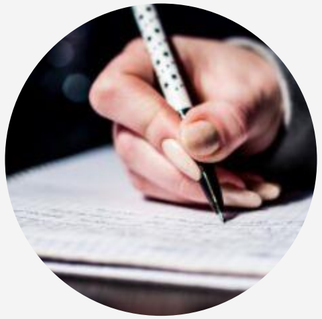
7 JULY 2019

DISCUSSION ON BETTER COMPETENCY DEVELOPMENT FOR SAFE AND QUALITY DENTAL CARE FOR PATIENTS

SDA Standing Committee

Contents



1. Background
2. Framework/COC Announcement
    1. Proposal
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3. SDASC Poll results
4. Arguments for/against “Framework”
5. Arguments for/against “Certificates of Competency”
6. Member Suggestions
7. Voting result

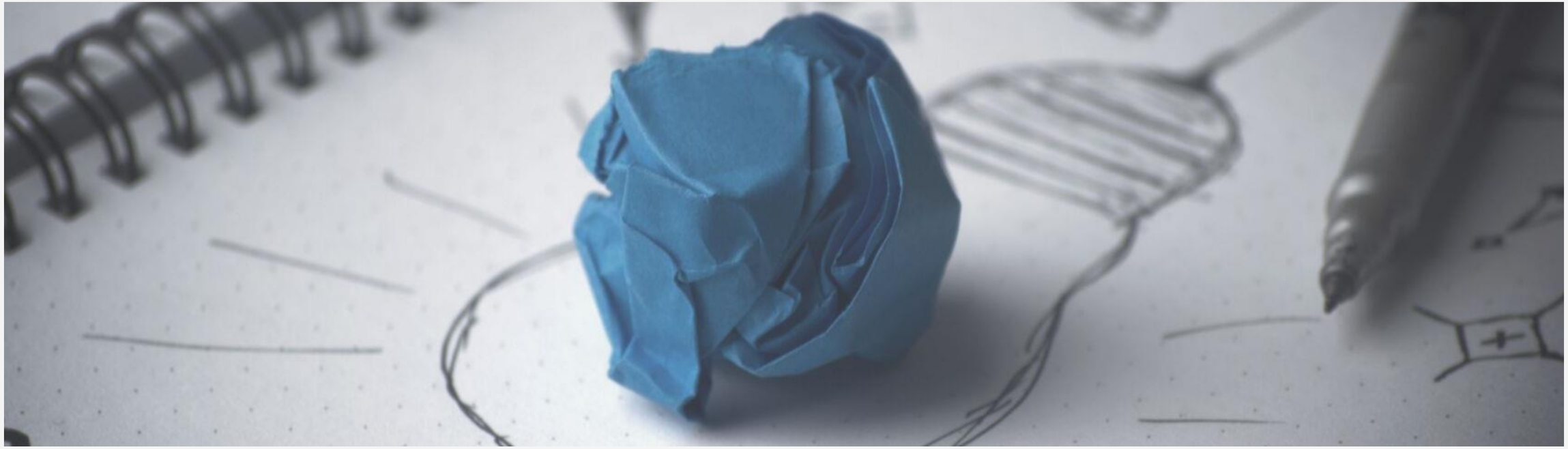
“The Why”

Background behind Framework and COC

- To review the provision of dental specialty services and advise on the scope of practice for the different levels of dental expertise in both the public and private sector
- Develop standardised framework/classification of dental procedures, based on
  a) The competency levels of dental students upon graduation from the FOD, NUS
  b) The competency levels of dental graduates during the four-year period (i.e. with training and/or co-management with specialists
  c) The approach for specialists to focus on specialist work, with inputs from Dental Specialists Accreditation Board
- Rising complaints (added later)

Source: *CGDP , SDA Presentation 19th March*

Framework and COC



Source: *Better Competency Development for Safe and Quality Dental Care for Patients*

The Rationale

Source: SDC Circular dated 25th May 2019
Better Competency Development for Safe and Quality Dental Care for Patients (Para 2,3)

1. INCREASING PATIENT COMPLAINTS + EXPECTATIONS

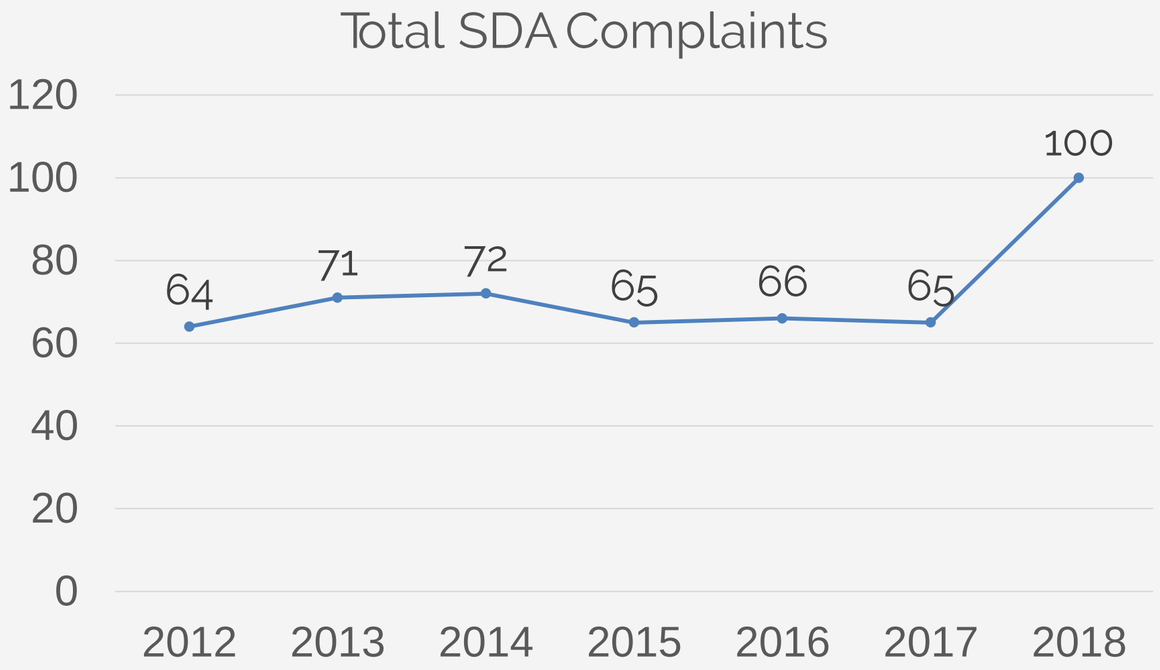
SDC: "In recent years… SDA has received over 100 annual complaints against dentists"

SDC: "…a four-fold increase in initial complaints… three-fold increase in statutory complaints"

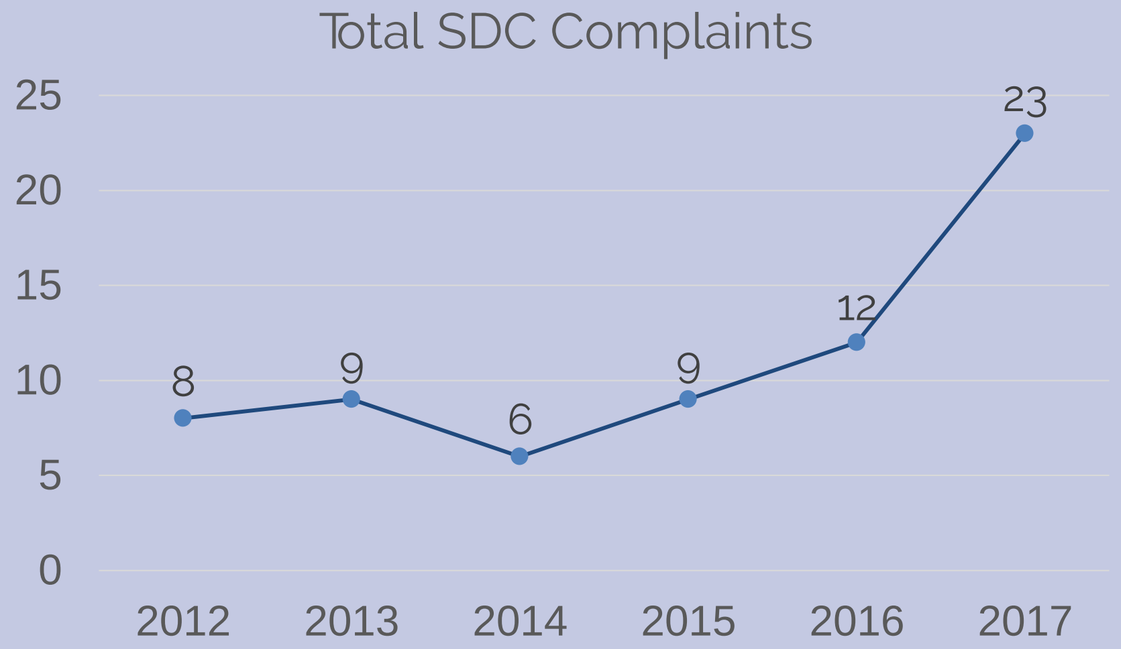
Source: 13 Apr SDA-SDC Dialogue

2. NUS BDS MAY NOT ADEQUATELY TRAIN YOUNG GRADS FOR CERTAIN PROCEDURES

-Prof Chew CL



Data Source: *SDA Ethics Reports 2012-2018*



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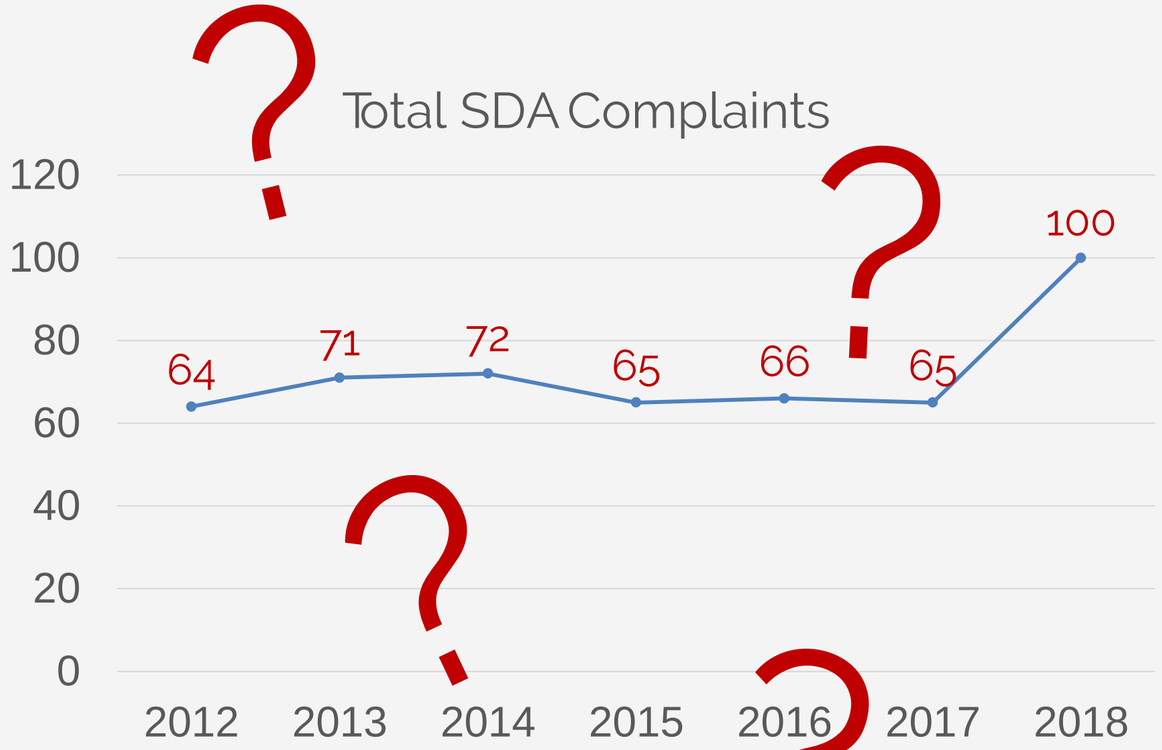
SDA: "over 100 annual complaints“ in recent years"

SDC: “more than x3 statutory complaints (2014-2018)”

Source: SDC Circular dated 25th May



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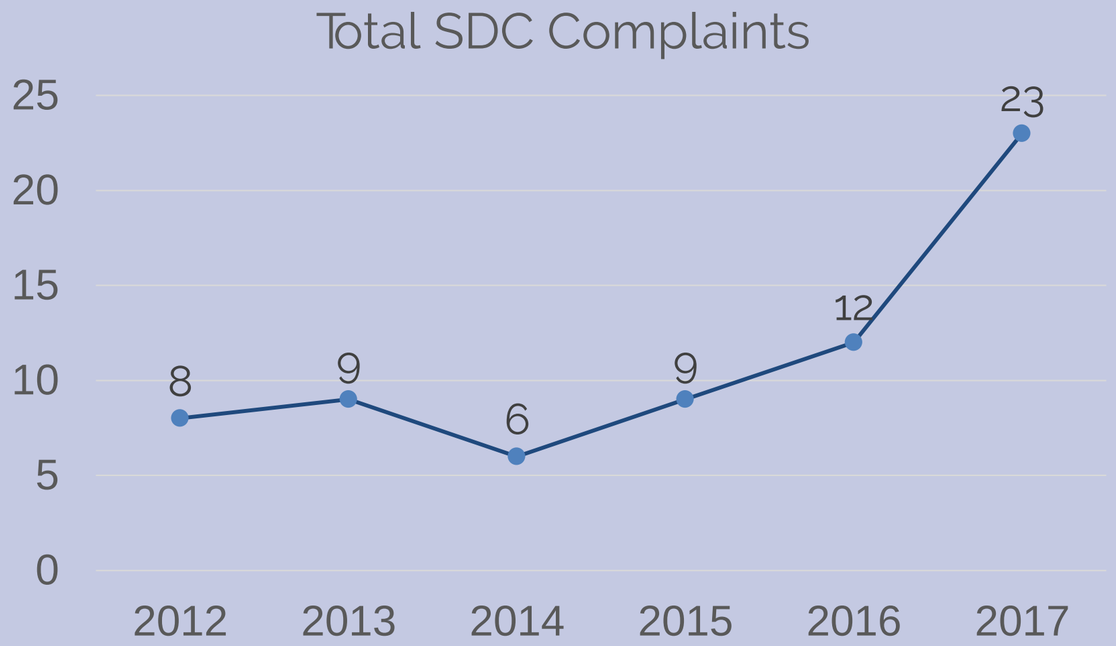

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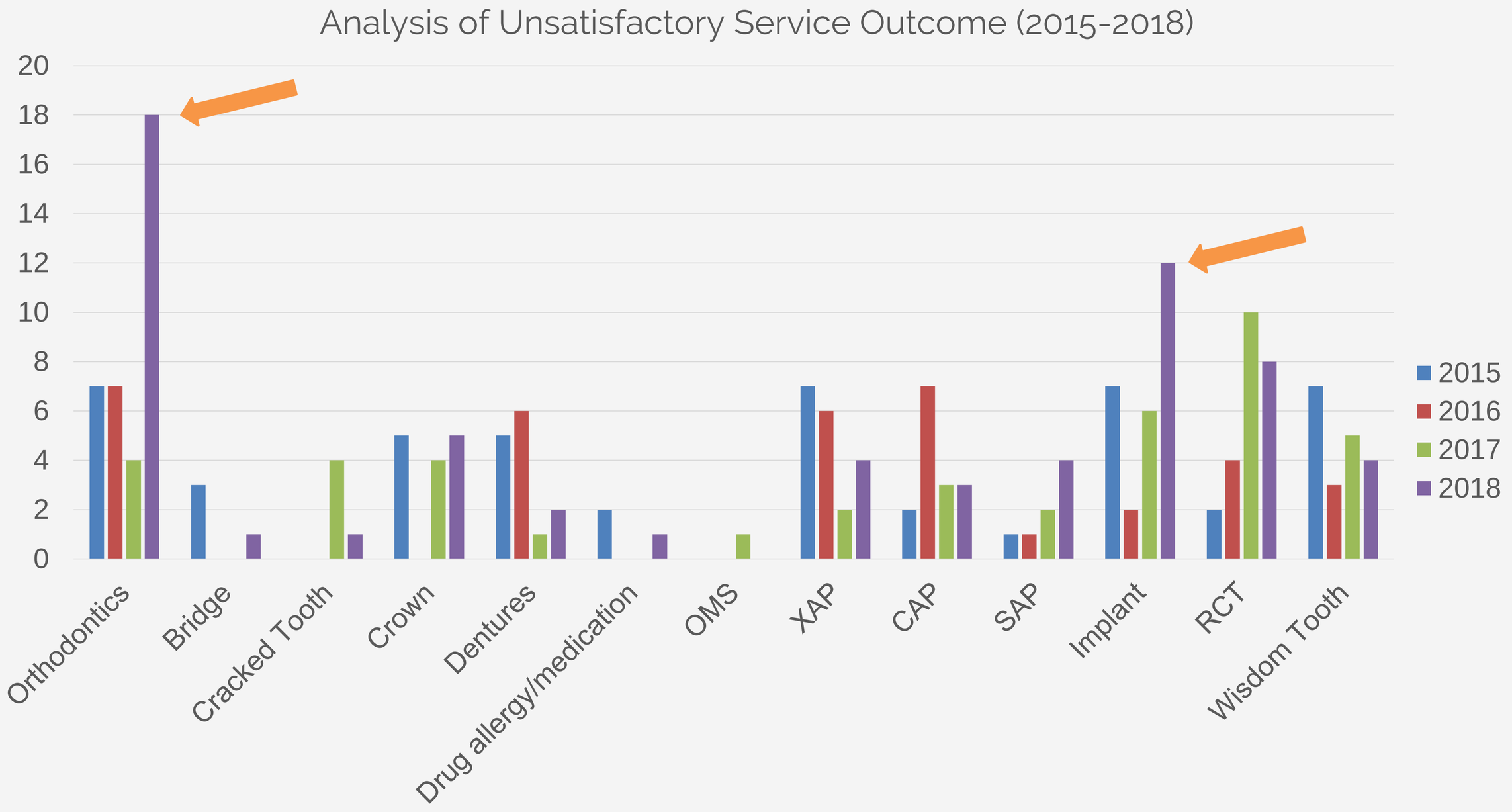

Data retrieved from SDA Ethics Reports 2015-2019

SDC Proposal

Source: *SDC Circular dated 25 May 2019*

COC + FRAMEWORK

acquire/update knowledge + skills to maintain high standards of competency and professionalism for safe and quality dental care

(Para. 3)

COC

increase patient confidence and operator competency

(Para. 8)

Framework

Basic	Intermediate	Specialist

After meeting SDC, they have expressly indicated that they are open to changing “Specialist” category to “Complex

Certificates of Competency (COC)

Issued

- On completion of SDC accredited courses
- New courses (eligible for CDE)
- Existing CDE courses

- Upon application, with proof of
- Past equivalent training courses
- On-the-job training
- Work experience

Source: *SDC Circular dated 25 May 2019*

COC

STILL IN DISCUSSION PHASE

Wisdom Teeth (?)

Implants (?)

Molar RCT (?)

Perio (?)

Veneers (?)

CBCT (?)

Deep Dive on The Rationale

INCREASING PATIENT COMPLAINTS + EXPECTATIONs

REASON 1

Increasing patient complaints and expectations

Critique

1. Complaints - not the only criteria to assess quality of care - assessment is hence incomplete

Performance indicators for quality of care (González et al, 2007)

2. COC/Framework may not solve the problem

Analysis of complaints from

- SDA (2015-2018)
- SDC (2012-2017)

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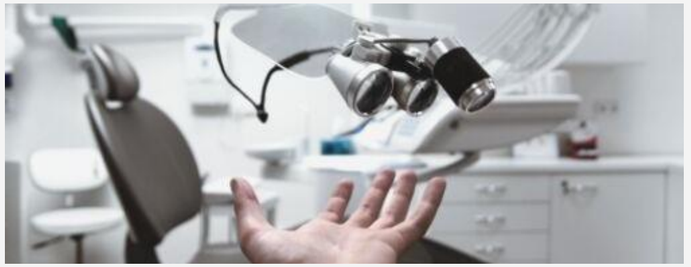
Quality of Care: Performance Indicators

Patients

- Acceptability
- Satisfaction
- Equity

Professionals

- Appropriateness
- Effectiveness
- Efficiency
- Safety



Healthcare System

- Accessibility
- Availability
- Equity

Performance indicators used to assess the quality of primary dental care (González et al, 2007)

Performance Indicators

Appropriateness
Effectiveness
Efficiency
Safety

Professional

Acceptability
Satisfaction

Equity

Patient

Accessibility
Availability

Healthcare System

Measured by

- Performance
  - technical performance
  - interpersonal relationships
- Failure/Success/Complication rates
- Professional satisfaction

- Health outcome
- Patient satisfaction, expectations, perceptions
- **Complaints**
- Subjective indicators

- Human/material resources
- Institutions
- Healthcare utilisation
- Finance/costs

REASON 1

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Analysis of complaints from

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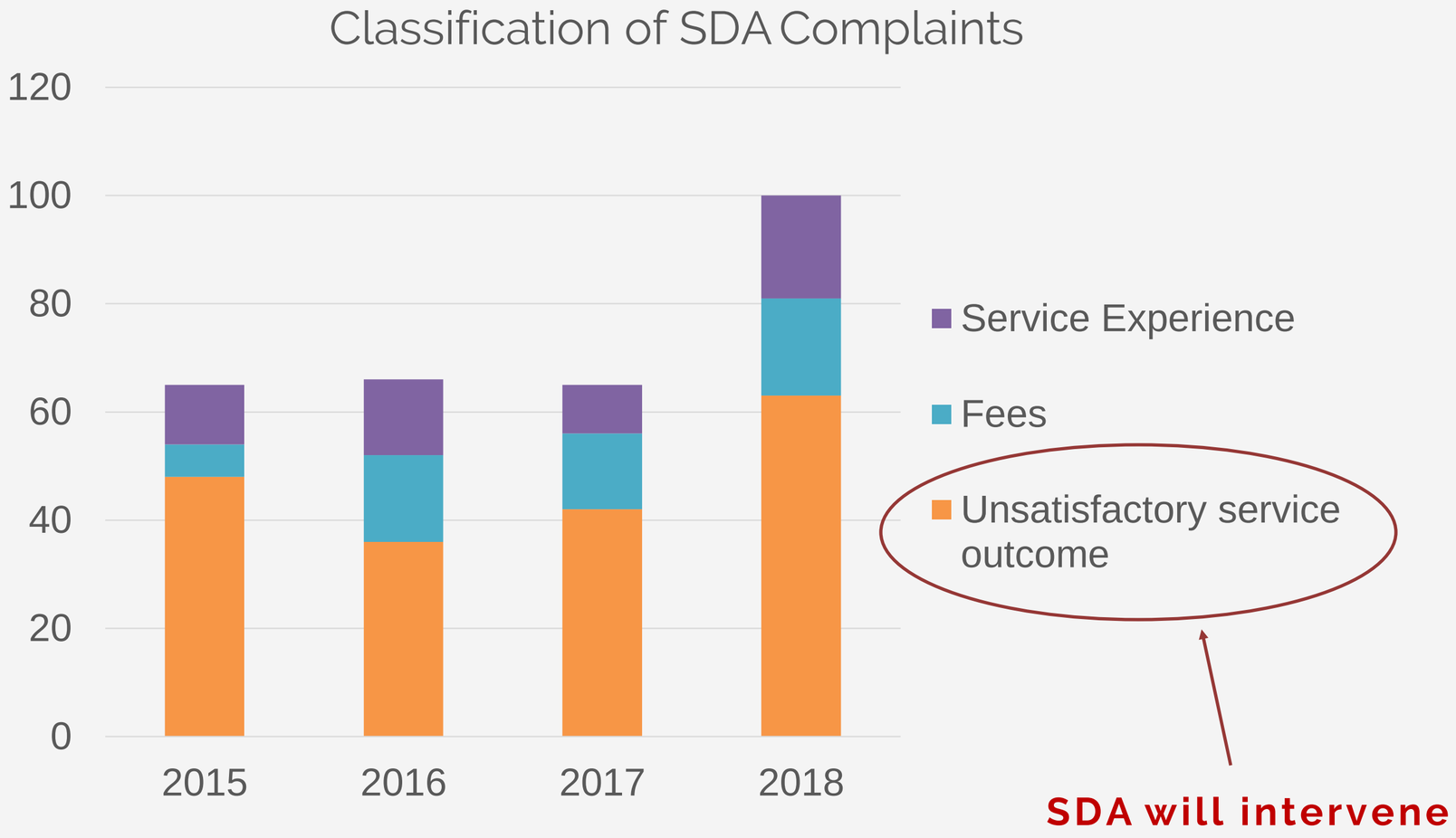
TYPES OF SDA COMPLAINTS (2015-2018)

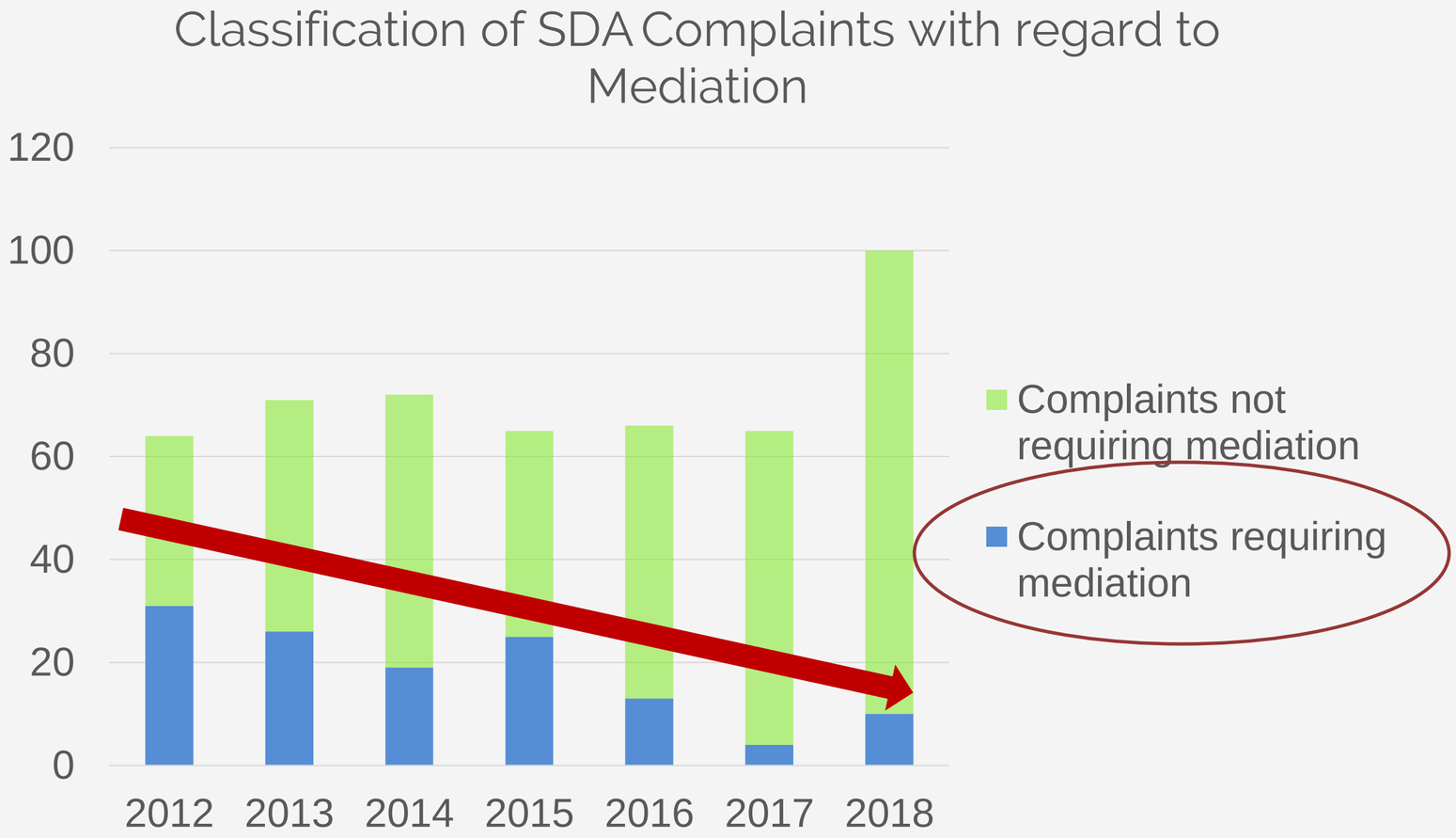
INCREASING TREND OF COMPLAINTS REQUIRING SDA INTERVENTION



Data source: *SDA Ethics Reports 2015-2018*

SDA COMPLAINTS REQUIRING MEDIATION (2012-2018)

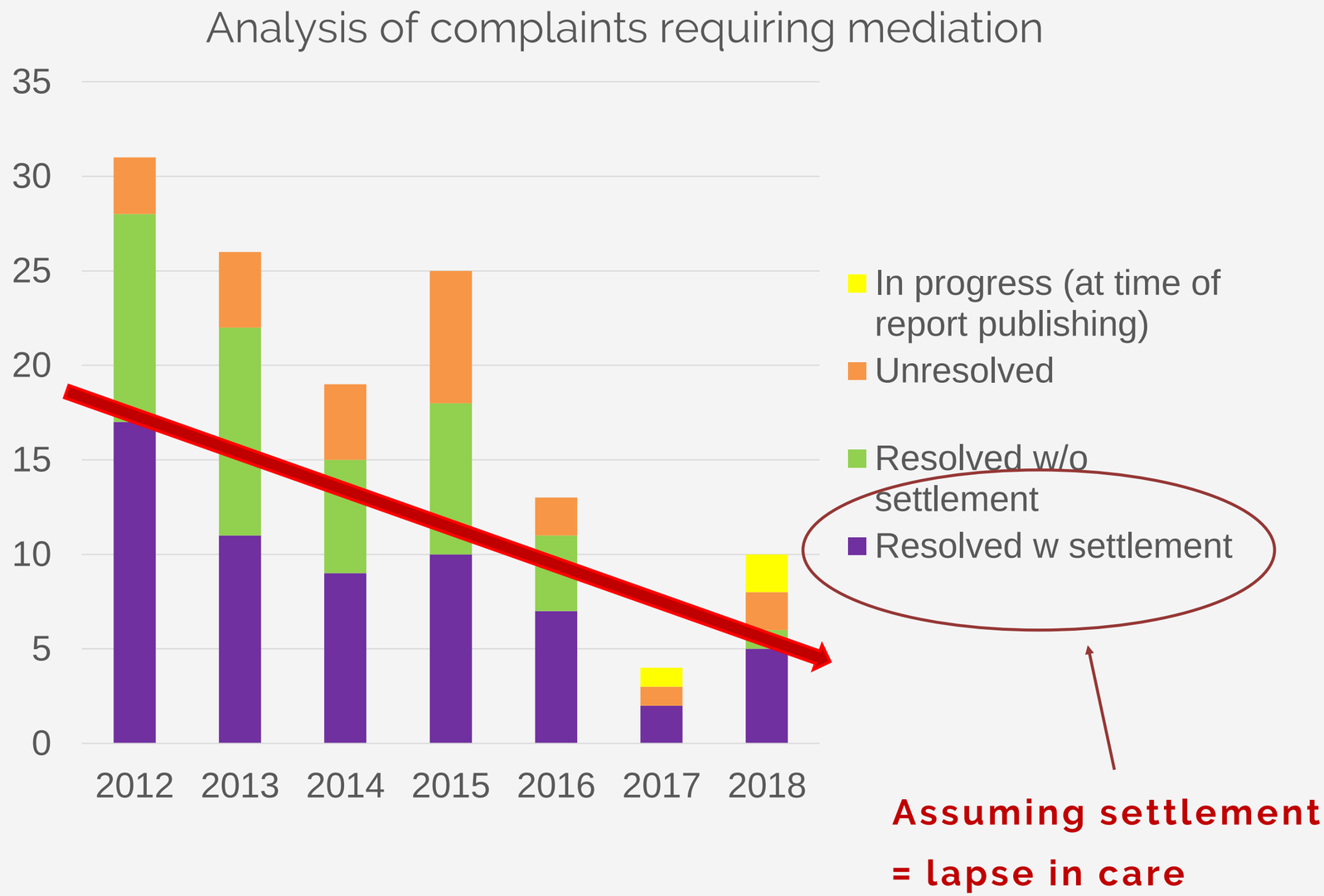
DECREASING COMPLAINTS REQUIRING MEDIATION



Data source: *SDA Ethics Reports (2012-2018)*

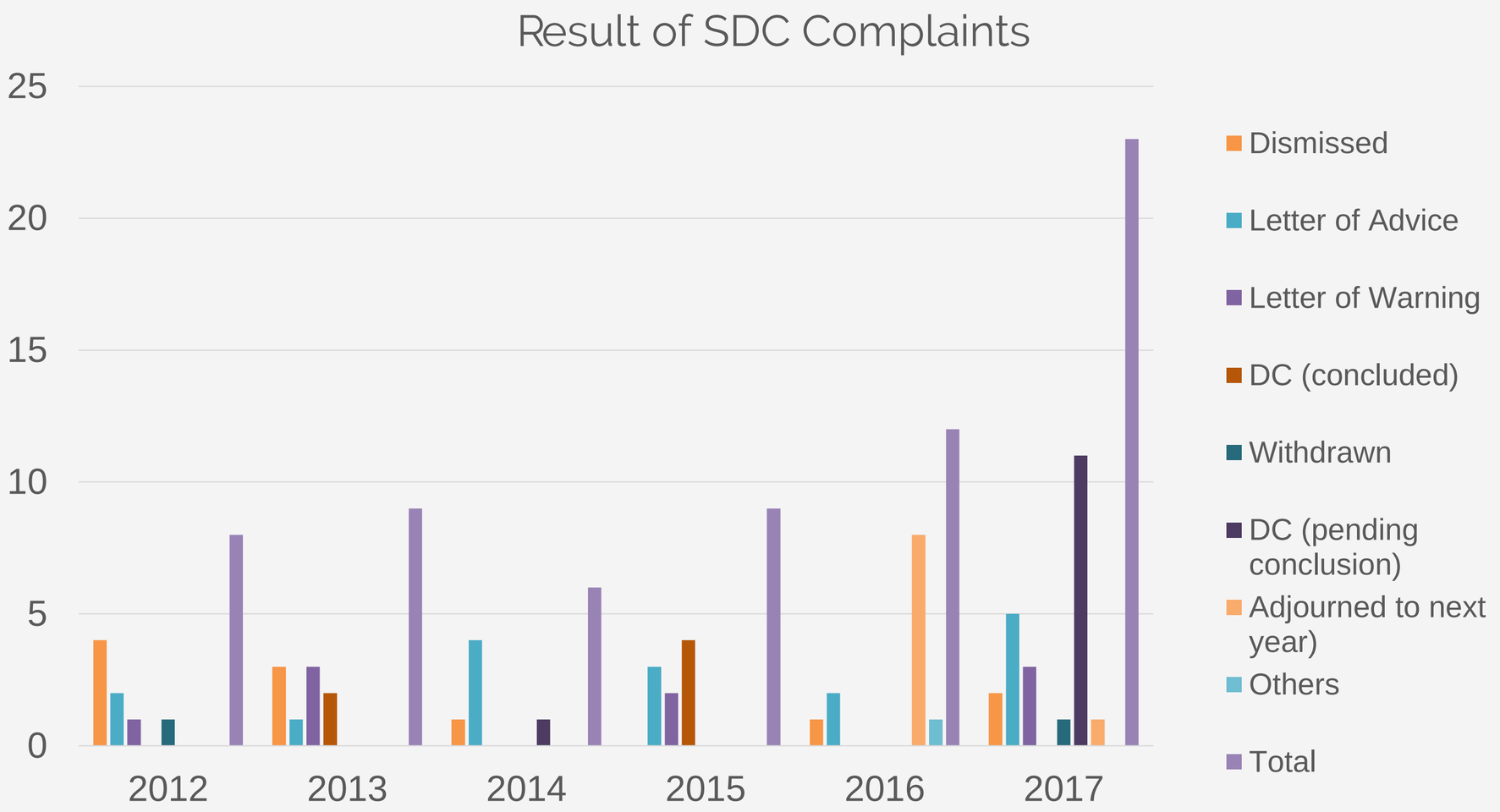
SDA COMPLAINTS REQUIRING SETTLEMENT (2012-2018)

DECREASING MEDIATION REQUIRING SETTLEMENT



Data source: *SDA Ethics Reports (2012-2018)*

SDC COMPLAINT MANAGEMENT (2012-2017)



Data Source: *SDC Annual Reports (2012-2017)*

SDC COMPLAINT BREAKDOWN (PRESS RELEASE)

"Lapses in care" due to lack of education/experience seems to be minority, not increasing (?)

Year	Clinical related	OHT Supervision	Division 2 dentist supervision	Molest	Medisave	No SDC Qualification	Drug dispensing error	Total
2012	1							
2014		1			1			2
2015						1		1
2016	1							1
2017	1	2				1	1	6
2018			1	1	1			3

Inappropriate treatment (ortho, veneers), failed to refer to specialist

Failed to wait the requisite time for bone graft to heal before implant placement

Inappropriate treatment (ortho), failed to refer to specialist

Data source: *SDC Press Releases (2012-2018) retrieved from SDC Website*

"Increasing Complaints" not due to 'lack of training"

Lack of Proper Communication?

- patients do not fully comprehend limitations of procedures
- may not have adequately expressed expectations --> apparent unmet expectations

(Nov 2017 CNA article,)

Not related to clinical quality?

No association between:

- post-op complications and patient satisfaction within surgical care.
- patient satisfaction scores and complication rate (total/major)

(Smocker et al. 2018)

Disclaimer: We do not have access to records of SDA/SDC complaints, hence unable to critique accurately

Possible Reasons for Rising Complaints

More media focus on malpractice

More critical backdrop created

Perception of dentists as "service providers"

Unsatisfactory experience easily prompt complaints

Easier to Complain

- Better access to information about how and where to complain
- More avenues to speak out

Understanding the rise in Fitness to Practise complaints from members of the public - UK General Medical Council, 2014

Possible Reasons for Rising Complaints

Patient-dentist interaction

- Poor communication
- ↓continuity of care, personal understanding →harder to contextualise on-off poor experiences
- Patients ↑ ownership of their health → better informed → ↑ expectations → ↓ deference to doctors → ↑willingness to question

Understanding the rise in Fitness to Practise complaints from members of the public - UK General Medical Council, 2014

Deep Dive on The Rationale

NUS BDS MAY NOT ADEQUATELY TRAIN YOUNG GRADS FOR CERTAIN PROCEDURES

REASON 2

NUS BDS may not adequately train young grads for certain procedures

Critique

1. Should not be used as an argument

CDO + SDC President who is also a Professor in FOD claiming inadequacy of training at NUS:

- ↓profession's standing
- Brain drain - less students will want to enrol, go overseas instead

2. Framework + COC to correct this problem seems roundabout

Why not improve/lengthen BDS instead?

Discussion on Framework

Arguments for and against

Submissions from the House

FOR

Framework + Restrictions

1. Only for **life threatening procedures** ie. for OMS

- SMC - minimal restriction approach
  - Restrictions only on life threatening procedures (eg. liposuction, endoscopy) reserved for specialists

AGAINST

Framework + Restrictions

1. Division between GP + specialists

- Framework to “encourage specialist to focus on their specialty”
    - Potential for abuse: Can add further restrictions in the future → end up as ringfencing tool for specialists

AGAINST

Framework + Restrictions

2. ↓ accessibility to care = Patient care compromised

- ↑ GPs providing advanced services =
  - ↓ prices for advanced services
  - ↑holistic care

- Restrictions:↓accessibility to holistic care at the private level
  - Contradicts govt's outsourcing of tx via CHAS/PG to reduce burden on public healthcare

Case Study

#47d pulpitic pain with impacted #48

GP TO SPECIALIST REFERRAL

4 CLINICS **6** VISITS **4** OPERATORS

Visit 1
GP
#47 pulpect

Visit 2
OMS
#48 LA-OP

Visit 3
Endodontist
#47 C&S

Visit 4
Endodontist
#47 Obturation

Visit 5
Prosthodontist
#47 crown prep

Visit 6
Prosthodontist
#47 crown
issue

MULTI-DISCIPLINARY PRACTICE

1 CLINIC **4** VISITS **3/4** OPERATORS

Visit 1
GP/Endodontist
#47 pulpect

OMS
#48 LA-OP

Visit 2
Endodontist:
#47 C&S

Visit 3
Endodontist:
#47 Obturation

Prosthodontist:
#47 crown prep

Visit 4
Prosthodontist:
#47 crown issue

GP MANAGEMENT

1 CLINIC **4** VISITS **1** OPERATOR

Visit 1
#47 pulpect
#48 LA-OP

Visit 2
#47 C&S

Visit 3
#47
Obturation
crown prep

Visit 4
#47 crown
issue

ACCESSIBILITY OF CARE

"Specialist procedures" for MDS only (7c)

↑ private specialist referral

↓ Continuity of care
Patient-operator relationship

↑ Time between different parts of tx
Inconvenience (locations)
Waiting time?
Cost

↑ SOC referral

Cost concerns

↑ waiting time for polyclinic appt for referral letter (for subsidised service)
Current waiting time 3 months-1 year

↑ waiting list/time for SOC
Current NDC RCT waitlist ~3 months, KTPH 1.5 years

↑ delay in necessary tx

↑ case deterioration

Overall decrease in Quality of Care for Patients

AGAINST

Framework

3. In conflict w SDC ethical code: lack of trust in operator's clinical + ethical judgement

- Medical Protection Society's **list of specialist procedures**: only a **guide**
  - trust in doctors' judgement of their own competency

- SMC's **restrictions only for life-threatening procedures**
  - Potential dental restrictions may be for tx that GPs have done safely for years

DENTAL REGISTRATION ACT IS INCLUSIVE

*(a) the performance of **any** procedure and the treatment of **any** disease, deficiency, deformity, malposition or lesion on or of the human teeth or jaws or associated structures, whether intraorally or extraorally*

*(e) the performance of **any** such procedure and the giving of any such treatment, advice or attendance as is usually performed or given by dentists;*

Source: *Dental Registration Act 2(a),(e)*

SDC ETHICAL CODE - PROFESSIONAL JUDGEMENT FOR REFERRAL

...dentist should practise within the limits of his own competence...

Where the dentist believes that the patient's condition or the treatment required is beyond his competence, the patient should be referred to another dentist, medical practitioner or specialist with the necessary expertise

...A dentist shall not persist in unsupervised practise of any dental procedure or treatment modality without having the appropriate knowledge, skill or required experience

---

Source: *SDC Ethical Code and Guidelines Para. 4.1.1.6*

SDA ETHICAL CODE - GP CAN TREAT IF PATIENT REFUSES SPECIALIST TREATMENT

*..**If a patient refuses to see a specialist,** the dentist shall counsel the patient adequately and if he still refuses, **it is acceptable for the dentist to treat the patient in consultation with a specialist.***

Source: *SDC Ethical Code and Guidelines Para. 4.1.1.6*

AGAINST

Framework + Restrictions

4. People who have trained in procedures under “specialist”category, no longer able to provide services

- Eg. Fixed Orthodontics / Clear aligners

5. Increased regulation will improve quality of advanced care (wrt ortho)

- Advances in AI - complex procedures becoming "simple"
- Orthodontic working group report NZ Dental Council

Should GPs provide ortho?

1. Risk from ortho ≈ risk from other advanced dental procedures

Most ortho procedures are reversible

2. Few dentists identified as providing inappropriate tx

3. Contact between GPs doing ortho + orthodontists is desirable

more constructive towards behavioural change compared to increased regulation

Source: *Orthodontic working group report, NZ Dental Council (Nov 2016)*

Should GPs provide ortho?

CONCLUSION

- **No need to change scope of practice for GPs** / create new practice standard for ortho

- Council's Standards Framework for Oral Health Practitioners adequately covered the professional and ethical behaviour required from dentists

Source: *Orthodontic working group report, NZ Dental Council (Nov 2016)*

VOTE ON FRAMEWORK

Note: “< 5” and “≥ 5” years refers to number of years after graduation

	GP		Specialist
	< 5	≥ 5	
(a) Accepting a framework consisting of “Basic, Intermediate, Complex”			
(b) Accepting a framework consisting of “Basic, Intermediate, Complex” as guidelines, **without restrictions**			
(c) Rejecting the need for a categorisation framework			

Discussion on COCs

Arguments for and against

Submissions from the House

PRECEDENCE

Certificate of Competence for Aesthetic Facial Procedures

Requirements

For Course Accreditation

Source: SDC website

1. Duration

- Partial accreditation: <8h
- Full accreditation:
  - ≥ 8h course
  - Complementary, non-repetitive partial accreditation courses combined to ≥ 8h

2. Content

- Basic science- anatomy and pharmacology
- Patient selection
- Techniques
- Management of complications
- Live demo
- Hands-on workshop – models/cadavers, patients

Requirements

For Course Accreditation

Source: SDC website

3. Test

- Theory/practical

4. Instructors

- Doctors/dentists registered by SMC/SDC
  - with requisite training and experience
  - accredited under the respective Aesthetic Practice guidelines
- If not registered: apply for Temporary Registration
  - Sponsoring registered dentist also must be accredited under the respective Aesthetic Practice guidelines

Requirements

For Course Accreditation

Source: SDC website

5. Organisation

- SDC/SMC Accredited CPD provider

6. Location

- In Singapore

FOR

Certificates of Competency

1. Ensure high treatment standards across the board

- SDC accreditation can ensure that there is sufficient **practical** training
- Have less training as compared to MDS graduates → Further accredited training can help GPs serve patients better

2. Prevent complacency

- Complacent dentists may not further CDE in certain areas
- COC will ensure they are kept up to date

FOR

~~Certificates of Competency~~

Amend to "additional accredited training courses during bond period"

3. Ensure equal training opportunities for DOs

- Only experience advanced procedures in specialty postings/DOIC
  - If stuck in non-specialty posting, less training than others
- **Training gap will be huge** between different DOs
  - **worsened due to increased posting duration** from 6 months to 1 year
- eg. 2 years polyclinic + 1 year SDS + 1 year SOC - only 1 year of training (possibly in only 1 discipline)

AGAINST

Certificates of Competency

1. Potential for overreaching

- Potential risk of continuous addition of procedures by the authority

2. Does not solve the problem of questionable ethics or miscommunication

- can be accredited and still do questionable things

AGAINST

Certificates of Competency

3. Bottleneck of CoCs for GPs

- Some cannot get accredited
  - patients cannot receive tx needed as GP is afraid of possible repercussions of tx w/o COC
- Will lead to jacking up of course prices

4. Redundant - already have further training

- 70 CDE points every 2 years
- 4 year bond w specialty postings (NUS)
- 2 year conditional registration (foreign)

AGAINST

Certificates of Competency

5. Double standards?

- specialists are grandfathered for 10 more years
  - no need to satisfy the specialist register retention criteria
- why do GPs need to attain COCs (satisfying training criteria) for public safety reasons?

6. Potentially exploited by patients?

- accuse dentist of 'incompetence" over previous tx results as had no COC then

6. Suppliers' adhoc CPE providers status will not be issued

- difficult to bring in speakers to update on any dental advances

Member Suggestions

Submissions from the House

General Suggestions

1.New regulations/ requirements only applicable for newly registered dentists

- All existing dentists grandfathered - like div 2 dentists

2.Remove words like "competency","mandatory"

- "Competency" is a term used for undergrads

General Suggestions

3.Stop linking complaints to the ability to do a procedure

- Not an accurate indication of quality of care. Mostly due to miscommunication

CoC Suggestions

1.Conducted by local specialist societies

2.Fair and up-to-date CoC accreditation committee

- Concern that well-known overseas courses may be rejected

- Claims that CDE committee rejected ortho/craniofacial research journals and some articles from the journal of periodontology

NUS BDS

COC Alternatives

- **Extend to 5/6 years in stages**
  - increase duration by 6 months every stage to allow public workforce to adapt to the difference

2. Review NUS Curriculum

- Currently no practical session for veneers
- LA-OP requirement reduced

FRESH GRAD TRAINING

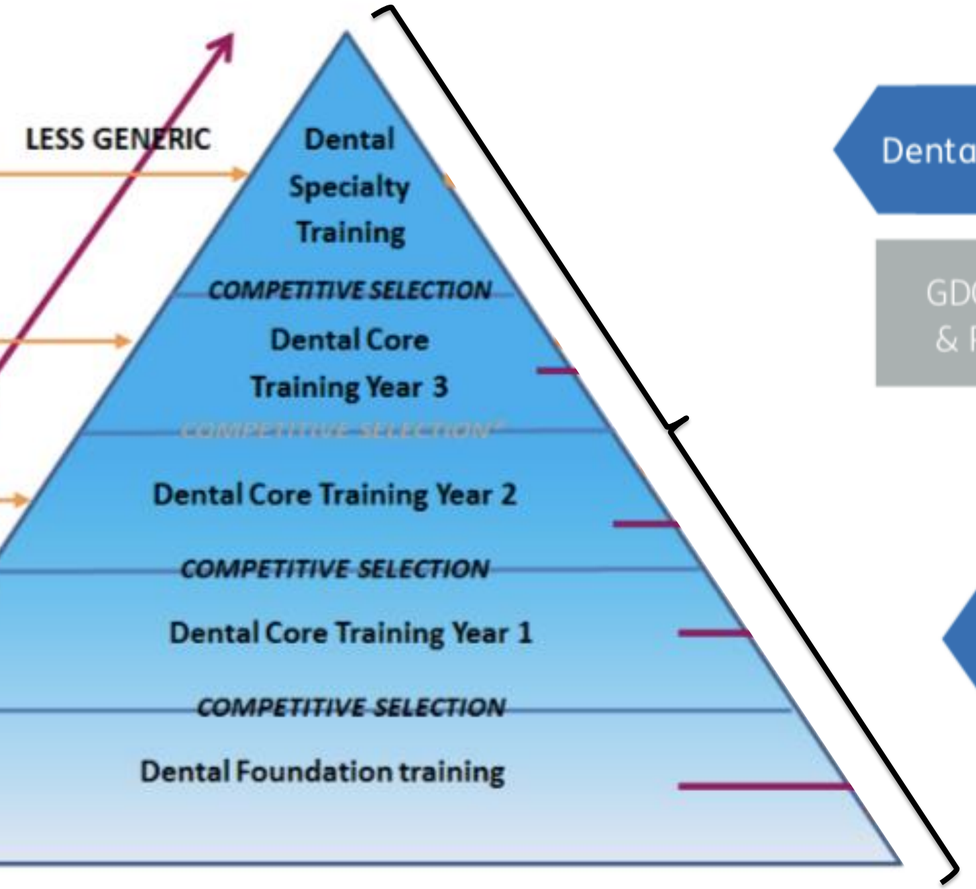
COC Alternatives

1.Alternative training programmes for DOs during bond period

- Can maintain/improve skills even in non-specialty postings eg. polyclinic

2. 1-2 years of compulsory pre-registration for all fresh grads (local/overseas)

- Similar to med Housemaship
- rotate through compulsory specialty postings that are deemed 'must-know-enough' to gain the necessary experience



Specialty Training (3-5 Years)

GDC Approved Specialty Training Curricula

Dental Core Training (2/3 years)

GDC Preparing for Practice & Postgraduate Curricula

DFT (1 year)

COPDEND DFT Curriculum

Dental Core Training

- Extends from the end of DFT
- DCT1 is designed to allow recent dental graduates to build upon the knowledge, skills, attitudes and behaviours learnt and developed in dental school and foundation training.
- DCT2/3 years is more focused on speciality experience, for those who express a keen desire to pursue dental speciality training

Dental Foundation Training

- Experiential learning within the General Dental Practice
- Gain experience directly through practice under supervision
- Trainers help with identification of individual learning needs, reflection, mentoring, tutorials, workplace-based assessments and high quality feedback
- Compulsory study day where small group teaching, guided peer discussion and problem based learning take place

Framework Suggestions

1.Partial restriction only for life threatening procedures

- Similar to SMC

Framework Alternatives

1.Guidelines from local specialist societies

- classifying simple/intermediate/complex cases eg. ortho, implants - refer accordingly
- Only a recommendation - is not a compulsory guide

SUGGESTIONS FROM MEMBERS

Voting

PROCEDURES THAT REQUIRE ACCREDITED TRAINING

Note: “< 5” and “≥ 5” years refers to number of years after graduation

	GP (<5)		GP (≥5)		Specialist	
	YES	NO	YES	NO	YES	NO
(a) Wisdom tooth surgery						
(b) Veneers						
(c) Cone Beam CT						
(d) Dental Implants						
(e) Molar Endodontics						
(f) Open flap / regenerative surgery						

VOTE ON COC

Note: “< 5” and “≥ 5” years refers to number of years after graduation

	GP		Specialist
	<5	≥5	
(a) Status Quo			
(b) Accept non-mandatory CoCs only			
(c) Accept CPGs without CoCs			
(d) Accept CPGs and non-mandatory CoCs			