry not presently recognised as a class on the specialist register. The only obligations are ethical, and in practice this is hard to control. The lack of a statutory protection for the use of the term 'specialist' means the Dental Council has limited powers to deal with unsubstantiated claims. The council is aware of dentists claiming that they are, for example, dental implant specialists, dental phobia specialists, cosmetic dentistry specialists, smile specialists etc. These additional protections are necessary and are consistent with the aims of the NOHP (Action 22) on developing advance oral healthcare centres.

Section 43 of the Medical Practitioners Act, 2007 obliges registrants to use their registration number on all prescriptions, documents and records relevant to the registrant's practice. This is a relatively simple measure that would greatly assist in the objective of this part of the submission.

9.5 Specialist Registration

POLICY PROPOSAL – Delete or omit the reference to an external body giving evidence to the Dental Council for the completion of specialist training (Sections 37(3) and (4) of the Act, and the associated provision under Section 30(1)(b) of the Act).

Rationale – This body has never existed as a body corporate and the workaround resulting from the provision in the Act has created regulatory ambiguity over the council's role in overseeing specialist programmes. The proposals set out in the Policy Theme – Education, Training and Competence section provide for a unified and appropriate mechanism to allow the council to ensure the quality of the clinical and theoretical training in all registerable programmes.

The way specialist training is delivered and regulated has changed significantly since the Act was introduced in 1985. The Act allowed for the introduction of the specialist register and gave the Dental Council a role, albeit indirectly, in overseeing the quality of specialist programmes, but specialist dentistry was not specifically regulated at the time. Specialist training has now moved away from an apprenticeship training model, where the required knowledge and skills were assessed by way of independently administered exit exams and confirmation that the candidate had completed the required clinical training. Now, the graduates of most specialist programmes receive an academic award (the exception being two small, hospital-based specialties). It is this award that confers an entitlement to register with the Dental Council, regardless of whether there is a confirmation that training was provided.

When the Act was introduced, it provided for the Dental Council to recognise a body to grant evidence of satisfactory completion of specialist training. Such a body did not exist. In 2001, the Dental Council assigned responsibility in this area to the Irish Committee for Specialist Training in Dentistry (ICSTD). This was a 'workaround' that weakened the Dental Council's ability to regulate specialist programmes and exposed the council to threat of judicial review. The Dental Council now administers the work of the ICSTD, but it exists in a way that is not quite inside the council structure, but not quite outside it either. The Dental Council acknowledges the significant expertise of the ICSTD, and the success of its role to date in driving a strong quality agenda throughout specialist dental training in Ireland. This proposal is intended to place the oversight and further development of specialist dental training and practice onto an equivalent statutory footing to undergraduate and auxiliary education, training, and practice. Operationally, the ICSTD provides an important function in preparing and overseeing the application of standards for specialist training and it should be fully integrated into the work of the Dental Council. In its proposals under Section 9.6, the council would incorporate the work of the ICSTD into a new Specialist Education and Practice Committee.

The Dental Council wishes to advise the minister that many of the policies concerning the delivery of specialist practice set out in the NOHP will require the creation of additional dental specialties and that this can be progressed under the existing provisions of the Act.

9.6 Revised Committee Structure

POLICY PROPOSAL – Establish the following statutory committees*:

- **Allied Dental Healthcare Professions Education and Practice Committee**
- **Dental Education and Practice Committee**
- **Specialist Education and Practice Committee**

**The Dental Council is also proposing changes to the fitness to practise committee structure and the rationale for this change is set out in the Policy Theme – Enhanced Fitness to Practise Provisions section of this submission.*

Rationale – This structure will greatly facilitate the Dental Council in implementing the NOHP. The new structure establishes statutory committees that are responsible for both the education and the practice standards for the three strands of dental practice. The specialist committee will replace the Irish Committee for Special Training in Dentistry and embed its work into the Dental Council. It will also put the education and practice of specialist dentistry on a statutory footing for the first time. This structure reflects the importance given to these three strands of dentistry in the NOHP.

In order to allow the Dental Council to properly implement its obligations under the NOHP it will be necessary to revise its statutory committee structure. The NOHP envisages significant and evolving changes across all aspects of dentistry, from wider scopes of practice for the allied dental professions, through to the way general practice is organised and to an increased significance for a specialist service. The *Policy Theme – Enhanced Fitness to Practise Provisions* section of this submission addresses the proposal to split the current role of the fitness to practise committee in further detail. This change is necessary to reflect best practice in healthcare regulation.

10. Policy Theme
Enhanced Fitness to Practise

Policy Proposals Concerning:

10.1 Weaknesses in the Present Structures
- 10.1.1 Preliminary Proceedings Committee
- 10.1.2 Allied Dental Healthcare Professionals

10.2 Additional Grounds for Enquiry

10.3 Sanctions

Dental Council
An Comhairle Fiaclóireachta

10. POLICY THEME: **ENHANCED FITNESS TO PRACTISE**

Overview of Fitness to Practise Proposals

In general, the provisions of Part 5 of the Act are procedurally efficient and have stood High Court scrutiny, both in cases involving the Dental Council and in cases involving the Medical Council and An Bord Altranais (as it was known then) under their previous Acts. This legislation was the same as the provisions of the Dentists Act and it meant that case law was equally applicable across the three regulators. The council notes that a number of the omissions from the 1985 Act were addressed in the Regulated Professions (Health and Social Care)(Amendment) Act, 2020.

The number of inquiries held by the Dental Council is low in comparison to other regulators and the council expects this to remain so. The Dental Council submits that notwithstanding this, there are some weaknesses in the present structure where the council may face legal challenge, and some changes that could be made to improve the efficacy of the Dental Council and enhance public safety.

The changes identified below will not increase the number of inquiries by a noticeable extent, but they will be of significant help in allowing the council to effectively manage the other matters that come to its attention. These measures will be important to reduce the number of cases proceeding to inquiry once the Regulated Professions (Health and Social Care)(Amendment) Act, 2020 is commenced.

The Dental Council is also proposing a change to the composition of its disciplinary committees, and especially the composition of the panel for fitness to practise inquiries, that is novel and represents a partnership and equality model that is consistent with the public interest and with the concept of meaningful co-regulation.

It should be noted that some of the proposals set out below are necessary because of other changes proposed by the Dental Council elsewhere in this submission.

10.1 Weaknesses in the Present Structure

10.1.1 Preliminary Proceedings Committee

POLICY PROPOSAL – Establish a separate Preliminary Proceedings Committee and Fitness to Practise Committee where no person can be a member of both. The membership of each to be as follows:

PRELIMINARY PROCEEDINGS COMMITTEE (PPC)

- **Chair – member of council (non-registrant)**
- **Provide for an equality in the numbers of registrant and non-registrant members**
- **Provision for the council to appoint non-council members to PPC committee**

FITNESS TO PRACTISE COMMITTEE (FTP)

- **Chair – member of council**
- **Provide for an equality in the numbers of registrant and non-registrant members**
- **Provide for equal numbers of registrant and non-registrant members to hear inquiries**
- **Provision for the council to appoint non-council members to FTP committee when required.**

Rationale – In addition to resolving a legal anomaly, this proposal attempts to marry the policy requirement to eliminate perceived biases from the disciplinary process with the realities of the council's fitness to practise workload. The key feature of the council's proposals is to have an equal number of registrants and non-registrants on each committee. This is a novel proposal, and the council is not aware of a similar arrangement in any other professional disciplinary processes.

The first potential weakness is that currently the Fitness to Practise Committee (FTPC) is responsible for both deciding that there is prima facie evidence of professional misconduct and for hearing the case at inquiry. There is strong legal argument, on both sides, as to whether or not this constitutes a breach in a registrant's constitutional rights to a fair process. This issue has not as yet come before the High Court for a determination, and if it did the result is likely to depend on the particular circumstances of the case. The main risk is that the FTPC may have considered prejudicial information in reaching a decision that there is prima facie evidence of professional misconduct that is not presented to the subsequent inquiry, and whether this information biased the decision at the subsequent inquiry. The Dental Council remains the only regulator for whom this is a potential source of litigation. The grounding legislation for the other regulators splits this function between a Preliminary Proceedings Committee (PPC) which is responsible for determining if there is prima facie evidence of professional misconduct and a Fitness to Practise Committee (FTPC) that hears the inquiry. No person can be a member of both committees. This separation in roles is necessary to protect the constitutional integrity of the process and to avoid a perception of a bias.

The Dental Council's strong view is that public safety cannot be protected retrospectively. The council acknowledges that it is fundamentally important that the public has confidence in its disciplinary processes. An effective regulator must be proactive, and with the ability to react appropriately to events. Most of the proposals in this submission are made with the intention of trying to address problems 'upstream' and before the matter becomes the subject of a fitness to practise inquiry. The Dental Council therefore submits that the following are pertinent when considering the public interest test in disciplinary matters in dentistry:

- The numbers of fitness to practises cases are very low comparative to the other regulators and this is expected to continue.
- The proposals made in Sections 10.2 to 10.4 below under this policy theme will increase the caseload being considered by the preliminary proceedings committee.

- Enhancing the council's advisory functions will increase the efficiency of the regulator in proactively protecting the public interest.

There is no uniformity in the legislation governing the fitness to practise procedures for the other four professional healthcare regulators established under primary legislation. The Acts provide for differing structures of the membership of both the preliminary proceedings and fitness to practise committees, in terms of both the proportion of council members on each committee and in terms of whether each committee has a registrant or non-registrant majority. For three of the regulators, the majority of those hearing an inquiry are non-registrants. But only two of the preliminary proceedings committees have a non-registrant majority. The Dental Council submits that because of the way it has framed the other Acts, the legislature accepts that the public interest test can be met in differing ways.

The Dental Council wishes to foster a sense of equality and partnership in its fitness to practise processes, and to move away from the partisan language of majority cohorts on committees. The council, and especially its fitness to practise committee, has always administered its work in a collegial manner with a common aim of arriving at a consensual decision; one that meets the legal requirements of the Act and common law, and which is also in the public interest. For this reason, the Dental Council is proposing that membership of both the Preliminary Proceedings Committee and the Fitness to Practise Committee, including when a panel of this committee hears an inquiry, is equally split between registrants and non-registrants. This would mean that in practice, four members of the Fitness to Practise Committee, consisting of two registrants and two non-registrants, would hear all inquiries. The council submits that this proposal meets the twin objectives of providing a confidence to the public on the integrity of its disciplinary processes and being consistent with the principle of co-regulation. The Dental Council is not aware of a similar model in healthcare regulation.

Under these proposals, the Preliminary Proceedings Committee will be the most important of the two committees in the disciplinary process as it will handle most of the council's caseload. As well as considering whether there is prima facie evidence supporting an allegation, it will also have the capacity to issue advisory notices and it can recommend that council accept an undertaking or a consent to a sanction from a registrant. The council submits that this is an important 'upstream' activity that is both in the public interest and improves the efficacy of the council's processes.

The main role of the Fitness to Practise Committee will be to hear inquires when the PPC decides that there is prima facie evidence under any of the grounds set out in the Act. In Section 10.2 the Dental Council is recommending adding five additional grounds for holding an inquiry to the existing list. If implemented, this will mean that there would be eleven grounds for holding an inquiry into the fitness of a registrant to practise.

A key part of Dental Council inquiries are the questions formulated and posed by the committee to witnesses after their evidence and cross-examination by the legal counsels for the registrar and registrant. This is particularly important at an inquiry where there are differences in the expert opinions, and this requires a good working knowledge of clinical dentistry. The legal tests for professional misconduct and poor professional performance require a strong knowledge of standards expected of a dentist. For this reason, the Dental Council is recommending that the inquiry team be made up of two registrants and two non-registrants. This appropriately balances the public interest in reducing the perceptions of bias in the process while ensuring that during the inquiry the committee is able to properly test the evidence given to it. Having equal numbers on the inquiry team will ensure that decisions are always supported by both registrants and non-registrants. The council submits that this meets the public interest test.

The Dental Council recognises that it is important that its processes are seen to operate in the public interest. It submits that the effectiveness of the two committees can be readily assessed and tested by analysing certain metrics, for example, the proportion of cases referred that result in at least one finding of professional misconduct (very high or low percentages could indicate a potential problem). The Dental Council does, at present, actively review the efficacy of its disciplinary processes.

10.1.2 Allied Dental Healthcare Professionals

POLICY PROPOSAL – That all registrants be amenable to the fitness to practise provisions.

Rationale – It is desirable from a regulatory perspective that all registrants can be held accountable for their actions as a registrant. In addition, the NOHP is proposing to significantly expand the scope of practice for the allied dental healthcare professions, including allowing direct access by patients to some classes. Professionals who practise in an independent capacity should be accountable for their practice to their regulator. This is an important public safety measure.

A second potential weakness also remains unaddressed. Fitness to practise provisions only apply to dentists and dental specialists. Auxiliary dental workers are outside the scope of the Act. It is legally problematic for the Dental Council to remove any auxiliary worker from the register for any misconduct related issue without their consent. The council presently receives relatively few allegations about auxiliary dental workers, but it is appropriate that there is an accountability structure in place should a serious matter arise. This will be increasingly important when allied dental healthcare professionals are practising independently.

10.2 Additional Grounds for Inquiry

POLICY PROPOSAL – Add the following to the grounds for applying to hold an inquiry under Section 38 of the Act:

- **Poor professional performance**
- **Breach of a condition attached to a registrant's name in the register**
- **Breach of an undertaking or consent given to the regulator**
- **Breach of a Dental Council Code of Conduct**
- **Contravention of the Dental Act or of rules or regulations made thereunder, or any other Act, or any regulation related to the practice of dentistry**

Rationale – to improve the efficiency and efficacy of the Dental Council's fitness to practise provisions. These additions are in the public interest as it allows the council more latitude to act than is presently provided. These provisions are also broadly consistent with the grounds available to the other healthcare regulators.

POLICY PROPOSAL – Allow the Dental Council to receive undertakings and provide for the registrant to consent to receive a lower-level sanction.

Rationale – This proposal is consistent with best practice in professional regulation, and it allows the regulator deal with low-level cases where there are no material matters in dispute. This proposal is both cost-effective and in the public interest. The provisions of Section 46 of the Pharmacy Act, 2007 seem the most appropriate starting point for the new provisions.

The Dental Council submits that there are some legislative changes that would significantly enhance the council's efficiency and reach. These proposals will allow the council act flexibly and proportionately and it will also reduce the cost of fitness to practise. These proposals also dovetail with other proposals made in this submission concerning ongoing competence, registration, and practice regulation.

The grounds for holding an inquiry under the Act are relatively narrow and need to be expanded to allow the Dental Council a greater flexibility to process allegations. The main ground for an inquiry under the present Act is professional misconduct, which are usually incidents considered be a serious falling short in the standards expected of a dentist. This ground is generally sufficient for the council to consider clinical matters that come to its attention, but it is insufficient in some other ways. For example, for the Dental Council to consider a matter where a registrant breaches or fails to fulfil a condition attached to their registration, the Dental Council has to first prove the allegation happened and then establish that this amounts to professional misconduct – in effect, the Dental Council has to prove two matters beyond reasonable doubt.

It is commonplace in the more recent professional regulation legislation to allow the regulatory body to receive an undertaking from a registrant and for a registrant to consent to receiving a low-level sanction. Dealing with matters on a consent basis will streamline the fitness to practise process as it will eliminate the need for a full inquiry to process matters where there is no material dispute regarding the facts of the case and where the matter at hand is at the lower end of the scale of seriousness. This will also ensure a broad consistency in the powers available to all healthcare regulators.

10.3 Sanctions

POLICY PROPOSAL – Allow the Dental Council to specify a period during which an erased registrant cannot apply to restore their name to the register.

Rationale – This proposal is consistent with the sanctions open to other professional healthcare regulators

POLICY PROPOSAL – To remove 'advise' from the list of sanctions open to the Dental Council after a fitness to practise inquiry, and instead to allow the Preliminary Proceedings Committee to issue advisory notices to dentists who are the subject of allegations that do not meet the threshold to hold an inquiry.

Rationale – These notices would not be regarded as matters to the detriment of a registrant (that is, they would not be disclosed in a letter of good standing or on the public register), but the notice could be considered at a future date should a similar matter come before the committee again. This facility will allow the council to assist the dentist in addressing matters that are of potential concern but do not reach the threshold of professional misconduct.

The sanctions open to the Dental Council in fitness to practise are largely in line with those open to other regulators but there are some differences. The Dental Council is the only regulator that does not have the statutory power to specify a period during which an erased registrant cannot apply for restoration. The Dental Council has had two cases where dentists erased from the register almost immediately applied to restore their names to the register, which resulted in further, expensive procedures.

Both the Medical Council and the Nursing and Midwifery Board have the power to fine a registrant who has been censured. The Dental Council view is that fines are not an appropriate regulatory sanction against a registrant's statutory registration. The Dental Council views that the power to levy a fine is a more appropriate sanction to deploy in the regulation of dental practices. This point is expanded upon under the *Policy Theme – Dental Practice Regulation and other Public Safety Measures* section of this submission.

The Dental Council views that the sanction of 'advise' is unnecessary at the conclusion a fitness to practise inquiry. The Dental Council has never just advised a dentist as a sanction at the conclusion of a fitness to practise process. The council submits that it would be more appropriate to allow the Preliminary Proceedings Committee to advise dentists regarding conduct or clinical treatment where the threshold of professional misconduct is not met. Importantly, under this proposal, the registrant has not been disciplined and so this advice does not impinge on the registrant's good standing within the profession, but the advisory statement may be considered again should another similar matter come before the committee in the future.

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