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Keynote address – “What patients want: competent oral health therapists

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Thank you, Robin, for the opportunity to present at this Dental Symposium. It's a privilege to be asked to open our discussion today.

I congratulate the Dental Council on grasping the nettle and starting a national conversation on recertification. I believe it's a timely discussion.

I've called my talk, “What patients want”. This is a room full of dental professionals – with a sprinkling of lay people, Council staff and colleagues who work in health regulation and quality. But I think it's appropriate to begin today's discussion with a patient perspective.

I'd like to start with some lines from the Irish poet WB Yeats. In, *The New Faces*, Yeats writes of an old and enduring friendship:

Where we wrought that shall break the teeth of time.

I came across the lines in a fascinating book entitled, *The teeth of time*, by Canadian historian Marshall Cook, about his friendship of 40-years with the remarkable scholar politician, Pierre Trudeau.

I thought of the lines today not just because teeth have been on my mind, but because our conversation today is asking us to question something – a social compact between dental professionals and the public – that has stood the test of time. Why would we seek to upset arrangements for recertification that many oral health practitioners see as workable and proven?

To answer that question, I turn to Yeats again. In famous lines in his poem *Easter 2016*, Yeats writes:

All changed, changed utterly. A terrible beauty is born.

Yeats is referring to the unsuccessful uprising against British rule in Dublin on Easter Monday 1916 – which led to most of the Irish republican leaders being executed for treason.

The lines were quoted by former editor of the *British Medical Journal*, Richard Smith, in 1998, to describe the seismic impact of the Bristol Inquiry on the medical profession in the United Kingdom (UK). For us in New Zealand, ‘all changed, changed utterly,’ with the Cartwright Inquiry.

It's 30 years this year since Judge Cartwright undertook the Cervical Cancer Inquiry into the ‘unfortunate experiment’ at National Women's Hospital. The Cartwright Report in 1988 was a wake-up for the medical profession and for the New Zealand public. It led to a legislated Code of Consumers' Rights, a Health and Disability Commissioner and consumer advocates, overseeing a complaint system independently from the health professions. Perhaps most importantly of all, it signalled a shift from health professional self-regulation to the co-regulatory system that exists today.

The Health and Disability Commissioner Act 1994 was the first important legislative change. The Health Practitioners Competence Assurance Act (HPCCA) 2003 was the next key regulatory reform, with its focus on public protection and maintenance of competence, bringing all health professions under one legislative umbrella. More than a decade since the HPCAA came into force, the full implications of the statute for the regulation of health practitioners are dawning on responsible

authorities, professions and the public – and the journey towards more effective means of ensuring competence is beginning.

Through all this, one thing has not changed. We, patients and the public, assume that we are placing ourselves in the good hands of competent professionals when we see our dentist or other oral health practitioner.

I flew into Wellington yesterday from Auckland, on Air New Zealand. Unlike my relationship with my dentist, which is a personal one based on trust, I have no personal relationship with the pilot who flew the plane that transported me. But I had complete faith in our national airline and in the regulation of air safety – including landings at Wellington airport. I know that pilots have annual medical checks and have to undergo regular flight simulation and competence checks.

When I fly, I know that I am in good hands. Yes, I know that the aviation system is safe – but I also know that the individual pilots are skilled and competent. I know they can't just get by with peer review and attending update conferences. I have no need to worry about their individual safety record, at least not for modern airlines from well-regulated countries. I know that I do not have to take "pot luck."

I do not believe that current methods of self-declarations of continuing professional development (CPD), peer review activities and compliance with professional standards give me the same level of assurance that my dentist or other oral health practitioner remains competent. I'm not sure I would want to fly on airline where only five of 2,500 pilots were audited each year.

Let me give you a roadmap for my talk. I begin with some personal background.

Personal background

My talk this morning draws on several strands of my working life:

- My fascination with the relationship between patients and health practitioners, which led me into a career in health policy and regulation.
- My decade-long experience in handling complaints as New Zealand's Health and Disability Commissioner.
- My research on international developments in medical revalidation, which resulted in my 2012 book, *The Good Doctor: What Patients Want*.
- My continuing work on the regulation of health professions in Australia and New Zealand.

I began my work as Commissioner in 2000 with a healthy respect for the skills and dedication of the vast majority of health practitioners. I left office in 2010, confirmed in my view that patients in New Zealand are generally very well served.

A perplexing problem

Most of my work as Commissioner focused on systems of care.

I undertook numerous inquiries into adverse events in hospitals. But in some of the cases I investigated, one issue emerged periodically and gnawed away at me - the poorly performing practitioner. It became clear to me that, despite supposed safeguards, some incompetent practitioners were able to continue in practice and harm patients. More worryingly, I observed the apparent unwillingness or inability of colleagues and regulators to tackle the problem.

The incompetent doctor was the practitioner who gave me most reason for concern. Time and again, I saw cases where it must (or should) have been apparent to colleagues, may well have been

suspected by patients, and would probably have been detected by thorough checks by a regulator, that a doctor or dentist was performing inadequately. Equally concerning, I saw cases where even reactive checking (following complaints and concerns) led to very limited assessment of a practitioner's performance.

Prevalence

Anecdote is all well and good, but what does research tell us about the prevalence of problem doctors? Research confirms that practitioner skills decay with time, the ability to assess one's own skills is poor, and less than 30 percent of physicians examine their performance data and try to improve on their own. Having read the Dental Council's literature review, it seems likely that these claims also hold true for oral health practitioners.

Estimates of the prevalence of substandard medical practice are very difficult to obtain, partly because regular periodic assessment of ongoing competence has not occurred. Most experts (here and overseas) agree that 1 to 2 percent of current doctors are probably not practising at an acceptable level; some privately concede that the figure may be as high as five percent.

Researchers in Ontario, testing competence assessment tools, estimate that 15 out of 1,000 (1.5%) randomly selected physicians will be found to have very serious problems that require mandatory education. That would equate to 65 oral health practitioners (in New Zealand's population of 4,362 oral health practitioners with annual practising certificates (APCs) who pose a significant risk to patients.

Whatever the size of the problem, there is undoubtedly an underbelly of problem dentists and oral health practitioners, beyond the ones who come to the attention of the Dental Council or the Health and Disability Commissioner.

This problem crosses jurisdictional boundaries. In my contact with overseas health ombudsmen and regulators, I learnt that other health and legal systems fail to detect incompetent practitioners before patients are harmed, and that rigorous checks are seldom undertaken before (and sometimes even after) problems arise. Too often, the end result of such cases is that a patient receives substandard care and may be harmed, the practitioner suffers the shame and ignominy of external investigations and, in extreme cases, there is a loss of trust in a health profession and in the regulators charged with protecting the public.

This was brought home to me most clearly when, in 2004, I was called as an expert to a seminar in Manchester, England on regulation and complaints, held as part of the Shipman Inquiry: the inquiry into the career of GP Harold Shipman, who murdered over 200 of his patients. Later, I read Dame Janet Smith's excoriating criticism, in her final report, of the planned system for revalidating doctors in the UK. How could something seemingly so simple – checking that registered doctors are competent and fit to practise – be so difficult?

My interest in the topic of recertification was sparked, and led me to research international developments and write my book.

Problem dentists

I want to focus for a moment on problem dentists, and some of the cases I saw as Commissioner. The Dental Council's database shows that 75% of competence, conduct and health cases over the past 12 years have involved dentists. It was certainly my experience at the Office of the Health and Disability Commissioner (HDC) that dentists are most prominent amongst oral health practitioners subject to a complaint.

One memorable case, involving a conduct rather than a competence issue, was the slapping dentist from Wellington, which led to this headline (“Slapping dentist outrages,” Dominion Post, A5, 22 February 2007) in 2007. Interestingly, the outrage was from other dentists, appalled that the errant practitioner had not been named and shamed by HDC! But I also saw many examples of poor care causing harm, expense and hassle to dental patients.

I recall the West coast dentist who mistakenly removed all 14 of a patient’s lower teeth, rather than the four teeth the patient had consented to have removed, as recorded on the treatment plan the dentist failed to check before the operation. He said he misheard what the patient said before he administered IV sedation. My expert advisor, in a classic understatement, said this was a, *‘moderate’ departure from professional standards* and that, *‘a prudent dentist would initially have consulted his treatment plan and notes’* before operating. (02HDC18228, 11 June 2004)

Just last year, HDC reported the case of a dentist mistakenly removing adult tooth 26, rather than a deciduous tooth, from a 15-year-old patient. The expert advisor noted that it is, *‘straightforward, essential and basic dentistry to identify the correct tooth to be removed’* and that the mistake in this young patient, who already had some congenitally missing teeth meant that she faced, *‘a lifetime of very complicated dentistry to ensure good function and cosmetic result.’* (05HDC01402, 23 May 2016)

Mistakes happen – but they may be a pointer to competence problems, and certainly warrant closer scrutiny of practice. In 2015, HDC reported the case of an 87-year-old man who suffered severe discomfort, pain and ulceration after a dentist left a cotton roll in his mouth, during a deep filling procedure on tooth 37. The patient returned to the dentist a week later with a swollen mouth and halitosis, and a cursory examination was undertaken. It took a visit to another dentist five days later before the roll was discovered and removed.

HDC’s expert said, *‘It seems almost unbelievable to me that the area worked on in the previous visit was not fully explored and the offending cotton roll found,’* noting that *‘in treating those more frail in society, even more care and attention to detail should be observed.’* (14HDC01267, 12 November 2015)

Other cases show frank incompetence – often leading to repeat visits to the dentist and avoidable pain, suffering and expense. It is notable that over 20 years, HDC has only publicly named three health practitioners for egregious or repeated breaches of the Code. The first was South Auckland dentist Natu Rama, who Commissioner Robyn Stent publicly named in February 2000, after repeated, proven complaints about poor treatment, records and communication with patients. (98HDC17882, 11 February 2000)

What patients say

The voices of patients who make complaints are powerful reminders of why competence matters. In an HDC investigation finding a lack of informed consent, inadequate treatment and poor documentation where a dentist inserted an inappropriate Maryland bridge to remedy a broken crown at tooth 21, the patient wrote to the dentist:

I have suffered a huge amount of stress and pain as a result of the treatment you gave me. I expressed my concerns to you and your staff throughout the treatment period and was constantly told that I was worrying unnecessarily and the end result would be fine. It is not. I now not only have a missing tooth, but I also have two more damaged teeth that were previously healthy. These teeth are also highly visible, making the damage ... more upsetting.’ (12HDC00550, 26 June 2014)

Another patient, who consulted a dentist with 40-years in practice, experienced months of problems, pain, multiple trips to the dentist and expense. Expert review found that the dentist had inserted an

incorrectly designed prosthesis but accepted no responsibility, used poor sterilization procedures, and had poor records and inadequate informed consent processes. The patient's wife recorded what the dentist said when the patient made an appointment to report his concerns:

Anything is conjecture except what I have written down in my notes

[You] stuffed the treatment by not complying with treatment recommendations.

You don't understand how we operate.

The patient wrote to the Dental Council, '*I question whether Mr X had the qualifications and level of skill required to provide treatment to an appropriate standard.*'

We, patients and the public, rely on the Dental Council to ensure that oral health practitioners are competent. We trust that proper checks are undertaken. Is our trust justified?

Patients and the public

What do we know about patient expectations about competence and checking that health practitioners remain competent and fit to practise?

In a 2009 survey of 289 customers of 10 pharmacies in Dunedin, 'competence' was ranked as the number one professional attribute for a doctor. Some researchers draw a distinction between 'competence' (knowing what to do) and 'performance' (doing it in practice), but I doubt that the general public makes this distinction.

Patients expect their doctors and dentists to be competent, to have maintained their skills, and be up-to-date. Patients generally report high levels of trust in their individual doctor, and the medical profession as a whole, scores highly for trustworthiness, certainly higher than lawyers, politicians and journalists. I suspect the dental professions rank closer to doctors and nurses, than to lawyers.

The majority of the public assumes that regular checks are undertaken of doctors' competence. In 2012, the King's Fund and MORI undertook research with focus groups of 200 patients in four cities in the UK, to better understand public views about revalidation. The report - *Public and Patient Involvement in Revalidation* - confirmed that people are surprised to find out that doctors are not already checked to make sure they are up-to-date and fit to practise.

MORI undertook similar research for the General Dental Council in 2009. Their report, *Revalidation: The Patient Perspective* was based on the views of 100 randomly selected patients, invited to focus groups in five UK cities.

The priorities for patients were ensuring that dental professionals are qualified, appropriately skilled and able, knowledgeable and up-to-date on procedures. Cleanliness and hygiene, and modern equipment, were also important.

Participants felt that revalidation is an important exercise that will help dentists keep track of their own professional development and protect patients. Many were surprised that a system does not exist already. People doubted the accuracy of self-assessment. The idea of multiple sources of information, such as spot checks and patient feedback, appealed to focus group participants.

Similar themes emerged in surveys undertaken by the Medical Council of New Zealand. Members of the public assumed that regular checks are already undertaken, and 75% of people said their confidence in doctors would be increased if they knew that doctors' performance was subject to a regular review – which is the direction in which the Medical Council has moved.

Professionalism

I want to say a little bit about professionalism.

Sociologist Eliot Freidson, in his classic work, *Profession of Medicine*, defined a profession as a work group that is given the right to control its own work. Freidson identified the hallmarks of a profession as:

1. expertise, the possession of special skills and knowledge
2. altruism or commitment to public service
3. self-scrutiny or the freedom to self-regulate.

Professionalism is a commitment by members of a profession to maintain high standards and serve the public, in return for the privileges accorded to practitioners.

Canadian scholars and surgeons Richard and Sylvia Cruess write that the privilege of self-regulation:

... entails an absolute obligation to guarantee the competence of members. The setting and maintenance of standards is of overriding importance, and issues such as recertification and revalidation are, without question, now regarded as professional obligations.

What do your professions say about the maintenance of competence? The professional standards set by the Dental Council are clear:

- You must practise within your professional knowledge, skills and competence, or refer to another practitioner.
- You must keep your professional knowledge and skills up-to-date through ongoing learning and professional interaction.
- You must protect the interests of patient and colleagues from any risk posed by your competence or conduct, or that of a colleague or employee.

The New Zealand Dental Association (NZDA) Code of Ethics (which, curiously, is not available on the public section of the NZDA website) states that the dentist's first responsibility is to the patient, and 'the most important aspect of that is *the competent delivery of quality care* appropriate to the circumstances presented by the patient'.

Law

Let me turn then to the law. What does New Zealand law say about a patient's right to receive competent care, and a regulator's duty to ensure that all practitioners are competent?

New Zealand law is clear. First, the Code of Consumers' Rights affirms a patient's right to receive good quality care. Right 4 of the Code specifies the requirements of 'reasonable care and skill', compliance with professional standards, and provision of services in a manner that is consistent with the needs of the patient, and minimises harm.

On the practitioner side of the equation, the law is equally clear. The title of the statute is revealing: the Health Practitioners *Competence Assurance Act* 2003. Responsible authorities, including the Dental Council, are required to check practitioners' ongoing competence. The Council may not register a health practitioner unless satisfied that he or she is 'competent to practise' within their specified scope of practice, nor issue an annual practising certificate (APC) 'unless it is satisfied that the applicant meets the required standard of competence'.

In practice, regulators exercise significant discretion in deciding what counts as satisfactory evidence of competence. The Dental Council relies on completion of a quota of CPD and peer review activities and self-declaration of compliance with professional standards as a proxy for competence. A random selection process is used to identify practitioners required to complete a practice questionnaire. This group is whittled down to identify 5 dentists (out of 2,500 practising dentists) for a practice visit.

This gives a whole new meaning to the phrase 'light touch regulation'!

Current recertification processes do not give patients and the public assurance that every practitioner with an APC is competent to practise.

Registration authorities internationally have a track record of failing to proactively check the competence of health practitioners. Margaret Stacey, who served on the General Medical Council from 1976 to 1984, wrote that the Council 'has never really ensured the continuing competence of registered practitioners' and 'on balance resolved the many tensions it faced in regulating the profession in favour of the profession rather than the public'. In survey research from Julian Archer and colleagues in 2012, one retired GMC doctor member is quoted as saying: 'We, the medical profession, have been operating a con over the years.' The checks that the public assumes are undertaken have not been occurring.

Time for change

It's time for a change. We are still using old medicines when it comes to checking competence. We need a new prescription.

Research confirms what common sense suggests: despite good intentions, many CPD activities are of limited utility in improving practice and targeting areas of suboptimal performance in practice, and they don't actually test anything. There is no verification that CPD activity has translated into good practice.

Ian St George spoke for many New Zealand GPs when he commented:

Why do so many of us have a sneaking feeling we are barking up the wrong tree with these recertification activities, participating for the sake of appearances rather than really for the sake of self-improvement?

More effective checks on the competence of oral health practitioners will not be popular. The Medical Board of Australia has faced resistance in seeking to introduce more effective means of revalidating doctors, as a poll from *Australian Doctor* confirms. Twenty-nine percent of respondent doctors thought that *no doctor* should have to go through revalidation, because it is "unnecessary".

The Medical Council of New Zealand is also getting strong resistance to its consultation on introducing of more rigorous recertification requirements for vocationally registered doctors.

Six years ago, I joined leading experts from the UK, the Netherlands, the United States, Canada and New Zealand in London at an international symposium on 'Revalidation: Contributing to the evidence base'. The meeting provided valuable insights into the slow progress towards mandatory revalidation of doctors in the UK – and lessons for regulators in other countries.

Despite the general support for revalidation, there was a lack of agreement as to its purpose. The most commonly expressed concern remains that revalidation will be used to weed out 'bad apples' and that it is not sensitive enough to do that effectively. Most participants agreed that the primary purpose is to give the public assurance that a practitioner meets minimum standards, and is thus 'good enough'; but that a second, not inconsistent purpose is to improve the quality of practice overall.

A recurrent theme was the need to make a start, accepting that the tools used in revalidation will become more robust over time. There was a lot of nervousness about the use of multi-source feedback, especially feedback from patients (one leading doctor commented, 'I don't want to be rated if it means I can't tell you to stop eating buns!'), but the consensus is that a number of questionnaires are sufficiently robust to be used for revalidation. Patient feedback is an important 'report on experience', and colleague feedback provides reliable information about a practitioner's performance.

International experience suggests it takes at least a decade to introduce such a major change; that how reforms are communicated to the profession is critical, given the cultural shift involved; and that regulators face enormous pressure to water down reforms to be palatable to the profession.

The principles set out by the Dental Council in its discussion document are a good start. Recertification must be *effective* in protecting patients, *fair* to all practitioners, and robust and *evidence-based*.

Conclusion

Let me conclude with some summary observations.

We have a problem - current systems do not ensure that all oral health practitioners are competent. Patients want proper checks, so we don't have to take potluck. Maintenance of competence is at the core of your promise to patients and the public. It is also what the law requires of the Dental Council. The case for more effective recertification is clear.

Within any profession, there will always be outliers - the gifted and the ordinary. I want to know that even the mediocre practitioner meets minimum standards, and is someone whom I, and my family, can safely consult. In my book, I called this a 'good enough' doctor.

Patients do not expect the moon. They often settle for a standard of care and information that is less than adequate, and does not justify the trust they place in their doctor. The community does not expect excellence, but people do expect to be protected from harm. In an ideal world, we would be assured that any oral health practitioner who cares for us is 'good enough' to meet professional standards.

I look forward to the day when we can all rely on the public Register as assurance that any oral health practitioner is competent.