
An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act

December 2018

The Honourable Adrian Dix
Minister of Health
Ministry of Health
Government of British Columbia
Victoria BC
Canada

December 21, 2018

Dear Minister Dix,

I am pleased to submit the report of my Inquiry into the College of Dental Surgeons of British Columbia. The report describes the recent difficulties that the CDSBC has had and makes recommendations for improved governance and regulatory performance in the interests of the safety of patients and the public.

You also asked me to consider how the Health Professions Act is operating and possible changes to the Act.

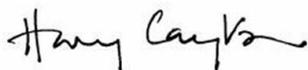
Part 1 of my report deals with the CDSBC and Part 2 with the Health Professions Act. Part 2 also makes recommendations for the wider reform of the statutory framework for health professional regulation in British Columbia.

I take this opportunity to thank the past and present members of the Board of the College for their courtesy and co-operation with my Inquiry. Past and present members of staff have been unfailingly helpful and generous with their time and knowledge.

I have also been assisted by the British Columbia Health Regulators group and by many individuals who have provided evidence. Your officials have provided excellent administrative support throughout.

Despite the contributions of many people I am, of course, personally responsible for the findings in this report and for the recommendations that I make.

Yours sincerely,



Harry Cayton CBE FFHP

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1. Introduction

- 1.1 This is the report of an Inquiry into the College of Dental Surgeons of British Columbia commissioned by the Honourable Adrian Dix, Minister of Health under section 18.1 of the Health Professions Act RSBC 1996 c183 and conducted under the provisions of the Public Inquiry Act SBC 2007.
- 1.2 The terms of reference for this Inquiry can be found in annexe 1 of this report.
- 1.3 The Inquiry began in May 2018 and concludes with the submission of this report to the Minister of Health in December 2018.
- 1.4 In order to carry out my Inquiry I have spent time in the College in May, July, September and October. In preparing this report I have drawn on:
 - Over 40 interviews with former and present Board members and senior staff members
 - Meetings and discussions with external stakeholders
 - Written submissions from other regulatory Colleges, from the Health Professions Review Board and the British Columbia Dental Association
 - Correspondence and telephone calls with members of the public, patients, individual dentists and other interested parties
 - Observation of College meetings including the Board, Governance Committee, Inquiry Committee, Nominations Committee, the Board Officers and Registrar meeting and the Senior Managers and Complaints meetings of staff
 - The Health Professions Act, the CDSBC Governance Manual, the College's internal policies and procedures, its Standards and Guidance and the wealth of information available on its website
 - Letters and emails concerning the College's business which have been submitted to the Inquiry
 - An audit of 30 complaint files
 - An assessment of evidence provided by the College against the Standards of Good Regulation
- 1.5 I consider that this evidence has been sufficient for me to form a fair assessment of the College in the matters set out in the Purpose of Inquiry, 1 (a)-(h) in my Terms of Reference.
- 1.6 I have not used individuals' names in this report. It is not my intention to criticise or blame any individual; the problems that the College has had are a corporate failure and only corporate action can remedy them. I recognise that some individuals will be identifiable by virtue of the office they hold. These are public offices and therefore they are accountable for their decisions and conduct in that office.

- 1.7 A small number of self-identified individuals has submitted evidence to me but asked that their names be kept confidential. I have respected their wishes. I have not received or used any anonymous submissions.
- 1.8 I have been assisted throughout this Inquiry by Michael Warren, Policy Manager, at the Professional Standards Authority (UK). I could not have completed this report without his consistent and reliable assistance. Luane Nisbet, Scrutiny Manager at the Authority, carried out the complaints file audit. Simon Wiklund, Senior Solicitor, has helped my thinking about reform of the Health Professions Act.
- 1.9 I am grateful to the past and present members of the Board of the CDSBC who have been unfailingly helpful and open and have welcomed my Inquiry. The staff team at the College have patiently answered every question even when they had told me the answer before and, without complaint, rearranged their working days to accommodate my needs. Some former members of staff have been similarly helpful.
- 1.10 Other individuals in British Columbia have been generous with their time and advice.
- 1.11 I have done everything I can in the time available to check facts. The confidential requirement on this report prior to its submission to the Minister has necessarily limited my ability to do that with the assistance of others. I am therefore responsible for any errors. Despite the considerable help I have received from many people the conclusions in this report are mine alone.

2. The Health Professions Act

The College of Dental Surgeons of British Columbia and its regulatory context

- 2.1 The College of Dental Surgeons of British Columbia is the regulator of dentists, certified dental assistants and dental therapists¹ in the province. The College registers 3762 dentists, 6535 certified dental assistants and seven dental therapists in a province with a population of 4,817,000.² There are three other professional regulators of dental professions in the province: the College of Dental Hygienists of British Columbia, the College of Dental Technicians of British Columbia and the College of Denturists of British Columbia.
- 2.2 First enacted in 1990, the Health Professions Act, R.S.B.C.1996, c.18313 (Health Professions Act) establishes the legal framework for the regulation of all self-governing health professions in British Columbia. The Health Professions Act sets out the duties and objects of a College in the province.³ It provides the College with the power to create bylaws whereby it can establish procedures to elect board members, create Board committees, establish standards of academic achievement and qualifications for registration, establish standards, limits and conditions for registrants' practice, and establish and maintain continuing competence and quality assurance programmes.
- 2.3 Prior to moving to the Health Professions Act in 2009, the College of Dental Surgeons of British Columbia was regulated by provisions in the Dentists Act, 1983.
- 2.4 The College is one of 21 health regulatory colleges in the province, regulating 25 professions. There are colleges of chiropractors, dental hygienists, dental technicians, denturists, dietitians, massage therapists, physicians and surgeons, midwives, naturopathic physicians, registered nurses, licensed practical nurses, registered psychiatric nurses, occupational therapists, opticians, optometrists, pharmacists, physical therapists, podiatric surgeons, psychologists, speech and hearing health professionals, and traditional Chinese medicine practitioners and acupuncturists. One health profession, emergency medical assistants, is regulated by a Government-appointed licensing board under a separate statute. Social workers are also regulated, by the British Columbia College of Social Workers under a separate statute.

Duties and objects of a regulatory College in British Columbia (Health Professions Act)

Duties

It is the duty of a college at all times:

(a) To serve and protect the public and (b) To exercise its powers and discharge its responsibilities under all enactments in the public interest

Objects

A college has the following objects:

¹ *Annual report 17-18*, CDSBC, 2018.

² *Canada at a glance 2018*, Statistics Canada

³ *Health Professions Act*, RSBC 1996, c 183

- (a) To superintend the practice of the profession
 - (b) To govern its registrants according to this Act, the regulations and the bylaws of the college
 - (c) To establish the conditions or requirements for registration of a person as a member of the college
 - (d) To establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants
 - (e) To establish and maintain a continuing competency programme to promote high standards amongst registrants
 - (f) To establish a patient relations programme to seek to prevent professional misconduct of a sexual nature
 - (g) To establish, monitor and enforce standards of professional ethics amongst registrants
 - (h) To require registrants to provide to an individual access to the individual's healthcare records in appropriate circumstances
 - (i) To inform individuals of their rights under this Act and the Freedom of Information and Protection of Privacy Act
 - (i1) to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair
 - (j) To administer the affairs of the college and perform its duties and exercise its powers under this Act or other enactments
- In the course of performing its duties and powers under this Act or other enactments, to promote and enhance the following:
- (i) Collaborative relations with other colleges established under this Act, regional health boards designated under the Health Authorities Act, and other entities in the Provincial health system, post-secondary education institutions and the government
 - (ii) Interprofessional collaborative practice between its registrants and persons practising another health profession
 - (iii) The ability of its registrants to respond and adapt to changes in practice environments, advances in technology, and other emerging issues.

Table 1: Duties and objects of a regulatory College in British Columbia (Health Professions Act)

2.5 The Health Professions Act also establishes the Health Professions Review Board, which hears registration and complaints appeals across all of the colleges established under the Act. Members of the Review Board are appointed by the Lieutenant Governor in Council. The Board is an independent administrative tribunal, and has the following powers and duties:

- To review certain registration decisions of a college of a designated health profession
- To review the failure, by the inquiry committee of a college, to dispose of a complaint or an investigation within the time required
- To review certain dispositions of complaints made by the inquiry committee of a college

- To develop and publish guidelines and recommendations for the purpose of assisting colleges to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair.
- 2.6 The Board, having reviewed a registration decision made by the College's Registration Committee or the handling of a complaint by the College's Inquiry Committee, may make an order either:
- Confirming the registration decision or disposition of the Inquiry Committee
 - Directing the Registration or Inquiry Committee to make a decision or disposition that could have been made by the Registration Committee or the Inquiry Committee in the matter
 - Send the matter back to the Registration or Inquiry Committee for reconsideration with directions.
- 2.7 The Health Professions Act provides that each regulatory college will have a board, which must 'govern, control and administer the affairs of its college in accordance with this Act, the regulations and the bylaws'. A board must submit an annual report to the Minister of Health. The Health Professions Act also provides that a board must ensure that its college has an accessible website that is free of charge to the public. A board has a majority of professional members, elected by registrants, and a minority of public members appointed by the Minister. A board may appoint an executive committee.
- 2.8 In addition, the Act provides that a board may make bylaws including to 'establish a registration committee, a quality assurance committee, an inquiry committee, a discipline committee and other committees the board determines are necessary or advisable'.
- 2.9 The legislative framework provides for both protected titles and the services that registrants may provide (called 'scope of practice') including restricted activities that only registrants may perform while providing services. The Health Professions Act sets out that the Minister of Health can prescribe protected titles which only registrants may use. The Minister's College specific regulation⁴ then sets out the protected titles that apply to College registrants: dentist, dental surgeon, surgeon, doctor, and dental therapist (the title 'doctor' is shared with the College of Physicians and Surgeons of British Columbia). The Minister's regulations also set out the services that may be provided by College dentistry registrants. These are recorded in Table 2 below. The services that dental therapists and certified dental assistants are authorized to provide are contained in the bylaws.

Restricted activities
Restricted activities for dentistry registrants
(a)make a diagnosis identifying, as the cause of signs or symptoms of an individual, a disease, disorder or condition of the orofacial complex and associated anatomical structures;

⁴ Dentists Regulation, 2008

- (b)perform a procedure on tissue of the orofacial complex and associated anatomical structures below the dermis or the surface of a mucous membrane;
- (c)perform a procedure on tissue below the dermis for the purpose of removing tissue for use in reconstructive or other surgery on the orofacial complex and associated anatomical structures;
- (d)perform a procedure on tissue in or below the surfaces of the teeth, including the scaling of teeth;
- (e)set a fracture of a bone of the orofacial complex;
- (f)reduce a dislocation of a joint of the orofacial complex;
- (g)administer a substance by
 - (i)injection,
 - (ii)inhalation,
 - (iii)mechanical ventilation,
 - (iv)irrigation, or
 - (v)enteral instillation or parenteral instillation;
- (h)put an instrument or a device, hand or finger
 - (i)into the external ear canal, up to the eardrum,
 - (ii)beyond the point in the nasal passages where they normally narrow,
 - (iii)beyond the pharynx,
 - (iv)beyond the opening of the urethra for the purposes of catheterization,
 - (v)beyond the anal verge for the purposes of monitoring temperature, or
 - (vi)into an artificial opening into the body;
- (i)put into the external ear canal, up to the eardrum, a substance that is under pressure;
- (j)apply
 - (i)ultrasound, for
 - (A)diagnostic or imaging purposes, excluding any application of ultrasound to a fetus, or
 - (B)the purpose of lithotripsy, in treating a disease, disorder or condition of the orofacial complex and associated anatomical structures,
 - (ii)electricity, for the purpose of destroying tissue or affecting activity of the heart or nervous system,
 - (iii)electromagnetism, for the purpose of magnetic resonance imaging,
 - (iv)laser, for the purpose of cutting or destroying tissue, or
 - (v)X-rays, for diagnostic or imaging purposes, including X-rays for the purpose of computerized axial tomography;
- (k)issue an instruction or authorization for another person to perform, in respect of a named individual, a restricted activity specified in paragraph (j);

- (l)in respect of a drug specified in Schedule I, IA or II of the Drug Schedules Regulation, B.C. Reg. 9/98,
- (i)prescribe the drug,
 - (ii)compound the drug,
 - (iii)dispense the drug, or
 - (iv)administer the drug by any method;
 - (m)if nutrition is administered by enteral instillation, dispense a therapeutic diet;
 - (n)prescribe a dental appliance;
 - (o)dispense or fit a dental appliance;
 - (p)conduct challenge testing for allergies
 - (i)that involves injection, scratch tests or inhalation, if the individual being tested has not had a previous anaphylactic reaction, or
 - (ii)by any method, if the individual being tested has had a previous anaphylactic reaction.

Table 2: Restricted activities for dentistry registrants

2.10 In Part 2 of this report recommendations are made as to changes to the Health Professions Act and in addition to the overall framework of health professional regulation to enable health professional regulation in British Columbia to promote the safety of patients, the well-being of the public and to work better in the interests of all citizens of the Province.

3. Governance, conduct and probity

Elections and appointments

- 3.1 The Health Professions Act (HPA) refers to the professionals who are regulated within its framework as both 'registrants' and 'members' of a college⁵. This reflects an inherent confusion as to the nature of a college and its relationship to the people it regulates. 'Members' implies that the dentists⁶ own and control CDSBC; 'registrants' that they are registered with and controlled by the College. These two conflicting perceptions run through the way the College and its board and registrants behave and how they perceive their roles and responsibilities. A former member of staff described it thus: *'My view is that the biggest problems here, the biggest resistance here, comes from two fundamental issues. The first is the misunderstanding of the role and duties of a regulator by this registrant base. A huge misunderstanding.... You know, the lack of understanding about what the College's role is causing a lot of the issues, a lot of the disappointment and the politicking and many other things stem from this. Either a refusal to acknowledge or a... plain ignorance as what the College's role is.'*⁷
- 3.2 This idea of membership is reinforced in the requirement under the HPA for an Annual General Meeting⁸ and for annual elections to the Board of the College.⁹ This level of accountability to and control by the members creates the persistent perception that the College exists for the benefit of dentists, that it is a club rather than a regulator and that volunteerism lies at its heart. I heard many comments from dentists about the importance of 'democracy' within the College and noted the time and energy and enthusiasm that goes into the annual awards event for selected volunteers. Much stress is put on the idea of voluntary service to the College despite the fact that the majority of dentists who volunteer legitimately receive some payment. The idea that the College is a voluntary organisation rather than a professional regulator also affects the relationship between the members of the Board and the staff (see paragraph 3.22).
- 3.3 It is worth considering just what 'democracy' means in the context of the CDSBC. In the years 2014 to 2018, the average percentage of dentists voting in elections for members of the Board was 40%. The percentage of CDAs voting was an even smaller 7%. In 2017 the average voting percentage for four Board positions was 29%. Voting of course implies a choice but three dentist members of the Board were elected unopposed in 2016 and six in 2018. The voting system operates as an electoral college which creates further inconsistencies. There are over 6000 CDAs who can elect only two people to the Board whereas 3000 dentists elect ten.¹⁰

⁵ Certified Dental Assistants and Dental Therapists are not 'registrants'. CDAs hold a certificate granted by the College but are not regarded as registrants or members. See 5.16 to 5.20 for more details on CDAs and Dental Therapists

⁶ The Health Professions Act defines a registrant as 'in respect of a designated health profession, a person who is granted registration as a member of its college in accordance with section 20'

⁷ All quotations, unless otherwise noted, are taken from recorded interviews with former or current Board members or senior staff during July 2018.

⁸ Health Professions Act, section 19.

⁹ Health Professions Act, section 17.

¹⁰ A proposal to reduce this to one and six was agreed by the board in September, then overturned in November 2018

Similarly, the geographical constituencies vary greatly in size. In the North district 151 dentists elect one member to the Board, in Vancouver district the electorate for one member is 1739. The faculty at the University of British Columbia (UBC) elect a Board member. There are only around 45 members of that electoral college and they are the only registrants who have two votes as they are also entitled to vote in their relevant geographical constituency. Dental Therapists meanwhile have no voting rights at all and no place on the Board.

- 3.4 Of course, elections apply only to professional members of the College Board. Public members are appointed by the Minister through a process which is opaque. It appears that 'public' members may either be approached directly by government officials or may put their own names forward by indicating an interest in general or in relation to a particular profession. Names may also be suggested by the regulator's Board Officers or Registrar either formally in writing or informally. Transparency could be improved in how the names of public members come to be considered by the Ministry of Health (the Ministry) and how they are subsequently selected and allocated to various bodies. 'Public' members include, somewhat surprisingly, people who are regulated health professionals but from a different profession.
- 3.5 The lack of clarity and transparency about how public members are put forward and appointed gives rise to suspicion on the part of some dentist members of the Board that the appointment process has been manipulated. Several former and present Board members alleged to me that the previous Registrar had 'appointed his friends to the Board' or had 'packed the Board with his friends'. This is not true. Decisions as to who should be a public member of the Board are in the hands of the Minister and it has long been the practice that regulatory Colleges in British Columbia may put forward names of possible candidates. In fact, a form is provided by the Ministry for exactly that purpose and names are put forward and signed off by the President. In any event there is something unconvincing in dentist board and committee members, who are often themselves friends and colleagues or former classmates or who may share business or social interests, suggesting that public members are unduly influenced by personal or professional relationships but that they themselves are not.
- 3.6 The CDSBC has 10 committees as set out in the by-laws¹¹. It has another committee which is described as 'technically a working-group'; the so-called Governance Committee¹². In addition, it has established three other working groups bringing the total to 15.¹³ The College has not established a Patient Relations Committee as set out in the HPA¹⁴; the Board has reserved this function to itself although it seems rarely to have discussed patient relations. The College does not have a patient relations programme (see paras 6.15-6.18 below). The terms of reference of these committees and working groups while written down are not

¹¹ *Bylaws of the College of Dental Surgeons of British Columbia, 2017.*

¹² *CDSBC Annual Report 2017/18*

¹³ Working groups include: Bylaws working group, Facial aesthetics working group, Governance Committee, Finance and Audit Working Group

Committees include: Audit Committee, CDA Advisory Committee, CDA Certification Committee, Discipline Committee, Ethics Committee, Inquiry Committee, Nominations Committee, Quality Assurance Committee, Registration Committee, Sedation & General Anaesthetic Services Committee,

¹⁴ Health Professions Act, section 19, (t).

always adhered to, and when interviewed, their chairs and members could not always explain to me with confidence what their roles and responsibilities were. Particular confusion seems to exist around the roles of the Governance Committee and the Nominations Committee¹⁵ and the relationship of the 'Finance and Audit Working Group' to the Audit Committee.

- 3.7 According to the 2017/8 Annual Report the Governance Committee 'provides governance, oversight and advice to the Board'. Its former Chair, who was also Vice-President of the College, wrote in that report 'the best governance is what works best for CDSBC'¹⁶. I find both these statements problematic. A working group of the Board cannot 'provide governance' to the Board, nor can a working group established by the Board 'oversee' the Board. Since all the members of the Governance Committee are members of the Board and two of them are officers (the current President also attends *ex-officio*) it seems that it is advising itself. If the College's definition of good governance is merely 'what works' it is hard to see what ethical or external wisdom that brings. In many conversations with Board members and with the former chair of the Governance Committee it was not possible to elicit a clear explanation from anyone of the Governance Committee's role or responsibilities.
- 3.8 Uncertainty about the Governance Committee's role is also shared by some of its members. At a meeting I observed, discussion took place as to why certain items were on the agenda and what if anything they had to do with governance. Several items appeared to me to be operational and should not have needed to come to a committee at all. Other items included a proposed charter of 'Patients Rights', which having been referred from the Governance Committee to the Board and back again was referred on to the Ethics Committee. Decisions were made and agreed by the Committee only to be revisited and changed at the intervention of individual members within a day. In line with the recently introduced practice of a declaration of interests at the start of the meeting the members agreed that they all had an interest in the item on the Expenses Policy. However, when that item was reached they discussed it from their personal perspectives without any acknowledgement of the interest they had previously declared. Since the Audit Committee is responsible for expenses it's not clear why this item was on the agenda at all. It is difficult to see what added value the Governance Committee brings.
- 3.9 The Finance and Audit Working Group was established May 2012. The College's Bylaws specify that the Audit Committee has only three members. The Working Group has four members. It does not meet separately from the Audit Committee but rather attends all its meetings. Although members of the Working Group are not members of the Audit Committee they take a full part in discussions. The former chair of the Committee said, '*I have to frequently look at my notes to know who is the member and who is on the working group*'.
- 3.10 The way in which both professional members are elected and public members are appointed to the Boards of Colleges does not help good governance although this is no criticism of the individuals so elected or appointed. I make recommendations for some changes the CDSBC could make now within its existing legislation in section

¹⁵ At its meeting in September 2018 the Board agreed to rename the Nominations Committee the Awards Committee and to transfer the nominations function to the Governance Committee

¹⁶ Annual Report 2017/18

6 below and recommendations to the Minister for changes to the HPA in Part 2 section 9.

Conduct of the Board

- 3.11 The Board of the CDSBC has not been a happy, well-managed or constructive governance body for several years. I acknowledge however that the behaviour of Board members and its conduct of business is improving and that Board members are aware of their own difficulties.
- 3.12 The sudden change of leadership at the College in 2016 is a recent but not only source of many of its governance problems. At that election a self-declared 'slate' of six candidates stood with the intention of replacing the then President and bringing the then Registrar under control. Five of those six signed a joint declaration addressed to 'Dentists of BC'. It begins
- 'Over the last few years the executive body of the College of Dental Surgeons of British Columbia under the mandate of 'public protection' has rescinded many of the public and dental professional rights in this province'. And it concludes, 'Our registrar and President seem out of control. A group of us have formed a political slate to run against the current executive so that we can 'right the ship".¹⁷
- 3.13 I should note that the dentist who was the leader of that group and was elected President in June 2016 told me, '*We did not have changing the Registrar as part of our platform. In actual fact I had no thoughts about a new Registrar or what a replacement would look like.*'¹⁸
- 3.14 The cause of this undoubtedly genuine discontent on the part of dentists was the introduction, or attempted introduction, in 2014/15 of new standards in relation to treatment by dentists of their own family and friends, to advertising by dentists and the challenges presented by the growth of corporate dentistry. Further a proposal to change the bylaws to have the officers appointed by the Board rather than elected by the registrants as a whole caused outrage amongst those dentists who thought the College should remain under the 'democratic' control of its members. It seems to me that these changes to College policies, reasonable and proper in intention although they may have been, were not well thought through, communicated or managed. As the President elected in 2016 told me, '*There wasn't an appropriate policy process. It wasn't run out to the registrants in an appropriate way in which they could understand the rationale for its incorporation and accept it.*' The consequences damaged not only the governance and reputation of the College but were a setback to the ethical standards for dentists in British Columbia.
- 3.15 Certainly, the style and intention of the new Board members was different from before. As one public board member at the time observed, '*[The new president] had no concept of governance. His agenda was for the benefit of the dentists. He didn't understand 'protect the public' from my perspective. He just comes there to fix all the things that we've done wrong against the dentists. He actually said that in that first workshop on the first day that he came.*' Similarly a dentist member told me, '*I thought that the new people coming on - they were elected as a slate, would they work on the Board as a slate or would they be independent? And it could be that they would be independent but in reality... they weren't independent at all. They*

¹⁷ 'Dentists of BC', undated, 2016

¹⁸ Interview November 2018

might say a few different things but they always voted the same. They would try to make sure that committee membership involved certain of that group and to try at the next election get more people involved that were of like mind. And sort of silence, or whatever, some of the people who had different opinions. And I think it affected staff morale especially.'

- 3.16 The former President has an understandably different view, he told me,¹⁹ *'I tried to follow the Governance Manual to understand my responsibilities. I had to pile my way through a huge volume of stuff. The Board had not done adequate scrutiny of policy and its development. My focus was that the Board were working in harmony within the governance manual to try and make them aware that they had a responsibility for oversight. The Board should be working with the Registrar and the staff in the public interest. Many board members had not read the governance manual and some said they had never seen it. I was only there to run the meetings. I had to generate trust with Board members. I didn't have an agenda. I aimed for mutual respect and no animosity but that was difficult because two thirds of the Board were very hostile.'*
- 3.17 Nearly every Board member, past or present, with whom I spoke, told me of lack of trust between board members and between the board and the staff team. A dentist who had served on College committees said, *'I think an organization cannot lose trust in all the different levels, from the Registrar, to the executive, to the Board, to the committees and to the staff here. And I think to the public at large after that. The public is who we're trying to protect at the end of the day but if there's loss of trust anywhere along the way, it becomes dysfunctional. That's what I saw the last two years'*. A public member, similarly said, *'Trust has three components; do I trust your motivation, do I trust your skill, do I trust your process? There has become a habit in this group of 'I don't trust your motives'. What they really seem to be thinking is I don't trust your skill or your process... This has deteriorated into a mistrust of motives.'* It is a matter of regret that despite serious efforts to rebuild relationships by both new and some long-standing members of the Board and by senior staff mistrust persists. A public member of the Board reflected, *'There a very strong mistrust that seems to be threaded though the Board itself.'*
- 3.18 The working relationship between the Board and the professional staff needs to be addressed with some urgency and I look at this issue in more detail below.

Relationships between Board members and the staff

- 3.19 Two examples of the lack of trust the Board has in its own staff are the complicated arrangements they have put in place for the secure storage of the personnel records of the Registrar and their unwillingness to have their own Board Secretary take the minutes of their 'private' meetings. In the first case the Board officers,²⁰ because they did not trust the Registrar with his own personnel records, removed them physically from the College premises and stored them securely with a legal firm. Between 2016-18 the Board held some 20²¹ 'private' meetings or telephone calls with no staff present. As I report elsewhere (para 3.58) inadequate minutes

¹⁹ Interview November 2018

²⁰ Board officers are the President, Vice-President and Treasurer.

²¹ Because of inadequate records it has not been possible to determine the exact number of meetings

were kept of these meetings by Board members themselves. Board members are now making arrangements, if private meetings are held, to have minutes taken by a secretarial agency, which should improve the quality of the minutes but shows a continuing lack of confidence in the professionalism of their own staff. A confidential web portal is being set up, to which staff will not have access, to store these minutes.

- 3.20 Two members of staff are former members of the Board. One officer of the Board is a former member of staff. Despite this rather unusual overlap, which one might hope would promote mutual understanding, there remains considerable tension between the Board and the staff team. Just as there has been a struggle within the Board for control over the direction of the College there is a struggle between the Board and the staff team for management of the operational functions of the College and about the staff's contribution to policy. As with the issue of elections this partly flows from the belief by many dentists that they 'own' the College, that the Board therefore embodies the College and that the staff are merely functionaries whose role is to do the bidding of the Board. One public board member observed, *'The Board as a whole don't mistrust staff, it's a minority that wouldn't have respect for staff but that minority would include board officers. I have heard that they have done too much by way of changing operational issues. The current Board, really the officers, don't know the line between supervising the Registrar and getting their hands on the College'*.
- 3.21 I have on a few occasions noted an unacceptable level discourtesy towards staff by individual Board members and some officers, past and present, sometimes publicly reprimanding them or challenging their competence. Unfortunately, although such damaging criticism is rare, it has gone unchallenged by other board members. Lack of respect for others if unchallenged rapidly becomes accepted conduct.
- 3.22 The tension between Board members and staff works both ways; if staff do not feel they are treated fairly by the Board or committee members they lose confidence in the leadership of the College. Staff can also be disempowered and uncertain of what is expected of them because of the unclear messages coming from the Board. As one public member observed, *'The [officers] and full Board do not use the registrar and senior staff in a very effective way. They rarely seem to turn to the registrar to ask for input, advice, and recommendations. I believe that most issues coming to the board should be framed in briefing notes which staff have researched and prepared. Staff should include a recommendation and rationale rather than posing open ended questions like, 'Staff are seeking direction from the Board.'*
- 3.23 A member of staff recently said to me, *'The staff are so frightened of the officers, they are so unpredictable, it's like walking on eggshells, so nothing gets done in case it's the wrong thing or they've changed their minds'*.²²
- 3.24 The resignation of the previous Registrar in April 2018 achieved what some dentist members wished for. One had written, *'Is there a culture in the conduct of the registrar's office which is not particularly favourable to CDSBC, the profession of dentistry in British Columbia and most importantly our duty to the public. Are we over influenced by persons trained in law and not dentistry?'*²³. Although the

²² Staff member, October 2018

²³Memorandum to members of the Governance Committee, June 14, 2017

Registrar's resignation was foreseeable it was some time in coming. When it came the Board had no plan. Some members did not like that Registrar but had no settled idea what kind of new Registrar they would like. The former President told me that he had no reason to think about what kind of Registrar was desirable because he had had no intention of getting rid of the registrar. This is not the perception of other members of the Board at the time. One public member told me, *'There were a group of six elected in July 2016, I've seen some of their election propaganda, including that the goal was to remove the President and the registrar from their positions. The language was very strong in some of the propaganda I've read.'* A board officer said, *'I had a lot of respect for [the Registrar's] knowledge but as time went on I had less respect for his character... I think now we are in a much better position.'* In any event, by the time the Registrar left, no new job description or person specification had been prepared, no timetable for recruitment had been put in place, no regard taken for the impact of the acrimonious departure of an experienced regulatory CEO on the staff team with whom he had worked with for five and a half years. It took several months to agree a contract with the Acting Registrar and at its meeting in September 2018 the Board was still undecided as to how or when to recruit a substantive replacement. In July 2018 one public Board member had observed, *'The Board seems unclear whether they want/expect the Registrar to take on the functions of the CEO despite there being a role description for the registrar that includes CEO functions and was signed off by the board in Jan 2012. It is included in the governance manual.'*²⁴ At the September Board meeting no decision was made except to set up a small working party to consider the matter further. A decision was finally made at the Board in November 2018 to appoint the current acting Registrar and CEO to the post but only for a two-year period. The terms of that appointment are still not agreed. It seems that this important issue of College leadership is unlikely to be resolved until well into the future.

- 3.25 The Board should be grateful to the staff team for their resilience in maintaining the College business against a background of mistrust, arguments, lack of planning and dysfunction within its elected and appointed leadership. It is primarily the staff who over the last two years or more have ensured that public protection has been a focus of College activity. As a former public Board member said, *'The biggest issue is the Board. The staff is an excellent group of people. I saw some excellent processes with complaints as well as strong performance in other areas. It's the functionality of the Board and how it works with staff which is the biggest barrier to how the College can become an excellent regulator and a good protector of the public'*. One of the College officers admitted, *'I know, the things that we were upset about didn't have a lot to do with patients' safety... I know a lot of the people who work here, so I knew that the patients were being protected. That that hadn't changed... But the board has been stuck, we have accomplished virtually nothing because of this issue'*. The former President disagrees. In his view the Board achieved numerous improvements to protecting the public during his period in office (see paragraph 6.8).
- 3.26 The view of some dentist members of the Board is that staff should not have opinions and that their knowledge and expertise is to be discounted; they are there to carry out the decisions of the Board and its committees. In an email to a staff

²⁴ The CDSBC Governance Manual has a section on Registrar/CEO succession planning (s26) which does not appear to have been discussed or followed by the board

member, copied to the rest of the rest of the Bylaws Working Group, the Chair made clear, *'It is not the role of staff to enter into policy discussions of the Board, a committee or a working group... You were asked to reformat my memo to the Board on behalf of the bylaws working group. Nothing more'*²⁵. This disparaging attitude is reflected in the communications of some dentists; one wrote, *'Let's face it the majority of 'research' is supplied by CDSBC staff. There have been numerous situations that staff members (especially complaints officers) have discounted research when it doesn't agree with their beliefs.'*²⁶

- 3.27 Members of staff should be treated as an asset by the Board and their expertise valued. They are not the servants of the Board they are partners with it in the College's important task of protecting the public.

Ethics and conflicts of interest

- 3.28 Every time somebody enters and leaves the College offices they pass a statement of its Standards of Practice. These remind registrants, staff and Board and committee members of their ethical responsibilities including that they should 'maintain accountability in the public interest' and ensure that they meet 'legislative requirements and professionals standards'.
- 3.29 Each Board member takes and signs an Oath of Office²⁷ on taking up their position. The wording of the Oath reads:

I do swear or solemnly affirm that:

- I will abide by the *Health Professions Act* and I will faithfully discharge the duties of the position, according to the best of my ability;
- I will act in accordance with the law and the public trust placed in me;
- I will act in the interests of the College as a whole;
- I will uphold the objects of the College and ensure that I am guided by the public interest in the performance of my duties;
- I have a duty to act honestly;
- I will declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest;
- I will ensure that other memberships, directorships, voluntary or paid positions or affiliations remain distinct from work undertaken in the course of performing my duty as a board member;

So help me God. *[omit this phrase in an affirmation]*²⁸

These are serious affirmations emphasising public trust, the public interest, and public duties.

²⁵ Email dated 20.10.18

²⁶ email dated 1.11.18

²⁷ HPA 17.11

²⁸ Health Professions General Regulation, 2017

3.30 In addition, the College had a 'Conflict of Interest and Confidentiality Agreement' as well as a 'Code of Conduct for Board and Committee Members'²⁹. Those were signed by all members who hold a role within the College. Financial conflicts are also covered briefly in the Financial Policies³⁰. There has been however no register of interests and no requirement for members to declare new or relevant existing interests prior to each meeting. This is now being introduced. I welcome the decision by the Board to introduce this as a standard agenda item and to have a publicly accessible register of interests. This should cover all Board and committee members and senior staff.

3.31 The College had a conflict of interest statement until 2016. It was comprehensive:

'A direct or indirect conflict of interests exists when you, a friend, a family member, business associate or your corporation or partnership stand to benefit by the result or consequences of a decision made by the committee on which you are serving. A conflict of interest can also occur when your own personal interest in the outcome of a situation could influence, impair or prevent you from pursuing an objective fair and principled approach to decision-making.'

3.32 It went on properly to highlight the importance of perceived conflicts of interest:

'The possibility that others will perceive that a Board or committee member is biased or has a conflict of interest in a given situation is also significant. This can arise when others perceive that the decision-maker would be unable to make an objective decision about an issue, quite apart from whether the decision-maker believes this perception to be true.'³¹

3.33 There is no doubt that perceived conflicts of interest can be damaging to confidence in public bodies and a failure to address them undermines their independence and their reputation. In 2016 the Governance Committee under its new chair, took issue with the Confidentiality Agreement as they thought it was too restrictive and didn't allow for any discussions with registrants. The Committee subsequently approved a Board Member Conduct Agreement which as well as reasserting that members should avoid bias and conflicts of interest and that 'Board members must maintain strict confidentiality', went on to itemise those occasions when confidential information could be shared³² Given the clarity of the College's Board Member Conduct Agreement and that all Board and committee members sign it is disappointing that very little regard seems to have been taken until recently to address the issue of real and perceived conflicts.

3.34 I address the relationship between the College and the British Columbia Dental Association below (para 5.21). That there is a possible conflict of interest is borne out by the College's own Governance Manual which specifies that:

'A Board Member must not simultaneously be a board or committee member of any dental professional body where there could be a conflict with the regulatory role of CDSBC, without prior consent of the board.'

²⁹ 'Code of Conduct, Board and Committee Members' and 'Conflict of Interest and Confidentiality' CDSBC, undated.

³⁰ CDSBC Financial Policies, 2016, p5.

³¹ CDSBC Conflict of Interest and Confidentiality, nd. P2

³² Governance Committee Minutes, 5 October 2016

'A Board Member should not serve as a board member of any provincial or national dental association until three years after the expiration of his or her term.'³³

3.35 A similar requirement for incoming Board members is set out in paragraph 3.4 of the Manual. It reads:

'Any person who currently serves or has served in the previous two years on the board of directors of any provincial or national dental association is ineligible to be a Board Member unless he or she has received prior written consent from the Board.'

3.36 This is a proper recognition of the separation of roles to limit conflicts of interest. It is odd that 3.4 specifies a two years separation and 7.6 three years. I recommend that three years should apply to both restrictions and that the discretion for the Board to over-rule best practice should be removed.

3.37 Dentists who are the subject of a complaint are able to stand for election to the Board and indeed to be elected, while that complaint is under consideration. This undermines the regulatory role of the College. I recognise that a complaint may not have been found to have any substance at that point and may indeed subsequently be found to be without merit. But that is not the point. Serving on the Board of a regulator is a public privilege not a professional right and all those who seek such responsibility should demonstrate their personal commitment to and respect for patients. Bylaw 2.3(8) says registrants should 'be in good standing' to be appointed to the Board. Being the subject of a live complaint puts that good standing in doubt and standing for election at that time undermines public confidence as it implies that the College has predetermined the outcome of the complaint.

3.38 Dentist members of the Board, past and present, have been quick to suggest to me that public Board members who know each other professionally or personally are inevitably conflicted and biased. This allegation was made repeatedly by former officers and some dentists against those public members of the board who had had professional or personal contact with the former Registrar. No actual evidence of how these supposed conflicts of interest played out in practice was provided except allegations of bias. As I have observed before (para 3.5 above) there is no similar recognition that if dentists are friends and colleagues that may also be perceived as creating bias. However, these are perceived conflicts of interest and as such no less damaging than actual conflicts. The Governance Manual again is clear:

'All appointed members should be independent of CDSBC; that is free from any relationship that might interfere with their independent judgement as a Board Member'

3.39 Of course, many dentists, some more than others, are properly involved in business with each other, whether it be sharing a practice, running training courses or study clubs. Others may be active in the British Columbia Dental Association or other representative or advocacy groups. There is nothing wrong with these relationships or activities. They may however, in particular or in general, give rise to an actual or perceived conflict of interest and this is why an up-to-date published register of interests is necessary and why new and relevant interests should be declared

³³ CDSBC Governance Manual 7.6

before every meeting. This is particularly important in the Inquiry Committee and the Board. I have seen the correspondence between a dentist member of the Inquiry Committee and the College concerning their suggestion that a dentist be required to take a course in which they had a financial interest. The inquiry panel chair wrote, *'One of the dentist members of the committee made comments about limitations of a...teaching center suggested by the college...and suggested that the college should consider sending the registree to the member's own teaching institute for further training. This is a serious conflict of interest and a very unprofessional attempt to advertise for business during a formal meeting...I noticed similar behaviours in past meetings and I expect the college to have certain guidelines to prevent this from becoming a pattern.'* The dentist concerned, despite having signed the Confidentiality and Conflict of Interest statement, rejected the suggestion responding, *'I note the suggestion I made may be unpalatable for another who may consider himself or herself a competitor.'* I should add that the College took action in this matter.

- 3.40 The College Board Member Code of Conduct requires members to 'maintain strict confidentiality of College business'.³⁴ The 'Conflict of Interest and Confidentiality' statement prior to 2016 went into further detail. No one could misunderstand what confidentiality is or what was required. Despite that a confidential legal report to Board members was leaked to the *Globe and Mail* in 2017. Several Board members told me that there were frequent leaks of information from *in camera* and private Board meetings. At the September 2018 Board meeting, the College's General Counsel reported that the level of detail in a Freedom of Information request received from a *Globe & Mail* reporter would seem to indicate that they were continuing to receive confidential information. All members of the previous and incoming Board, except the President, have now signed a new additional Confidentiality Certification.³⁵
- 3.41 In spring 2016 a serious complaint was made to the College. I make no comment on the nature or content of that complaint or on its outcome. However, it is appropriate for me to review the manner in which the College Board dealt with the consequences of the complaint.
- 3.42 In February 2017 that second report was submitted to the Board. The only people who had copies were the Board members and subsequently the Registrar. The report was unequivocal in its criticism of the Colleges handling of the complaint and proposed a number of actions to remedy the matter. It advised the Board that the matter should be kept confidential. It was not.
- 3.43 On May 11, 2018 the Board held a private meeting by telephone to approve an agreement with the complainant made through their lawyer. They agreed a payment to cover the complainant's legal costs. They also agreed a donation to a charity to be made in the complainant's name. A few Board members queried the appropriateness of the latter payment. There were two concerns; was it proper for the College to make such a payment, that is, was there provision in the HPA for CDSBC to be making charitable donations and to a charity entirely unconnected to its purpose; and why was the donation to be made directly to the charity and not to the dentist? Despite these doubts the Board approved the payments. As one Board

³⁴ [CDSBC Code of Conduct](#), 2017, Page 2

³⁵ Board meeting 15 September 2018 item 22

member said, 'There were a lot of people, board members opinions, that felt that it wasn't our duty to be making a donation of \$25,000 in anybody's name. I think the bottom line was that we agreed to it just to bring the issue to an end.' Two members of the Board asked that their dissent be recorded in the Minutes³⁶.

- 3.44 The internal and external strife that has engulfed the College in recent years has inevitably involved obtaining legal advice and meeting its own and other's legal costs. Legal advice does not come cheap and in the three and a half financial years 2015/16 to autumn of 2018/19 the College has spent some \$320,000 on the external legal cost of protecting its own interests. In the same period the external legal costs of protecting the public were \$91,000. The College has a procurement policy but this has not been followed in the selection of any of the eight different external lawyers who have advised it during this time. There has been no formally agreed brief and no process of competitive tendering for any such contract as set out in the College Financial Policies.³⁷ The College has General Counsel on its staff, as permitted by the Bylaws³⁸ but their opinion on external legal advice has not been sought by the officers or the Board. In November 2016 without the necessary approval of the Board (which was given subsequently) the officers commissioned external legal advice on the interpretation of the HPA.³⁹ Advice which their General Counsel, an expert on the legislation, could have provided at no cost. Again, this reflects the Board's general lack of respect for or confidence in the expertise of its staff and a disregard for its own policies and procedures.

Management of meetings

- 3.45 College Board meetings are long. They generally last all of a Saturday and may be preceded by a full day workshop. They are divided into three parts: a public session, an *in camera* session and a private session. The *in camera* session is closed to the public but staff attend. The private session is Board members only. I welcome the recent decision by the Board to move more agenda items into the public part of the meeting. One of the disadvantages of having public and *in camera* sessions is that some items are discussed twice. The Bylaws set out a list of items that might need to be taken in closed session but stresses 'the public interest in Board meetings being open to the public'.⁴⁰ There was a discussion at the September 2018 Board meeting of the possibility of allowing members of the public to speak and ask questions. The matter was passed to the Governance Committee, where in October 2018 it was discussed again. Some Board members seemed quite concerned that the public, to whom they are accountable, might publicly hold them to account. Suggestions were made to restrict the public to written questions in advance, or to no more than three minutes, or to a separate meeting entirely. One dentist member suggested that the public might be unable to understand the business of the Board. I believe the Board will move in the right direction and I urge them to do so without restrictions on the public except that of polite and proper behaviour. The College regulates on behalf of the public and should be willing to be accountable to the public.

³⁶ *In Camera* minutes, May 12 2018

³⁷ CDSBC Financial Policies, July 2016, p7.

³⁸ By-Laws 3.14

³⁹ DLA Piper report

⁴⁰ By-Laws 2.15(9) (a)-(k)

- 3.46 Meetings of both the Board and its committees could be more productive if they were shorter and more attention was given to three kinds of agenda items:
- reports for information,
 - reports on performance requiring challenge
 - and approval and papers requiring discussion and a decision.
- 3.47 Additionally, I note that the roles of a Board are:
- to ensure the College complies with its mandate and the law
 - to set strategy, to monitor performance
 - and to hold the registrar and chief executive to account for delivery
- 3.48 Board agenda items and papers should reflect those roles. At every meeting the Board should be asking itself: how are we protecting the public, what will the decisions of this meeting add to public protection? When Boards lose their way they become over-concerned with process and procedure rather than with effective decision-making and outcomes. The background papers that the Board receives should be prepared to help the Board achieve its purpose not merely to report on activities. I note that the Board is proposing to move more of its papers into what it calls a 'consent agenda', that is reports that are to be received and noted by the Board but not discussed. This is one way of freeing up Board time for more important items. However, it raises the question of why those reports are being prepared for the Board at all if they are not worthy of discussion.
- 3.49 A Reading of the minutes of meetings reveals that sometimes matters are discussed formally or raised informally which subsequently disappear from view despite the Board having proposed that some work should be undertaken. For example, the creation of the Policy Development Working Group. After the initial 'appointment' of the Working Group, there is no more information about the outputs of it in next Board meeting minutes. Sometimes, the reverse may happen where a piece of work may be completed but with no recording in the minutes that this was initiated: for example, the disbanding of the Registrar Search Working Group in 2012. There appears to be no mention of the Working Group being set up.
- 3.50 Decisions made by the Board may be challenged by a committee and decisions made in a committee overturned by members subsequently. There seems to be no formal way of recording and tracking decisions except when motions are proposed and carried. Even those appear sometimes to be contested or changed after the event. The style and format of committee minutes is not always consistent.
- 3.51 Voting on resolutions does not lend itself to consensus building or to the development of corporate responsibility. Indeed, the practice of proposing formal motions, gathering amendments and voting on them seems completely out of step with modern governance. It reinforces the idea that the College is a club and that board members represent and vote on behalf of their electorates. An effective board absorbs information, debates and discusses and aims to reach a consensus. The Chair will summarise and confirm back to a board what they have agreed. If the board are deeply split that may need to go to a vote but rarely. The Chair should not vote unless the board is evenly split. I note that at the September 2018 meeting the resolutions relating to proposals from the Bylaws Working Group on the size and membership of the new Board was by secret ballot, whereas all other votes were by show of hands. When I asked the President after the meeting why this was so, he

said that it was because the items were controversial. I do not see that is a reason for secrecy, in fact quite the opposite. Voting should be open and transparent, secret ballots have no place in a public body.

3.52 The Governance Committee had in fact discussed this very issue at a meeting in November 2016. The relevant minute reads:

‘System for casting votes at the Board level.

[Name 1] suggested a polling mechanism such as Della Smith (*sic*) uses. [Name 2] said this was not the way to go as it is important to hear everyone's opinion and for openness and transparency especially when discussing policy. These important policy decisions need to be discussed openly, consensus sought and then a decision through a motion or consensus agreement. [Name 3] agrees, saying an anonymous voting system is not transparent or consistent with good governance. The Governance Committee was satisfied with this discussion. No further action required’⁴¹

3.53 Although at least four members of the committee which made that decision two years earlier were present at the Board in September 2018 no one questioned or challenged a procedure previously rejected by the Governance Committee as not consistent with good governance. At the November 2018 Board meeting, despite by then having had the Governance Committee's conclusion drawn to his attention the President continued with secret ballots.

3.54 As noted above the Board has not only held meetings *in camera*, but also private meetings where no staff were present. Proper records of some of those meetings have not been kept. This is a failure of governance. At many of those meetings important decisions affecting the reputation, probity and finances of the College were made. That such decisions were made in secret and without proper records or subsequent approval of those records is a significant failure in a statutory body. The current President has with considerable diligence and effort gathered together such records as do exist and shared them with me. He informed me, ‘*I believe one of the Board officers (President, Vice-President or Treasurer) was often responsible for the minutes and more often than not this may have been the Treasurer but this is not absolutely clear*’. He continues, ‘*There is no indication that the minutes were approved in any formal way...Some of the minutes were held confidentially at the College. The remainder were stored electronically with one of the Board officers.*’⁴² The staff, at the request of the Board, is now putting in place formal arrangements for the minuting of private meetings and the secure storage of this minutes. Having read the minutes and other documents provide to me by the President I consider that they do cover matters which is was appropriate for the Board to discuss in private.

3.55 Transparency is a great antiseptic. It reveals what organisations and people say and do and promotes public accountability. I welcome the moves the Board is making towards greater openness; moving more items on the agenda into the public meeting, inviting members of the public to ask questions at the end of the meeting, establishing a proper register of interests and introducing declarations at the start of meetings. I consider it should actively limit its use of both *in camera* and private

⁴¹ Governance Committee, 24 November 2016 Item 7.

⁴² Letter dated October 8, 2018

board meetings and have clear criteria for which items should be discussed at *in camera* meetings. Private meetings should be reserved for confidential human resources issues which rarely require the involvement of the entire Board. The CDSBC should consider establishing a small confidential remuneration committee to advise it on such matters.

- 3.56 In this context it is appropriate to commend the quality and accessibility of the College's website. The website is well presented and encourages and enables members of the public to understand the College's role and to make a complaint. It is easy to find most but not all information. I consider that some of the information could be better organised particularly that around standards of dentistry. A user has to search through five web pages to find the actual standards and the language used is inconsistent; 'practice resources', 'practice guidelines', 'standards and guidelines', 'professional practice', 'standards of practice', 'policies'. This is confusing and the College should use consistent language separating the internal policies of the College from Standards and Guidelines for dentists. (see paras 4.49-57 below)

Financial oversight

- 3.57 This is not a financial audit of the College. I have no reason to think that the College is not well managed financially. All my questions which have related to financial matters have been answered in full and with commendable speed. It is apparent however, that the Board has not always followed its own financial policies and procedures particularly in relation to the procurement of legal advice. It is to be hoped that the Board can put behind it the many legal challenges it has recently faced but it must introduce proper procedures for the appointment of legal advisors and the management of legal contracts. It should do this through its own General Counsel to ensure an objective process.
- 3.58 It is unusual for an Audit Committee to spend time checking individual expenses claims instead of ensuring that there is a properly administered policy subject to internal audit. This is an inefficient use of its time and expertise. There is no internal audit function. In an organisation of this size it would not be proportionate to employ an internal auditor but it would be helpful to commission independent internal audit advice to the Audit Committee from an accountancy firm contracted for that purpose.
- 3.59 The College does not have a formal risk register managed by the Registrar and senior staff, reviewed by the Audit Committee and reported twice yearly to the Board. Such a Risk Register would have alerted it to some of the legal, financial and reputational risks that it has encountered in recent years and enabled it to mitigate them more effectively. Risk management is specified in the Governance Manual as one of the responsibilities of the Audit Committee.⁴³
- 3.60 The Audit Committee is an important part of the checks and balances within the College. It has an important role in maintaining financial oversight and probity. It needs to hold both the staff team and the Board to account for financial and risk management and oversight. It cannot do that effectively if officers of the College attend its meetings and compromise its independence from senior decision-makers.

⁴³ CDSBC Governance Manual, 10.3.5

4. Performance of the College

The Standards of Good Regulation

- 4.1 As part of this Inquiry the College has submitted evidence of its performance of its key regulatory functions in the light of the 28 Standards of Good Regulation. A formal performance review has not taken place but the College's internal processes and procedures have been examined. As part of this Inquiry I have observed internal complaints meetings and a meeting of the Inquiry Committee and an Inquiry panel. Thirty complaint files chosen by me were audited against the Professional Standards Authority's audit framework. I have also received submissions from dentists, patients and lawyers expressing their views on the College's conduct of complaints.
- 4.2 The Standards of Good Regulation (see Appendix 2) cover the key functions of:
- Registration
 - Standards and Guidance, and
 - Complaints and discipline
- 4.3 In addition, I have reviewed the College against the Standards for Governance (Appendix 3). In order to meet each Standard a regulator needs to demonstrate with evidence that it does so. It is not sufficient to have policies and procedures which would meet the standard if properly applied; it is necessary to show that those policies and procedures are properly applied in practice and that they produce outcomes that meet the Standards. Many regulators have proper policies and procedures but do not measure their impact or outcomes and so may meet the Standards but cannot demonstrate that they do so. This is the case with the performance of the CDSBC against some of the standards.
- 4.4 My overall conclusion is that the College meets 17 of the 28 Standards of Good Regulation as set out below. It may meet others but I cannot conclude that it does because the evidence is not available. I conclude that it has not met 11 Standards.

Registration

- 4.5 There are four standards for registration:

Only those who meet the regulator's requirements for registration or certification are registered

- 4.6 The HPA requires College registrars to 'maintain a register setting out, for every person granted registration under this Act, the following:
- (a) the person's name, whether the person is a registrant or a former registrant, and, if the person is a registrant, the person's business address and business telephone number;
 - (b) the class of registrants in which the person is or was registered;
 - (c) if the person is a registrant, any limits or conditions imposed under this Act on the practice of the designated health profession by the registrant;
 - (d) a notation of each cancellation or suspension of the person's registration...

- 4.7 The requirements for registration are set out in Bylaw 6 for dentists and in Bylaw 7 for Certification of Dental Assistants.
- 4.8 The College has detailed information about registration on its website. Dentists and CDA's wishing to be registered or certified by the College must show that they have passed an examination set by the National Dental Examining Board (NDEB) or National Dental Assistant Examining Board (NDEAB). The College is able to check the veracity of the information provided by applicants through the two examining Boards.
- 4.9 Applicants must fill in a detailed set of questions to verify their identity and background. Applicants submit a statutory declaration as part of the application and have it notarized. They attest that the information in their application is true and accurate. If an applicant provides any unusual information about the requirements or their background or they have admitted to any previous issues with conduct or competence in response to application questions, the application is forwarded to the Registration or Certification Committees for consideration.
- 4.10 The College responds to developments to keep its requirements current: for instance, the 2015 Dalhousie University dental student scandal in which a group of male fourth year dental students posted sexually explicit and misogynistic comments online. Questions were raised about whether those students should ever be registered as a dentist in any of the Canadian Provinces and, along with some other regulators the College added additional questions to the application form.
- 4.11 As part of registration and reinstatement for dentists, Certificates of Standing (COS) are required for all outside jurisdictions that the applicant has ever practiced in. The COS must be sent from regulator to regulator and is in the format of a common template. The COS includes confirmation that they have complied with quality assurance requirements and whether there are any previous complaints. If there are open complaints or any current or past disciplinary action these are sent to the Registration Committee for consideration.
- 4.12 As part of certification and reinstatement for CDAs, Letters of Standing are required for all outside jurisdictions that the applicant has ever practiced in. These letters confirm that they have met the quality assurance requirements in that jurisdiction. The letter must be sent from regulator to regulator and includes a note about any open complaints and any current or past disciplinary action taken. The Canadian dental assisting regulators are working on a template for a Certificate of Standing similar to the one used for dentists and we will start requiring it if the applicant is coming from a Canadian jurisdiction.
- 4.13 CDSBC provides Certificates of Standing for registrants applying to other jurisdictions.

This Standard is met.

Through the register, everyone can easily access information about dentists, dental therapists and CDAs, except in relation to their health, including whether there are restrictions/conditions on their practice

- 4.14 CDSBC provides an online registrant lookup which includes all active registrants. The online register includes all registrants who are active. The lookup indicates the following information for dentists:

- Full name
- Registration category
- Gender
- Education, graduation year and initial registration date
- Limits or conditions of their registration (if any)
- Regulatory Action (if any)
- Practice location and contact information
- Whether they are qualified to provide sedation

4.15 Similarly, the Registration look-up provides information about certified CDA's:

- Full name
- Certification category
- Gender
- Whether they hold a Module (Orthodontic or Prosthodontic)
- Whether they have obtained a sedation certificate
- Limits or conditions to practice (if any)
- Regulatory action (if any)

4.16 For dental therapists currently only the name is shown.

4.17 The 'Registrant Lookup' is clearly indicated on the homepage and users can do a quick or advanced search of each of the three types of registrant. The registrant lookup is also in the top, right-hand menu bar of the website, which can be accessed from any page of the website.

4.18 Currently, the Registrant Lookup includes only active registrants. It does not include those who are retired, resigned, or those who have voluntarily withdrawn. It directs users to contact the College if they are looking for information about a registrant who is not listed on the online lookup. The College is seeking to improve the database to create an up-to-date listing which will include all current and previous registrants.

4.19 It is important for patients or prospective patients to be able to identify if an individual dentist or CDA has any limitations on their practice or any disciplinary findings against them. The way in which the definition of 'serious matter' as set out in the HPA is used in the complaints process to keep some consent agreements and limitations on practice confidential means that the information on the register is not always complete.

4.20 As part of considering this Standard a small sample of registrant entries on the public register was checked and no errors were found.

This Standard is met.

The public and others are aware of the importance of checking a dentist's, dental therapist's or CDA's registration. Patients and members of the public can easily find and check a registration and certification

4.21 CDSBC has participated in two public awareness campaigns, beginning in 2013, led by the BC Health Regulars promoting the importance of seeing a registered dentist, dental therapist or CDA and who patients should contact if they have concerns about the care they received. The first campaign was delivered in English, French, Spanish, Cantonese/Mandarin, Punjabi, Korean, Vietnamese, Tagalog, and Farsi.

The materials included print, television, speaking engagements, bus shelter advertising, community/ethnic newspaper ads, cinema slides, and public service announcements on a local news station

- 4.22 The second campaign in 2015 ran with the message, 'Saying you are one doesn't make you one: make sure your health professional is regulated and accountable'. The campaign ran advertisements on bus shelters, in multicultural media and on social media. It also included short television advertisements featuring children playing the role of registered health professionals. I have viewed these advertisements which are well conceived and made. There has unfortunately been no formal measurement of their impact on public awareness of health professional regulation.
- 4.23 CDSBC reminds registrants to check that their associates, employees and co-workers are registered or certified and includes that advice in media statements and publicity.
- 4.24 The College gives publicity to anyone identified as having practised illegally. The website lists people who have been the subject of legal action for providing unauthorized dentistry services; the public can click on each name for more information.

This Standard is met.

Risk of harm to the public, and of damage to public confidence in the profession, related to non-registrants using a reserved title or undertaking a restricted activity, is managed in a proportionate and risk-based manner

- 4.25 The College takes immediate action if it is alerted to possible illegal practice. A private investigator is appointed and if warranted, a search and seizure court order is sought from the BC Supreme Court to enable a College Inspector to attend.
- 4.26 The College Inspector, the private investigator and their team in addition to police officers attend to inspect, catalogue and seize evidence.
- 4.27 The CDSBC provided evidence of the action it had taken to stop illegal practice. In 2013 it took rapid and effective action against a man who is who was believed to have provided dentistry illegally to 1,500 patients. The College issued notices along the way to keep the public, registrants and other interested stakeholders updated. It also worked with Health Authorities to draw attention to the risk of infection for patients. Advertisements were also placed in Chinese and mainstream media to inform the public of the court findings. The College offered a reward for information leading to the arrest of the dentist after he went missing. He was subsequently detained in Ontario.
- 4.28 The College is able to demonstrate that its response is proportionate in the case of another person practising illegally where the risk of infection was not considered so great that a public health notice needed to be issued.
- 4.29 The College website records action against six people for illegal dentistry between 2013 and 2015.

This Standard is met.

Standards and guidance

- 4.30 There are five standards for standards and guidance

Standards of Practice and professional ethics reflect up-to-date practice and legislation. They prioritise patient safety and patient-centred care

- 4.31 The Health Professions Act charges the College with ‘establishing, monitoring and enforcing standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice’.⁴⁴
- 4.32 Expectations for dental practice are set out in the CDSBC Code of Ethics, and Standards of Practice documents. There are also guidance documents and topic-specific materials such as information sheets and interpretive guidelines and policies.
- 4.33 The ‘Code of Ethics’ and ‘Standards of Practice’ documents are very brief. The first is two pages and sets out five values and 13 ethical principles. It is clear and succinct. The second is only one page and has five ‘standards’ concerned with how dentists should deliver care. The College has explained that Standards are mandatory and Guidelines are recommended. It states:
- ‘Guidelines are highly recommended but – while being evidence of a standard – are not, strictly speaking, mandatory. Guidelines contain permissive language such as “should” and “may.”
- Standards are, by definition, mandatory and must be applied. Standards are clearly identified by mandatory language such as “must” and “required.”⁴⁵
- 4.34 However, the word ‘must’ does not in fact appear in the ‘Standards of Practice’ document, which refers instead to ‘responsibilities of dentists, dental therapists and certifies dental assistants in providing care.’ It is unclear as to the status of many of the variously named ‘Standards and Guidelines’, of which there appear to be 11, ‘Information sheets’ of which there are five and ‘policies’ of which there are eight. I cannot find any document, apart from ‘Standards of Practice’ which is transparently a standard. The majority are described as guidelines, practice guidelines or merely given a title describing their subject matter. At the same time some documents called guidelines use mandatory language; the ‘Dental Record keeping Guidelines’ say ‘Dentists *must* (my emphasis) now keep complete dental records...’ and ‘Other records that must be retained...’ There are no standards for Patient Relations. The ‘Patient Relations Program’, despite being a requirement in the HPA, falls under ‘policies’ not standards or guidance and the relevant document merely refers the reader to separate ‘guidance’ on the treatment of spouses. There is no description of a patient relations standard or of what the ‘program’ is. There is a statement that the HPA requires the College to have such a program.
- 4.35 The purpose of information sheets is also unclear. For example, ‘Building the Dentist-Patient Relationship’⁴⁶ where the first few lines are, ‘The core of the dentist-patient relationship is a trusting relationship. This document provides some of the *key obligations* (my italics) and roles’ that each of the dentist and the patient can expect of each other.’ If this is a key obligation why is just an ‘information sheet’ and is a ‘key obligation’ different from a required standard?

⁴⁴ HPA s. 16(2)(d)

⁴⁵ *Standards & Guidelines*, CDSBC website.

⁴⁶ CDSBC *Building the Dentist Patient relationship*. 2015

- 4.36 The College has a range of documents covering good clinical practice in a wide number of areas. The College's ethical principles prioritize 'the health and well-being' of patients and its standards of practice state that the first responsibility of dental professionals is 'patient-centered care'.
- 4.37 The College does respond to new issues in dentistry such as the development of 'corporate dentistry' It is currently revising Patient-Centred Care and the Business of Dentistry, first published in 2015 to address new business models for dentistry, specifically concerns about the corporatization of dentistry. It addresses the conflict between the dentist as healthcare professional and as a business person, and requires that the dentist put the healthcare needs of their patient above all other considerations.
- 4.38 The College has recently responded to the legislation of cannabis in Canada by issuing a reminder in October 2018 that the new law does not change registrants' obligations; they cannot practise while impaired, they cannot prescribe marijuana, and patients who are impaired cannot provide informed consent.
- 4.39 The evidence demonstrating that the College meets this standard is mixed. There is significant lack of clarity about what is a standard and what is guidance, and this makes it difficult to understand what is mandated and what is optional good practice.

This Standard is not met.

Additional guidance helps registrants apply the regulators' standards to specialist or specific issues, including addressing diverse needs arising from patient-centred care

- 4.40 The College issues Information Sheets on specialist topics:
- Appropriate use of VELscope in Dentistry (to provide clarity to registrants and the public regarding the use of VELscope screening to identify potential oral mucosal diseases, including oral cancer)
 - Schedule 1 Drugs and Dentists Scope of Practice (addresses the use of Botox by dentists)
 - Confidentiality clauses in settlement agreements (registrants cannot dissuade or prohibit anyone from making a complaint to the College)
- 4.41 When the College identifies issues that may affect public safety, it may publish topic-specific information. For example, in 2016 it reminded dentists of their legal and professional obligations in dental emergencies and in 2018, in response to a rise in the use of CBCT (cone beam computed tomography) scanners it issued a reminder about best practices regarding Diagnostic Interpretation.
- 4.42 Because the College does not have a systematic and accountable program of identifying new topics for standards, guidance or information it is not possible to judge whether these are the most important or necessary new topics for improved patient centered care. Nevertheless, the evidence suggests this Standard is met.

The regulator has an effective process for development and revision of standards and guidance, the regulator takes account of stakeholders' views and experiences, external events, developments in provincial, national and

international regulation, and best practice and learning from other areas of its work

- 4.43 The College does not have a systematic and accountable program of identifying new topics for standards, guidance or information. Nor does it have a regular and consistent program of revision of existing documents. Although ultimately the Board is accountable the manner by which topics emerge as important enough to require new standards or guidance or information provision is haphazard.
- 4.44 Three committees have some direct responsibility written into their terms of reference. The Quality Assurance Committee, 'develops and reviews practice standards, other than sedation and general anaesthetic standards, and recommends to the Board changes that the Committee considers appropriate to those standards.' The Sedation and General Anaesthetic Services Committee has a specific purpose; 'to review the sedation and general anaesthetic standards and recommend changes as appropriate, and to assess the compliance of dentists with the standards'. The Ethics Committee's terms of reference have as one objective, 'reviews standards of professional ethics and recommends changes as required'. The Quality Assurance Committee is also responsible for overseeing and improving continuing professional development. It is not apparent how a programme of work is prioritised and coordinated between these three committees and the Board and the professional staff.
- 4.45 In 2015/16 the College created a new 'policy development process'. This was in response to two deeply unpopular changes to guidance where registrants felt there had not been adequate consultation and/or strongly disagreed with the College's approach. The policy development process applies to standards and guidance as well as to the College's internal policies and procedures.
- 4.46 The College says it has started working on a process to review standards and guidelines and that it is developing closer collaboration between its complaints and quality assurance functions.
- 4.47 These initiatives are necessary and welcome but the College must establish an accountable, managed process for the development and revision of standards and guidance.

This Standard is not met.

The standards and guidance are published in accessible formats. Registrants, potential registrants, educators, patients and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed

- 4.48 I welcome the College's intention to clarify what are Standards and what is Guidance but inconsistencies of style, presentation and language remain. Finding Standards and Guidance documents on the College website is not straight forward. The entry point is headed 'Practice Resources', from there you click on 'Standards & Guidelines'. A website user is then faced with 11 documents only one of which is called 'Standards and Guidelines', five are described as 'guidelines', six are not identified in their title as one or the other.

- 4.49 None of these documents are referred to as a 'Standard'. Along the side of the same page are the headings 'Code of Ethics and Standards of Practice', that takes a website user to two documents. In this case 'Standards of Practice' describes principles, such as 'do no harm' and 'maintain accountability in the public interest'. These are good principles for dentists to follow but are they measurable Standards? Below the heading 'Standards of Practice' there is another, 'Standards and Guidelines', this has the same list of 11 documents none of which on the face of it appear to be a 'Standard'. The practice of anaesthesia is potentially highly dangerous so a clear Standard is to be expected. Instead we are faced again with a document titled only 'Sedation and Anaesthesia', with the introduction, 'All general dentists and certified specialists administering sedation and general anaesthesia must adhere to the requirements outlined in CDSBC's relevant standards and guidelines.' This is odd because it uses 'must' in relation to guidelines and because the link takes you to the 'Registration and Renewal' page of the website not to the Standards. There appear to be three separate standards for sedation and anaesthesia, each with several unconsolidated addenda. Below 'Standards and Guidelines' are the headings 'Information Sheets' and 'Policies'. Information Sheets seems straightforward, but why is 'dismissing a patient' an information sheet not guidance? 'Policies' is even more confusing; 'Patient Relations' is a policy; I would expect a Standard saying what sexual boundaries were, what standard of conduct the College required and what action the College will take, including removal of licence, if a dental professional were proved to have breached this Standard. Instead a web user follows a link to the bylaw that says it is not sexual misconduct to sleep with your spouse even if you are providing them with dental services.
- 4.50 It is not clear why some topics are policies, some are information sheets, some are guidance and virtually nothing is clearly and unequivocally a Standard.
- 4.51 The College does have an active communications policy using both digital and print media to communicate to registrants and the public about our initiatives, events, consultations and news -- including new and revised 'expectations for practice'. Hard copies of standards and guidance documents are mailed to registrants. Changes and updates are published in the electronic and print newsletter. Registrants are regularly reminded of the need to keep their contact information current, and may not unsubscribe from College publications.
- 4.52 When the Infection Prevention and Control Guidelines were created the key points were published on a wipeable Infection Prevention and Control Wall Poster that was distributed to all registrants. It does not appear however that there is any requirement on registrants to display the poster.
- 4.53 The College provides courses and presentations for registrants and has a presence at the two main annual dental conferences: the Pacific Dental Conference and the Thompson Okanagan Dental Conference. It also delivers courses to regional dental societies in British Columbia and hosts events in various parts of the province.
- 4.54 The College has a social media presence and tries to communicate effectively through provincial newspapers and broadcast media.
- 4.55 Information about how to complain is easy to find on the College websites and its complaints information is translated into seven languages. Translation services are used during the College's investigations if appropriate, to ensure it understands the concerns raised by patients.

4.56 The Standards of Good Regulation need to be understood as a complete requirement; the College has an active communications programme and information about action that can be taken if Standards and Guidance is not followed is readily available. But the Standards and Guidance are difficult to find and even more difficult to interpret so it is not clear to a dentist what they must do and even less clear to a patient or member of the public what they can expect. The taxonomy and format of documents needs to be consistent and their publication clear and accessible.

This Standard is not met.

The regulator has a systematic approach to ensuring dentists, dental therapists and CDAs are up to date and able to practise safely

4.57 All registrants must meet Quality Assurance requirements to renew their registration annually. These requirements include:

- Dentists: 90 continuing education credit hours per three year cycle and minimum 900 continuous practice hours in the previous three calendar years
- Dental Therapists: 75 continuing education credit hours per three year cycle and minimum 900 continuous practice hours in the previous three calendar years
- CDAs: 36 continuing education credit hours per three year cycle and a minimum 600 continuing practice hours providing the restricted activities in the previous three calendar years

4.58 Registrants are required to submit evidence of the completion of these requirements through the College website. Those reports need confirmation by College staff.

4.59 Each autumn the College identifies those registrants who have not met the continuing education requirement. Those registrants are reminded that they have until December 31 to complete the requirement or they will not be able to renew their registration.

4.60 Each year at renewal registrants submit the hours they practised for the previous year and these are logged.

4.61 The College creates and delivers continuing education courses for registrants, both in-person and online. The courses are developed for the topics that relate specifically to the College's mandate of public protection and for which there is not an alternative.

4.62 The College is currently consulting on a significant revision of its Quality Assurance programme. This has been a lengthy process and involves substantial changes. On the face of it the current consultation is throwing up important practical difficulties as well as support for the intention of the programme. In order to strengthen its programme the College may wish to consider how it can measure the impact of the Quality Assurance programme rather than just recording inputs and activity. The College needs as part of its consultation to be smarter about measuring outcomes rather than inputs.

This Standard is met.

Complaints and discipline

4.63 There are ten standards for complaints and discipline

Anybody can raise a concern, including the regulator, about a registrant

- 4.64 Patients, or their advocates or other members of the public who have concerns about a registrant can raise their concerns with the College. Registrants also can complain and, in some cases, have a duty to report. Insurance companies also report on registrants as do other health colleges. To make it easier for patients to raise concerns in 2018 the College added an online complaint form. The new form provides clarity to patients about what information is needed from them when they submit a complaint.
- 4.65 An overview of key complaints information has been translated into seven additional languages: Chinese (simplified and traditional), French, Hindi, Korean, Punjabi, Spanish and Vietnamese.
- 4.66 The College says that inquiries staff assist the public by directing them to other agencies or providing advice regarding the complaints process. However, complainants who have contacted me during the course of this Inquiry have reported difficulty in getting the College to respond as they expect. It is understandable that the College requires a complaint in writing but this does not always seem to be clear to complainants. Nor is the offer of telephone help to those who need it made directly. In an email exchange shared with me as part of its evidence the complaints officer stresses to the complainant, 'If you wish to lodge a complaint, we require your complaint in writing with your signature'. This is after the complainant has already provided the information asked for in a series of emails. There is no offer of help over the telephone. Another email from the College reads, 'If you still wish to lodge a complaint with the College, we may be able to review your complaint with respect to staff relations and dentist/office supervision of staff and perhaps ethics. However, the College requires signed complain submissions before it can be reviewed by the Intake Panel of the Inquiry Committee for approval to open a complaint file and to conduct an investigation.' There is a bureaucratic and formal tone to these official responses which are intended to be helpful but feel discouraging.
- 4.67 As well as complaints being accepted from patients, dentists, CDAs and others the registrar can initiate a complaint and the Inquiry Committee can investigate on its account for instance if concerns about one dentist emerge while investigating a complaint about another.
- 4.68 The College needs to review the tone and language used in its initial exchanges with potential complainants so that the College can obtain the information it needs to assess if a complaint is valid as quickly as possible and with the least inconvenience to the complainant.

This Standard is met.

Information about complaints is shared with other organisations within the relevant legal frameworks

- 4.69 Information regarding registrants of other health colleges is shared with the appropriate college when public safety is identified as a potential issue. For

example, the CDSBC informed the College of Hygienists that a dentist may have been practising at a hygiene clinic after his withdrawal from practice.

- 4.70 Public notification of resolutions to complaints or discipline matters is provided to other regulators in British Columbia and Canada as a matter of routine or elsewhere as required by the HPA and the CDSBC Bylaws.
- 4.71 As part of registration and reinstatement for dentists, Certificates of Standing (COS) are issued to outside jurisdictions. The COS is sent from the CDSBC to the other regulator and is in format required between all Canadian jurisdictions. The COS includes a listing of previous complaints both open and closed and any disciplinary action taken.
- 4.72 The legal framework of the HPA restricts public access to full information about complaints against dentists and CDAs but the College complies with all its responsibilities.

This Standard is met.

The regulator will investigate a complaint, determine if there is a case to answer and take appropriate action including the imposition of sanctions. Where necessary the regulator will direct the person to another relevant organisation

- 4.73 All complaint letters are considered. A few are closed by the registrar as not raising health or competence issues. They are reviewed and risk assessed by the complaints team. The majority are referred to the intake panel of the Inquiry Committee the same day.
- 4.74 If following the risk assessment it appears that action is necessary to protect the public during the investigation of a registrant, or pending a hearing of the Discipline Committee, the College may take interim action to restrict practise or suspend a dentist or CDA.
- 4.75 The College employs inspectors who investigate complaints. Most are dentists, legal expertise is also available in the team.
- 4.76 An investigation report is provided to the Inquiry Committee. It includes a summary of the steps taken in the investigation and relevant information received. The investigator's comments are set out separately.
- 4.77 The Inquiry committee is composed of dentists, CDAs, and public volunteers. They are expected to review all the materials in advance of the meetings. At each meeting the Committee has a long list of files to review and more often than not meets by telephone conference. This makes it difficult for volunteer members to engage fully in discussion. My observation of an Inquiry Committee is that there was very little discussion or analysis of individual files by the Committee. In the majority of cases the proposals put forward by the complaints team seem to have been accepted.
- 4.78 The vast majority of complaints are resolved by consent. In 2016/17, four percent and in 2017/18, ten percent were referred to a Disciplinary Committee and all of those were subsequently closed by consent.

4.79 During the course of an investigation the College advises patients with concerns about criminal behaviour of a registrant to contact the police. If appropriate the College will contact the police directly.

4.80 It is difficult to determine if the action taken by the College in relation to the many complaints that are resolved by consent is 'appropriate'. The number of dentists continuing to receive complaints after they have agreed to remedial action by consent suggests that the original decision by the Inquiry Committee was not appropriate. A decision in favour of further remedial action is also therefore likely to be inappropriate.

This Standard is met.

All complaints are reviewed and risk assessed on receipt and serious cases are prioritised

4.81 The CDSBC has recently introduced a basic risk assessment tool to its consideration of incoming complaints. There is simple categorisation of risk (no risk, minimal, low, moderate, high) at the bottom of the 'New Correspondence Checklist.' The checklist is accompanied by a series of tables headed 'Elements of Risk Analysis'. These list criteria under five areas of practice that those assessing risk could take into account.

4.82 There are also criteria attempting to indicate the meaning of 'low', 'moderate' risk and so on. These include what regulatory action might result having regard to the seriousness of the complaint. Since action in response to complaints is entirely the responsibility of the Inquiry Committee and only then after the complaint has been fully investigated I do not think it right for those assessing the initial risk of as yet uninvestigated, unproven complaints to be having any regard for a possible outcome.

4.83 Complaints are considered on receipt at the weekly complaints team meeting and potential issues identified. The complaints team receives a copy of the registrant's complaint history if there is one. Any files assessed as low risk are addressed quickly, usually with a letter or telephone discussion about practice advice. Other matters are fully investigated. The Initial Intake Form directs attention to action that should be taken to prevent a high-risk dentist or CDA from practising or to restrict their practice by consent. Matters of high risk for potential harm are identified and flagged to immediately ask the Inquiry Committee to address as a section 35 proceeding for an extraordinary remedy.

4.84 The introduction of the new risk assessment process is an important and welcome step but it needs to take into account a wider range of matters and to be focused on immediate risk of harm to patients from continuing practise by the dentist complained about. The risk assessment approach was only adopted in principle by the Inquiry Committee at its meeting in October 2018 and therefore is not yet in place. I suggest that the College trials this approach and assesses its effectiveness.

This Standard is not met.

The complaints process is transparent, fair, proportionate and focused on public protection

- 4.85 The College provides clear information about the complaints process on its website. The, albeit limited, feedback from its complaints survey suggests that both complainants and registrants understand the process.
- 4.86 In the course of this inquiry I have received a range of opinions from patients, dentists and lawyers all criticising the complaints process and alleging unfairness of various kinds. Unsurprisingly the criticisms and perspectives are inconsistent and do not lead to any particular solutions. In my view some of the problems arise from the HPA itself and I address these in Part 2 below. Others arise from the approach that the College has chosen to take, particularly as regards Memorandums of Acknowledgment and Understanding. Requiring dentists to take remedial action whether or not the failing is susceptible to remediation (such as dishonesty) or when insight is not demonstrated or there are repeated similar complaints does not appear to be effective.
- 4.87 The requirement in the HPA for the Inquiry Committee to determine that a matter is 'serious' before it has been fully assessed risks inconsistency and much bargaining between registrants and the College.
- 4.88 Another concern is the lack of independence of the process and therefore potentially unfairness. The Inquiry Committee is not independent of the College Board. Members of the College Board sit on the Inquiry Committee. If Board members are involved there is a perceived or actual risk that the interests of the College (cost of legal action, time, inconvenience) may influence decision-making. Moreover, dentist members of the College Board are elected and therefore beholden to their colleagues.
- 4.89 I am aware of one incident in which a dentist Board member of the College raised a live investigation with the Registrar expressing a view on the evidence in relation to a dentist they knew personally. This is completely improper and has the potential to invalidate the objectivity of the complaints process.⁴⁷
- 4.90 The Inquiry Committee has too much work to do and therefore has difficulty in giving all complaints the thorough and objective assessment they deserve.
- 4.91 The Inquiry Committee is not sufficiently independent of the staff. The investigators frequently make recommendations to the Committee rather than objectively presenting the findings of their investigation. The staff also prepare proposals for Memoranda of Acknowledgement and Understanding, these are shared with the dentist concerned *before* they have been put to the Inquiry Committee and have sometimes been signed off by the dentist in advance although they are not asked or expected to do so. This procedure has no doubt developed with good intentions, to speed up the process and facilitate a consent order. In practice it subverts the independence of the Inquiry Committee in making its own decisions independently of the investigators. It is important too that the legal advisor does not direct the Inquiry Committee but advises it only on matters of law.
- 4.92 The Health Professions Review Board does provide a check on fairness as complainants can ask it to review if an investigation was adequate or a disposition

⁴⁷ Personal communication, November 2018

reasonable. At a HPRB review the College will provide the investigation file and the complainant receives a copy. A registrant can also seek review if the investigation is delayed. I acknowledge that very few CDSBC decisions complained about are criticised by the HPRB.

4.93 The HPRB can also assist with mediation between dissatisfied complainants and the College. This is a valuable process even if not always successful in resolving differences.

4.94 The majority of complaints which are taken forward are resolved by consent and with a range of remedial activities to be undertaken by the registrant. The monitoring of compliance is not as robust or consistent as it should be. The Complaints team are under resourced in this regard. Data on the effectiveness of this remedial approach has recently begun to be collected and I welcome this. In due course it will be possible to see if the public is protected by this approach. The high number of dentists who continue to be complained about after remedial action suggests that it is not. When sufficient data is available the Inquiry Committee and Board should review its position.

4.95 I make recommendations about improvements that could be made to the Inquiry Committee process within the existing legislation in para 6.28 below. On the basis of current evidence I cannot say this Standard is met.

This Standard is not met.

Complaints are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of all individuals involved. Delays do not result in harm or potential harm to patients

4.96 The CDSBC recognises that it has challenges with the length of time some complaints take to be investigated and resolved. Delays are sometimes the result of defensive action by the registrant or their legal advisors so it is not possible to establish a definitive timeline. Nevertheless, the College should have but does not have indicative target times for each stage of the complaints process. For example⁴⁸:

Median time in weeks:	2014/15	2015/16	2016/17
From receipt to IC/case examiner decision	48	40	41
From IC/case examiner decision to final panel or other disposal	39.1	41	42
From receipt to final panel or other disposal	93.3	94	90

⁴⁸ Tables come from the Professional Standards Authority's 2016/17 review of the UK General Dental Council.

Number of open cases:	2014/15	2015/16	2016/17
More than 52 weeks old	335	288	252
More than 104 weeks old	95	95	79
More than 156 weeks old	43	40	46

Table 3: UK General Dental Council complaints data tables

- 4.97 Unless the College collects this kind of data or similar it is not in a position to measure its own performance or to identify where more resources are needed or where performance is improving or getting worse.
- 4.98 The College does prioritize cases assessed as high risk and if there is a serious risk of harm these cases will proceed quickly to the Inquiry Committee for consideration of an extraordinary proceeding.
- 4.99 The length of time taken to resolve a complaint may have an impact on the safety of patients if a dentist continues to practise while unsafe. The new risk assessment process being introduced should reduce this possibility.
- 4.100 The CDSBC is aware that complaint file lists are very long and the potential for harm is not always immediately apparent at intake. It is working towards a process for reassessing potential for harm by having investigators review records once received. The Board and senior management are aware of the need for a significant increase in resources which should decrease the length of time to reach a resolution.
- 4.101 I do not think the College can be confident that it meets this Standard although it does everything it can within its current process and resources to do so.
- 4.102 This Standard is not met.

All parties to a complaint are kept updated on the progress of their case and supported to participate effectively in the process

- 4.103 The complaints team acknowledge complaints with an opening letter. The registrant is notified, provided with the complaint submission and asked for a response and the complete patient record and if relevant, the names of other dentists or providers involved in patient care. The parties receive timeline letters as required by the HPA.
- 4.104 If a complaint progresses staff begin collecting records and other responses, including setting up telephone meetings with registrants and complainants. The investigators as well as the director of professional conduct monitor the progress. The investigator provides a draft of the investigation memorandum to the registrant and any response is captured before a final memorandum is sent to the Inquiry Committee.
- 4.105 As a complaint is being investigated, the complainant is updated and included by providing the response from the registrant and the complainant is invited to comment on the response. Investigators have telephone or in person meetings with the complainant to ensure their concerns are heard.
- 4.106 Complainants may receive the second opinion reports if they choose to seek a review through the Health Professions Review Process.

4.107 Complainants receive notice of how their complaint is resolved in a closing letter. The complainant is informed if the Inquiry Committee has directed a citation has been issued and if any matters set for hearing are resolved through a consent order.

This Standard is met.

All decisions at every stage of the process are well reasoned, consistent, protect the public and maintain confidence in the profession

4.108 The HPRB in its Annual Report reminds Colleges of the importance of giving reasons for decisions.

'The importance of adequate reasons in...inquiry committee dispositions cannot be overstated. In this regard the Review Board encourages colleges to avoid conclusory statements and to strive to provide thorough analysis and justification to help complainants and applicants to understand the foundations for their conclusions. Well justified reasons and minutes that properly document these decisions are a key element in the proper administration of justice'.⁴⁹

4.109 The weekly 'complaints meetings' which review incoming complaints and progress on current investigations aid consistency. The new risk assessment element of the 'New File' form will also help this. The discussions I have observed are thorough but the minutes of the meeting are brief and record decisions but not reasons.

4.110 Memoranda to the Inquiry Committee are detailed and comprehensive however where there is a recommendation to the committee a reason for that particular recommendation is not provided.

4.111 Discipline citations include the particulars of the allegations of misconduct. The drafting of the citations follows a consistent process and the evidence for the allegations is provided.

4.112 Inquiry Committee directions are recorded in minutes of meetings however full reasons for those decisions are not recorded as a matter of routine.

4.113 Subsequently the Discipline Panel will make determinations and issue a decision. The public report of the decision does not provide reasons.

This Standard is not met.

All final decisions, apart from matters relating to the health of a dentist, dental therapist or CDA, are published in accordance with the legislation and communicated to relevant stakeholders

4.114 The HPA restricts the amount of transparency of decisions made though the complaints process. The CDSBC limits this further by seeking to close the majority of complaints by consent. This is very unsatisfactory from a patient's perspective but complies with the legislation.

4.115 Where a matter has been determined to be serious and/or it has reached a disciplinary hearing the complaint and its outcome are published. These decisions are clearly reported on the College website and are easy to find. The complainant is

⁴⁹ HPRB, Annual Report 2017

informed of the outcome. It appears however that a dentist is not obliged to inform their patients of a finding against them.

This Standard is met.

Information about complaints is securely retained

- 4.116 CDSBC has developed a Privacy and Security Policy to clarify and enhance the retention of complaints information.
- 4.117 All complaint records are kept on site and protected. Access to the database is assigned according to staff job responsibilities. Only the complaints department can access the complaints area of the database.
- 4.118 There is a portal for the Inquiry Committee to gain temporary secure access to complaints files that they are reviewing at a given meeting. Granting access to the inquiry committee portal is done at the discretion of a departmental manager according to the policy. Identification of patients is protected: patients names are redacted from citations. At a recent hearing public attending were asked to sign a visitor policy and maintain confidentiality regarding witness personal information.
- 4.119 Consistent with the new Privacy and Security Policy, all patient information and other confidential records that it sends will be encrypted; this is already happening in some instances. The College plans to roll out a secure file share server for outside sources to upload content. The security of complaints information should be improved as a result of the expansion of the College's office space in 2019. All complaints information will in a separate office which will require a security pass to access.
- 4.120 The new Privacy and Security Policy and the changes being introduced will enhance data security which is already well managed in relation to complaints. The College has confirmed that there were no data breaches in the last year.

This Standard is met.

Governance

- 4.121 The historical problems with governance of the College are described in section 2 (above) of this report. The question, in applying the Standards of Governance to the College, is: Is the College meeting the Standards now, not what did it do or fail to do in the past? There are nine standards for Governance.

The regulator has an effective process for identifying, assessing, escalating and managing organisational risks, and this is communicated and reviewed on a regular basis by the senior staff and the Board.

- 4.122 The College has a number of mechanisms for assessing and managing risk. Although these may be useful and effective in themselves, they do not appear to be part of an overall assurance framework. There is no formal risk register which can be assessed periodically by management, the Audit Committee and the Board.
- 4.123 The Registrar provides an 'Executive Limitation report' quarterly to the Board. This seems to be a bureaucratic and time-consuming process for managing a perceived risk that the Registrar might exceed their authority. The Limitation Report sets limitations on their discretion and requires them to report on what they have not done. The Executive Limitation reports cover matters such as 'Treatment of Registrants', 'Treatment of Staff', 'Financial Conditions and Activities'. I have never

seen any other board treat its chief executive as though they were a risk to be managed.

4.124 The senior staff discuss reputational risks at weekly management meetings and these are brought to the attention of the meetings of the Registrar and board officers and subsequently to the Board as determined by the Registrar and President. There is some evidence that this can operate effectively, for example the recent referral to the Board of quality assurance for non-certified chairside assistants who are providing radiography. This is however, a risk to patients rather than to the College. It appears that in terms of the risks to the College (reputational, financial, legal and personal), the significance of a serious complaint was entirely missed and such actions as were subsequently taken were focussed on damage limitation and crisis management.

4.125 I recognise that the management team pay some attention to risk and elevate recognised risks appropriately but I do not find that the College has an effective process for identifying, assessing, escalating and managing organisational risks.

This Standard is not met.

The regulator has clear governance policies that provide a framework within which decisions can be made transparently and in the interests of patients and the public. It has clear terms of reference for committees and working-groups and effective reporting mechanisms.

4.126 The CDSBC Governance Manual is a comprehensive document and is widely used by the Board and committees. It undoubtedly sets a proper framework for the conduct of College business. It might be seen sometimes as a straitjacket, hindering common sense decisions but it has undoubtedly been valuable at times of internal disagreement.

4.127 The Governance Manual sets out in detail the Terms of Reference of Committees although these do not always seem consistent and may benefit from updating. The Board is aware of the inconsistencies between aspects of the Governance Manual and the College Bylaws and recently has produced a document highlighting those inconsistencies so that they can be addressed.

4.128 The Board receives quarterly Committee reports and Committees raise issues with the Board and seek Board approval for their work. The Board also refers matters to the Committees for their consideration.

4.129 As is noted elsewhere (para 3.54 above) the tracking of decisions and programmes of work is not always clearly reported but I conclude that this Standard is met.

The regulator has effective controls relating to its financial performance, so that it can assure itself that it has the resources it needs to perform its statutory functions effectively, as well as a financial plan that takes into account future risks and developments.

4.130 The Audit Committee alongside the Finance and Audit Working Group is responsible for oversight of the College Finances.

4.131 The College has appropriate Financial Policies in place and internal controls are set out and subject to external audit.

- 4.132 Monthly financial statements are reviewed by the Audit Committee and Finance Working Group following the approval of the Registrar. The Board reviews the most recent financial statements at each Board meeting.
- 4.133 There is a budget setting process with appropriate levels of approvals at each stage. The annual budget is approved by the Board and outlines how funds are allocated to best fulfil the College's mandate and strategic plan objectives. The Audit Committee keeps the budget and expenditure under review.
- 4.134 The College has an Investment Policy for the proper and cautious management of its reserves. It also holds a Contingency Reserve Fund for unanticipated or unbudgeted expenses which are consistent with the objectives of CDSBC. Any disbursements from the Contingency Reserve Fund require a special resolution of the Board.
- 4.135 Several restricted reserve funds have been established to manage the building which the College jointly owns, to provide for investment in information technology, and to provide for legal costs related to complaints and discipline.
- 4.136 Following the external audit, the Board reviews the post audit report and approves the audited financial statements.
- 4.137 I have pointed out elsewhere (paragraph 3.48) that the Board has not followed its own procurement policy in relation to legal advice. I have also said that I consider the hybrid Audit Committee plus Finance and Audit working group is unsatisfactory in terms of the proper independence of the Audit Committee.

Nevertheless, I conclude that this Standard is met.

The regulator engages effectively with patients and the public

- 4.138 The College does not have a patient and public engagement policy. In some aspects of its work it does try to engage effectively. It has good public facing communications.
- 4.139 The College website is well designed and apart from my concerns about the difficulty of actually identifying the Standards dentists and CDAs should meet, it is welcoming and user friendly for members of the public and patients. The website is accessible and information for patients clearly signposted.
- 4.140 Open and closed consultations are posted on the website and are also distributed to public patient groups depending on the topic under consultation. This fall the College added an online consultation forum in an effort to make its consultation and engagement efforts easier for participants. Anyone can now post their response to a consultation, see what others have to say, and respond.
- 4.141 The College issues public statements in response to public concerns such as the brain injury suffered by a child in Alberta while undergoing dental sedation or the group of male dental students at Dalhousie University, who were alleged to have made online threats of violence against women.
- 4.142 The complaints process provides a valuable source of patient comments. Complaints staff respond to well over 100 calls per month: they answer questions and provide information. The College recognises this but does not capture the information provided or the personal contacts in a systematic way. In 2016, the College instituted an exit survey for registrants and complainants to help in

evaluating the College's complaints process. When a complaint file is closed, both the registrant and the complainant receive an invitation to provide their feedback on the complaint process. The surveys are administered by an external research company. This has the potential to be a valuable initiative but so far the response rate is so low as to severely limit the reliability of the findings.

- 4.143 Members of the public who contact the College about how to make a complaint or about the complaint process are provided with information on how to do so. Complainants can now submit a complaint online. Key complaints information and 'Frequently Asked Questions' about the process are available in seven languages. The College has adopted the Declaration of Commitment to Cultural Safety and Humility. I was concerned to learn that staff answering enquiries had been told not to inform patients that their dentist was required to have insurance. This has now been corrected.
- 4.144 The Board is currently considering opening Board meetings to questions and comments from members of the public.
- 4.145 The College undoubtedly strives to communicate effectively with patients and the public and to be supportive and helpful to those who wish to make a complaint.
- 4.146 College should bring its patient-facing activities together. In order to add value to its understanding of patients there needs to be better internal coordination and sharing of information. I welcome the objective under Goal 2 in the new Strategic Plan⁵⁰ 'to actively engage the public and patients in decision-making'.

Overall, I consider this Standard is met.

The regulator is transparent in the way it conducts and reports on its business.

- 4.147 The Board and the senior staff are clear in their commitment to increased transparency. The new Strategic Plan for 2019-22 (approved in November 2018) highlights the College's commitment to transparency. Its values include, 'ethical, open and transparent' and its goals 'Identify and strengthen productive relationships with stakeholders'.
- 4.148 The College publishes an annual report, and aims to make improvements to the information/data it provides on an ongoing basis. For example, in the 2017/18 annual report, it added more information about the complaints files that are referred to by the Health Professions Review Board and enhanced the financial information that was presented so it now includes pie charts for each of revenue and expenses.
- 4.149 The names of committee and Board members, including a short biography and a photo, are published on the website, as are the names of staff. It is not possible through the website to contact individuals directly.
- 4.150 CDSBC publishes annual summaries of complaints where the decision required the registrant to take action to address concerns found during the investigation. This is beyond the publication requirements outlined in the *Health Professions Act*. Discipline notices or notices of complaints involving serious matters are published on the CDSBC website for 10 years.

⁵⁰ CDSBC Strategic Plan 2019-2022

- 4.151 The Annual General Meeting is webcast. The Board is currently considering opening the public sessions of Board meetings and the AGM to questions and comments from members of the public.
- 4.152 The College held 'listening sessions' for dentists around the province in 2017-18 to provide an opportunity for registrants to be engaged early on with policy development initiatives.
- 4.153 CDSBC has a policy development process that emphasizes engagement with registrants and other stakeholders. The website lists open and closed consultations.
- 4.154 Public Board minutes are posted on the website after each meeting once they are approved, although the content of the minutes is limited.

This Standard is met.

The Board has effective oversight of the work of the senior staff and effective reporting to measure performance

- 4.155 As described above (paras 3.20-26) the relationship between the Board and the staff team needs further work to develop mutual trust and an effective partnership. The Board currently requires a significant level of reporting from the staff; quarterly management reports, quarterly registration reports, quarterly complaints reports, quarterly financial reports, operational plan progress reports. My observation is that these reports are about activity rather than performance. The volume is such that the Board has neither the time nor the ability to analyse the reports effectively. A board does not need to know everything. It needs to know that its strategic objectives are being delivered, that the organisation's resources are sufficient and effectively deployed and whether performance is improving or declining.
- 4.156 There are no agreed key performance indicators or regular reporting against them, nor is there a corporate risk register.
- 4.157 The quarterly Executive Limitation report is not about effective oversight but, as its title suggests, about limiting and controlling the registrar. The line summarising the purpose of each section of the report begins, 'The Registrar shall not cause or allow...' or 'The Registrar may not...' This is not a sensible risk management nor staff management for that matter.

This Standard is not met.

The Board sets strategic objectives for the organisation

- 4.158 A strategic planning process is set out in the Governance Manual. During 2018 the Board has developed a new Strategic Plan which is a significant improvement on before. The plan was developed through two Board workshops. It involved a pre-survey of board members, an environmental scan, a SWOT analysis, identification of key strategic issues and initial priority setting. In September the Board reviewed and refined the draft. It was published for consultation and was subsequently approved at the November 2018 meeting.
- 4.159 The new Strategic Plan has four high level goals, a set of operational objectives and identified success measures. It is to be hoped that the Board will use this new Strategic Plan to refocus and improve the way staff report to the Board so that it can measure performance against its agreed goals and success measures.

This Standard is met.

The regulator’s performance and outcomes for patients and the public are used by the Board when reviewing the strategic objectives of the organisation

4.160 The development of the 2019-22 Strategic Plan was rightly a forward-looking exercise. Although the process for developing it included a wide range of background information and a SWOT analysis it is not based on an understanding of the College’s impact on outcomes for patients and the public as the College does not consistently collect or analyse this information.

4.161 The new strategic plan should provide a framework for the College to refine and improve its measurement of outcomes for patients and the public and to incorporate that into its operations and strategy in the future.

Currently, this Standard is not met.

The Board works cooperatively, with an appropriate understanding of its role as a governing body and members’ individual responsibilities.

4.162 As Section 3 of this report illustrates the Board in the recent past has not worked co-operatively, has not understood its role as a governing body and some individuals have behaved badly. This is improving. There are still tensions of course as building internal trust and corporate confidence within the Board will take time. The new public members have brought depth of experience in governance and changed the balance of internal debate for the better.

4.163 On the basis of recommendations of the bylaws working group the Board made some difficult and forward-looking decisions about changing its membership composition and the selection of its officers at its meeting in September 2018. Unfortunately, that decision was reversed at its meeting in November.

4.164 The Board reversed the decision it had made in September at its meeting in November. It is apparent that not all officers or Board members are yet committed to refining the Board's role, reforming its committees, or to addressing its relationship with its registrants or their representative body. If the Board can commit to realising the aspirations in its Strategic Plan it may meet this Standard in time.

This Standard is not met.

Type	Standard	Met or not met
Registration: 4/4 Standards met	Only those who meet the regulator’s requirements for registration or certification are registered	Met
	Through the register, everyone can easily access information about dentists, dental therapists and CDAs, except in relation to their health, including whether there are restrictions/conditions on their practice	Met
	The public and others are aware of the importance of checking a dentist's, dental therapist’s or CDA's registration. Patients and members of the public can easily find and check a registration and certification	Met

	Risk of harm to the public, and of damage to public confidence in the profession, related to non-registrants using a reserved title or undertaking a restricted activity, is managed in a proportionate and risk-based manner	Met
Standards and Guidance: 2/5 Standards met	Standards of Practice and professional ethics reflect up-to-date practice and legislation. They prioritise patient safety and patient-centred care	Not met
	Additional guidance helps registrants apply the regulators' standards to specialist or specific issues, including addressing diverse needs arising from patient-centred care	Met
	The regulator has an effective process for development and revision of standards and guidance, the regulator takes account of stakeholders' views and experiences, external events, developments in provincial, national and international regulation, and best practice and learning from other areas of its work	Not met
	The standards and guidance are published in accessible formats. Registrants, potential registrants, educators, patients and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed	Not met
	The regulator has a systematic approach to ensuring dentists, dental therapists and CDAs are up to date and able to practise safely	Met
Complaints and discipline: 6/10 Standards met	Anybody can raise a concern, including the regulator, about a registrant	Met
	Information about complaints is shared with other organisations within the relevant legal frameworks	Met
	The regulator will investigate a complaint, determine if there is a case to answer and take appropriate action including the imposition of sanctions. Where necessary the regulator will direct the person to another relevant organisation	Met
	All complaints are reviewed and risk assessed on receipt and serious cases are prioritised	Not met
	The complaints process is transparent, fair, proportionate and focused on public protection	Not met
	Complaints are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of all individuals involved. Delays do not result in harm or potential harm to patients	Not met

	All parties to a complaint are kept updated on the progress of their case and supported to participate effectively in the process	Met
	All decisions at every stage of the process are well reasoned, consistent, protect the public and maintain confidence in the profession	Not met
	All final decisions, apart from matters relating to the health of a dentist, dental therapist or CDA, are published in accordance with the legislation and communicated to relevant stakeholders	Met
	Information about complaints is securely retained	Met
Governance: 5/9 Standards met	The regulator has an effective process for identifying, assessing, escalating and managing organisational risks, and this is communicated and reviewed on a regular basis by the senior staff and the Board.	Not met
	The regulator has clear governance policies that provide a framework within which decisions can be made transparently and in the interests of patients and the public. It has clear terms of reference for committees and working-groups and effective reporting mechanisms	Met
	The regulator has effective controls relating to its financial performance, so that it can assure itself that it has the resources it needs to perform its statutory functions effectively, as well as a financial plan that takes into account future risks and developments.	Met
	The regulator engages effectively with patients and the public	Met
	The regulator is transparent in the way it conducts and reports on its business.	Met
	The Board has effective oversight of the work of the senior staff and effective reporting to measure performance	Not met
	The Board sets strategic objectives for the organisation	Met
	The regulator's performance and outcomes for patients and the public are used by the Board when reviewing the strategic objectives of the organisation	Not met
	The Board works cooperatively, with an appropriate understanding of its role as a governing body and members' individual responsibilities.	Not met

Table 4: Summary of review of standards

5. External relationships

- 5.1 The Health Professions Act requires a College ‘to promote and enhance collaborative relations with other Colleges, regional Health boards designated under the Health Authorities Act and other entities in the Provincial health system post-secondary education institutions and the government.’⁵¹
- 5.2 The Board Code of Conduct summarises the requirement well:
- ‘As stewards of the public trust, the Board aspires to maintain the confidence of the public, the government, and the dental profession in the College’s ability to fulfil its important statutory responsibilities. Board members must: Exercise all powers and discharge all responsibilities in the public interest above all other considerations.’⁵²
- 2.2 Overall the College appears to have good working relationships with its partner organisations both in dentistry and in regulation. Understandably it directs most of its interest and energy to dental associations and organisations and is active in Provincial and Canadian national bodies for dental education and regulation: ‘The nature/extent of our external relationships is in keeping with the relative importance of stakeholders in upholding our mandate. In other words, we work more closely with organizations such Canadian Dental Regulatory Authorities Federation, Canadian Dental Assisting Regulatory Authorities, the National Dental Examining Board, Commission on Dental Accreditation of Canada, other health regulators in BC, and the educational institutions that train our registrants.’⁵³
- 5.3 I suggest the College also needs to direct some of its attention to improving engagement with the wider health community in British Columbia and with the patients and the public whom it exists to serve.

Dentists

- 5.4 The relatively small proportion of dentists who vote in College elections or respond to most College consultations suggests that the College does not figure largely in their professional lives. There is nothing very unusual or odd in that. As Right-touch regulation proposes, regulation should create a framework for professionalism⁵⁴. Recent research by the Professional Standards Authority found that:
- ‘Professional identity exists independently of the register. The register acts as a means of validating existing professional identity and giving evidence of a community of practice of shared professional identities but it does not generate professional identity. The register is a tangible way of viewing a community that already exists’.*⁵⁵
- 5.5 In general, the study finds health professionals draw their sense of personal commitment and value from their teachers, mentors, colleagues and professional community not from being a regulated profession. Regulators need to understand

⁵¹ HPA s16.2(k)(i)

⁵² *CDSBC Board Member Conduct Agreement*, CDSBC, 2017.

⁵³ Email from CDSBC, November 18, 2018

⁵⁴ *Right-touch Regulation*, Professional Standards Authority 2010 and 2015

⁵⁵ *The regulator’s role in professional identity: validator not creator*, Professional Standards Authority, 2018

the limits of their influence and their role within the profession and to work beyond it with others to promote the safety of patients and public protection.

- 5.6 Self-regulation needs the consent of the regulated. It does not need their enthusiastic support but it does need their acceptance. A small number of dentists are active and vocal in their criticisms of the College. Their objections appear to focus on all and any attempt by the College to issue new standards and guidance, to change its governance and on the alleged unfairness of the complaints process. If their belief is that as professionals they can be trusted to behave well without the guidance or supervision of the College that is hardly borne out by the intemperate and sometimes abusive language they use or the extreme opinions they express. Self-regulation needs the consent of the regulated but it also needs the confidence of the public. The undermining of the CDSBC by some of its own registrants puts the survival of the College itself at risk of loss of public and Government confidence.
- 5.7 The College relies very substantially on volunteers to populate its committees. Many people are generous with their time and expertise but volunteers are not chosen against any formal set of competencies, instead they either self-nominate or are approached by a board officer or committee chair who knows them. Training for voluntary roles within the College is limited. Some dentists have got involved only when they have felt their personal interests have been threatened by the College and so arrive with a declared bias or intention of their own. This is particularly so when the College has tried to put the public interest before dentists' convenience or financial freedoms as in the 2015 proposed 'Boundaries in the Practitioner-Patient Relationship', One dentist who stood for election on the basis of opposition to that proposed standard admitted, *'So we arrive only to discover, and this is again perhaps a bit of a revelation to me, because you typically run I suppose on an election thinking somehow you can change something. Only to discover that the people that elected you, you don't really speak for them. So I find myself in this environment in this building in the College as a Board member. I go, oh okay, it is not quite the way I thought it would be... Okay because quite honestly I didn't really have a clear idea.'* After lobbying led by the BCDA, and for which that Association subsequently took credit, the proposed Standard was reduced to Guidance and now only asserts some principles and leaves dentists to make their own decisions.
- 5.8 The former President, elected as he was on a wave of discontent, was active in taking the message of the College to dentists through British Columbia. He ran a large number of meetings throughout the Province: *'I took a different approach and went out to the registrants and basically said, 'We're here, our mandate is to protect the public what are you seeing out there to give you concerns that the public is not being looked after...so that we could come back to the Board and identify what those issues were and develop policies to address that.'*⁵⁶
- 5.9 In November 2018 the College consulted on its enhanced Quality Assurance programme. Quality Assurance is the term the CDSBC uses for setting requirements for continuing professional development for both dentists and CDAs. The new Quality Assurance standards have been several years in planning and have engaged many dentists in their development. The enhanced programme has appropriate objectives:

⁵⁶ Interview, November 2018

- Promote career-long hands-on learning
- Encourage collaboration among colleagues
- Improve treatment outcomes for patients

5.10 There will be a further consultation after this one and the new programme is not expected to be implemented until the end of 2019. The tone and content of the consultation responses varies from the positive and constructive:

'I have reviewed the proposed changes to the Quality Assurance Program... Your changes are well thought out and absolutely required... I realize some of these changes will be difficult... Of course the office visits will meet the most resistance. As talking is easy, however, for some the walk may not be so easy... My experience in life has taught me that money and egos often lie in the path of change... Objective learning becomes the criteria by which we ALL can become better clinicians and professionals Peer review and objective learning is the hallmark of every trusted professional organization... As a group we have to be concerned with the overall drop in public trust and the results of that loss in confidence will not only affect us now but all the future generations of dentists... It is TIME TO UP OUR GAME....

5.11 To professional self-interest:

'I think this will unnecessarily add to the many challenges that a dentist has; ie staff problems, competition, paying student loans and struggling to manage a business financially. In my opinion instead of making a dentist's life more difficult than it already is, there should be more control over the number of newly licensed dentists each year. This will ease the existing competition and give dentists more time to pursue more continuing education courses'.

5.12 To an appropriate 'right-touch' question; 'where's the evidence?':

*'I have practiced in this province for 25 years. The CE requirements in my opinion has always served the profession well. These new guidelines are added regulation for the sake of regulation. I'm sure that the liberal minded out there agree with them but I do not. If someone can point to an increase in danger to the public over the last 10 years as a result of lack of regulation of this type I would gladly reconsider my viewpoint, but I don't think it exists. Forcing this down the throats of our membership is unwarranted and unnecessary.'*⁵⁷

5.13 These are understandable disagreements and the range of views is unsurprising, what is of more concern is the low number of respondents. It seems that despite this lengthy engagement with dentists, efforts by the College to educate and engage the dental community in British Columbia still have a long way to go.

5.14 The College needs to build a different relationship with its dentist registrants; one of both mutual respect and distance. It cannot do so when its Board is elected by

⁵⁷ Comments posted on the consultation forum, November 9, October 31 & September 20, 2018

registrants and partially subject to their control. It is hard for it to build a new relationship with the profession when it is so closely tied financially and through personal contact and individuals to the BCDA and other dental organisations. An independent, effective, efficient, fair and public focussed regulator is good for the dental community as a whole. It is especially good for skilled and ethical dentists who never have a complaint.

Certified Dental Assistants

- 5.15 The College's relationship with Certified Dental Assistants is ambivalent to say the least. Some of the problem derives from the College bylaws which do not give CDAs equal status within the College. CDAs hold a certificate granted by the College but are not regarded as registrants or members. Despite there being twice as many CDAs as dentists they have only two seats on the Board in comparison to the dentists' 10'.⁵⁸ At its meeting in September 2018 the Board voted, in reducing the size of the Board, to limit CDAs to one seat only. As one CDA remarked, *'We can run their practices for them but we can't run their College.'*⁵⁹
- 5.16 The College used to collect the fees for the Certified Dental Assistants of British Columbia (CDABC) but soon after the College was established it voted to stop doing so. As one CDA remarked *'Dentists sometimes don't play nice'*.
- 5.17 The College does not require dentists to employ CDAs as assistants. They can employ anyone as a 'chairside assistant' although those persons are not able to carry out independent activities as CDAs can.
- 5.18 The College has two CDA Committees; a CDA Certification Committee and a CDA Advisory Committee. It has not sought to develop a proper scope of practice for CDAs, something which they would welcome as an enhancement of their professional practice. CDA issues seem rarely to be discussed or given much attention by the Board. It is hard to avoid the impression that for some, CDAs are second class citizens.

Dental Therapists

- 5.19 The initiative by the Acting Registrar to develop an active relationship with the First Nations Health Authority is to be commended. There is a very small number (seven) of Dental Therapists working with First Nation communities but their role is important. The College as a regulator needs to understand the necessity to be flexible in developing new roles to meet the particular requirements of this community. This is an area where the old professional boundaries may no longer be fit for purpose and I encourage the College to continue to work with the First Nations Health Authority to support good quality dental therapists. The Board should take an active role in recognising the oral health needs of First Nations communities. CDSBC is a signatory to the Declaration of Commitment that is based on the principles of cultural safety and humility.⁶⁰ This includes promoting the value of cultural safety training to the professionals it regulates. Its recent decision to acknowledge this at the beginning of all meetings is a positive move in this direction.

⁵⁸ CDSBC Board, CDSBC.

⁵⁹ It reversed that decision and other reforms at its meeting in November 2018

⁶⁰ All regulated health professions commit to a safer health system for First Nations and Aboriginal People, First Nations Health Authority, 2017.

The other dental colleges

5.20 There are four separate Colleges registering or regulating seven occupations within dental practice. The College of Dental Hygienists of BC has 3874 registrants. The College of Denturists of BC has 263 registrants. The College of Dental Technicians of BC regulates or registers 894 dental technicians Dental Assistant Technicians and Dental Technician students.⁶¹ There are also unregistered or regulated ‘chair-side assistants’ employed by some dentists who perform limited support roles. The HPA requires Colleges to promote ‘interprofessional collaborative practice’⁶² and yet there seems to be little contact or collaboration between the four dental colleges. No regular meetings between the four colleges take place to discuss shared issues or problems or to work together to promote the oral health and well-being of patients. Not one of the Colleges of Hygienists, the Denturists or the Dental Technicians had views on the CDSBC that they wished to contribute to this Inquiry. It may just be that these colleges are so small they just do not have the resources to fulfil all of the functions required of them by the HPA. In any event it does not seem that the Colleges relating to oral health and dentistry are actively promoting interprofessional collaborative practice.

The British Columbia Dental Association

5.21 The relationship between the College and the British Columbia Dental Association is too close: *‘When a registrant pays their fees to the College, a portion of that fee goes to support the advocacy group, the British Columbia Dental Association. To me that makes the separation of the College’s role of public protection difficult for consumers to see when it has this close financial relationship to the professional body’* (former public member of the Board).

5.22 The Governance Manual recognises the importance of the independence of the College. It stipulates a gap of two years before someone who has served on the board of directors of any provincial or national dental association is eligible to be a Board Member and three years after a member of the Board has left the College before they can serve in a role with a regional, provincial or national dental association⁶³.

5.23 A former dentist member of the Board commented, *‘So point number eight, relationship between the college and the stakeholders. They have a very close relationship with the BCDA, which can create problems... Also the College of Dental Surgeons regulates dental assistants. I have said I think this is odd since dental assistants are often employed by dentists, this is an imbalance of power.’*

5.24 That the objectives of the Association and College are closely aligned, at least in the minds of some dentist leaders is, apparent in an email from the then President of the Association to the incoming President of the College in June 2016, *‘The College and the BCDA need to support a strong profession- so let’s make that tomorrow’s goal!!!’*⁶⁴ The then President of the Association is now President of the College. The dentist who was elected vice-President of the College in 2016 received a Merit Award the same year from the Association for campaigning against

⁶¹ Figures obtained from the Annual Reports or on-line registers of the Colleges

⁶² HPA 16.2(k)(ii)

⁶³ Governance Manual, page.3.2, section 3.4.

⁶⁴ Email from BCDA President to CDSBC President-elect dated 29 June 2016

the College's proposed Standard on 'Boundaries in Practitioner-Patient Relationships', so that it 'did not negatively impact the profession.'⁶⁵ When the College published that guidance (no longer a Standard) for consultation it did so through a joint letter with the BCDA, signed by both Presidents, praising the 'leadership' of the BCDA. The new guidance was described as 'in the best interests of the public and the profession'⁶⁶

- 5.25 The closeness of the relationship is recognised by those outside of the dental community. In its submission to this Inquiry the British Columbia College of Nursing Professionals observed that during the three nursing colleges' conversations about amalgamation, they took into consideration, *'the CDSBC's governance challenges...and aimed to ensure that special interests, such as those of a professional advocacy association or union, would not undermine the College's public interest mandate by negatively impacting the new College's Board composition.'*⁶⁷
- 5.26 The Bylaws say that the College 'may' collect fees for the Association⁶⁸, not that it must or should. This is very clearly a discretionary power. In a letter to this Inquiry the BCDA observed that, *'it is the legislature that has expressly permitted a public body to collection [sic] of such membership fees, a clear indication that, as a matter of public policy, the legislature has concluded that such a practice is not inconsistent with the public interest; otherwise, the HPA would specifically disallow it.'*⁶⁹ That interpretation is reasonable but at the same time the legislation permits the College not to collect such fees so it is for the College and the College alone to determine that it is in the public interest and if it is proper for the College to do so. The legislation is permissive not directive. The College has already determined not to collect the fees for the CDABC so it is clearly free to make the same decision in relation to the BCDA should it wish to do so.
- 5.27 The College agrees annually by a motion of its Board to collect the fees for the Association. The Association does not publish its annual accounts or provide the College with a justification of its fee for the coming year, it merely provides the College with a statement of the amount it requires to be collected on its behalf. As there is no breakdown of the Association's expenditure there is no way the Board can make an assessment of the extent to which the fees are justified by 'the public interest' as distinct from the professional or private interests of dentists.
- 5.28 When the College collects fees for the Association and itself from dentists it does so as a single fee and does not differentiate between the sum for registration with the College and the payment for membership of the Association. This is not transparent. The Association does not provide the College with a list of its members from whom to collect its fee. Both the College and the Association appear to assume that every dentist wishes to be a member of the voluntary Association. I am informed that dentists are not required to be members of the Association but as the College collects fees from them whether they are or not that discretion is non-

⁶⁵ *Celebrating 2016 Award Recipients*, BCDA, 2016.

⁶⁶ Joint letter from the CDSBC and BCDA dated 6 November 2015

⁶⁷ Letter from the BCCNP to the Inquiry dated September 24, 2018

⁶⁸ CDSBC Bylaws 3.10

⁶⁹ Written evidence to the Inquiry from the BCDA dated September 17, 2018

existent. I do not know on what legal basis the Association does this. Its effect is to create a private monopoly.

5.29 It is not that the CDSBC Board is unaware of the issue:

'A lot of the people that come onto the board now are Association people and therefore come in with their own viewpoint in terms of what their College stands for. The second problem is that I think if you were to ask most dentists in this province the difference between the Association and the College they would not be able to tell you the difference... There are things that Association has done over the last few years has been very positive in terms of serving the public quite frankly or serving the underprivileged. And the concern was those would have difficulty going on if we said, okay the association has to collect their own money, because the membership would not see the value of the Association. The College had the right by legislative power to of course collect money for the running of the regulation part. So the College had no concern but we wrestled with it and again when word got out that there was talk of the board perhaps making that separation, the lobbying was so strong that we had to back off.' (former officer of the College).

5.30 Recently the CDSBC President agreed to a proposal by a dentist member, to put the matter on the agenda of the Board. However, having been proposed for the June 2018 meeting, then for September, it finally appeared on the Board Agenda in November 2018. Prior to that meeting the President of the CDSBC wrote personally to the Executive Director and President of the BCDA inviting them to make a presentation at the College Board meeting on November 30th, prior to the vote on the collection of their fees by the College. He wrote, 'as I have suggested in the past, the focus might be all the good things you do - the 'BCDA in the Public Interest'⁷⁰. He attended and spoke at the BCDA Board meeting the week before the BCDA presented to the College Board. At my request the BCDA shared the background information to their presentation to the Board of the College with me. The documents provided an overview of the BCDA's access to care activities and policy direction.⁷¹ At the November Board, following an address by the BCDA to the Board they voted to maintain the current relationship.

5.31 In a 2018 article in the BCDA magazine, entitled 'Two Organisations: One Profession', the President of the Association drew attention to occasions in which the Association had lobbied successfully to change the College's policies and commenting on the 'recent events regarding the College' wrote, '*Good governance rests with transparency and clear decision-making policies.*'⁷² I agree with that. The College would benefit from a transparent fee collection process and a clear separation of its decision-making from influence by the Association.

5.32 In forming a view that the close working relationship between the College and the Association should end I make no judgment on the value of the Association to dentists or of its usefulness to the community. The Association's work is outside the

⁷⁰ Email from the chair of the CDSBC to the Executive Director and Chair of the BCDA dated October 18, 2018.

⁷¹ CDCA A Path to Addressing Critical Gaps in Dental Healthcare, 2017 and BCDA Submission on Poverty Reduction, 2018

⁷² 'Two Organisations; One profession' in The Bridge, Spring 2018, p7.

scope of my Inquiry. My judgment is only about the interests of the College and its mandate of public protection and I consider that that is best served by a full separation from the Association whose role is to promote the interests of dentists.

- 5.33 The College must be an independent regulator focused on its mandate to protect the public, respectful of many stakeholders but beholden to none. The College cannot be an effective independent regulator of dentists, CDAs and dental therapists when it is physically, financially and humanly intertwined with the BCDA. I make recommendations for the separation of the CDSBC from the BCDA at the end of this section.

Post-secondary education

- 5.34 The College actively contributes to and collaborates with educational institutions. Representatives of the College present at University of British Columbia (UBC) Dentistry in various years of the program, and the College meets with an associate dean of UBC Dentistry on an as-needed basis to discuss updates/changes to the dentistry program curriculum and the registrar has attended meetings of UBC Dentistry and their Curriculum Teaching Effectiveness Committee, The College staff also present to CDA schools around the province on an annual basis.

The BC Health Regulators

- 5.35 The grouping known as the BC Health Regulators (BCHR), which brings together the registrars and other senior colleagues, and on occasions Board members, is a model of collaboration and debate. I commend the energy and purpose and good intentions which it demonstrates. The CDSBC plays an active and constructive role in the BCHR meetings.
- 5.36 All the British Columbia health regulators were written to as part of gathering information for this Inquiry. They were invited to comment on both their relationship with the CDSBC and their views on reform of the HPA, ten of the 23 replied. All but two of those told me that they had nothing to say about the CDSBC itself. Nine of them provided helpful comments on the workings of the HPA and these are taken into account in Part 2 of this Inquiry. The College of Physicians and Surgeons commented directly on one aspect of the CDSBC's performance, the inspection regime, which I address in para 6.22 below. The British Columbia College of Nursing Professionals described how they had taken note of the CDSBC's governance problems in designing their new merged structure (see 5.26 above). A list of those who submitted evidence appears as Annex 3 to this report. I recognise that at the same time as this Inquiry is taking place the BC Ministry of Health has asked the BC Health regulators for a collective response to a number of important questions about the futures of health professional regulation in BC and that the focus of members of the BCHR has properly been on that.

Health Practitioners Review Board

- 5.37 The Health Professions Review Board (HPRB) provides an independent review of certain decisions made by British Columbia health regulators on an appeal by the complainant. It also considers delays in proceedings on behalf of registrants. The HPRB conducts two kinds of review; disposition – whether the investigation was adequate and the decision by the regulator reasonable and timeliness- if the

regulator is unable to resolve the complaint in the time specified in the HPA.⁷³ During 2017/18 the HPRB received nine applications for review of complaint file dispositions in relation the CDSBC and two regarding timeliness. The CDSBC and the HPRB have appropriate professional relationships and only a very small number of referrals are made in relation to College decisions. An even smaller number of those result in an adverse decision by the HPRB. I consider the HPRB is a valuable part of the health regulatory framework and that its role could be further strengthened. I address this in Part 2, below.

The Ministry of Health

- 5.38 The HPA grants colleges freedom to self-regulate in the public interest but also ties the regulator into public responsibility and accountability to government. The CDSBC has regular communication with Ministry of Health official, and occasionally with the Chief Dental Officer. Officials have addressed the College Board.
- 5.39 The Ministry, along with the Crown Agency Board Resource Office (CABRO), is responsible for deciding who is appointed as a public member of the boards of the Colleges. Colleges have raised concerns that this process can lack transparency and efficiency.
- 5.40 I asked all the colleges if they had current or imminent vacancies for public members on their boards. My calculation is that at the time of submitting this report, there may be over 25 vacancies unfilled at the end of 2018 and that at least seven colleges may not have enough public board members to comply with their bylaws.
- 5.41 It is possible that the current system of appointing public members to boards could work more efficiently and transparently. That is a matter for the Ministry not this report.

Patients and the Public

- 5.42 The College has no systematic engagement with patients as individuals or through their representative groups. In fact, as reported above (para 3.49) some board members seem wary of the public and unwilling to engage with them directly or to open board meetings to their comments and questions. The acting registrar and colleagues have shown themselves willing to engage directly with patient complainants, to address their concerns and to learn from them. I commend this and encourage the College to be more purposeful in meeting, hearing and responding to patients directly.
- 5.43 The College does conduct a complaints survey⁷⁴ which covers both complainants and registrants. This is a welcome attempt to obtain feedback. Unfortunately, the numbers of complainants responding is so low that its usefulness is extremely limited. In the 2017-18 period only 16 complainants responded. The Annual Report for that period records that the College received 309 complaints. Given that those few respondents disagree with each other on many questions, except that College staff are courteous and respectful, it is not possible to draw any useful conclusions. Conducting a survey of this kind is desirable but the College really must rethink its

⁷³ HPA s50.55

⁷⁴ *Complaints Process Exit Survey, March 2017-February 2018*, CDSBC, 2018

approach to enable it to collect a meaningful number of responses which it can use to check and improve its performance.

- 5.44 I recommend that the College develop a patient and public engagement strategy, seeking to inform the public about its role, to make it easy for them to respond to consultations, to engage with patients who complain to learn from them and to improve the College's response to them. Patients and the public are not a threat to the College as some seem to believe but a resource for learning and improvement. The new Strategic Plan agreed in November 2018 provides a good opportunity to do this.
- 5.45 Regulators cannot work effectively alone or in isolation from the wider social structures of which they are apart. In the past, to some, self-regulation meant self-determination and isolation. A sentiment which lingers on in the claims 'We are different', 'We are special', 'We can be trusted to be left alone'. None of those claims are sustainable in the face of the many failures of professional regulation in many jurisdictions over many years nor in response to the needs of modern health services.

6. Protecting the public

- 6.1 Fifteen years ago, the British Columbia Ombudsman reported on self-governance in health professions. He wrote,
- 'My experience in investigating complaints about the colleges confirms the Minister's observation that some colleges have failed, on occasion, to act in the public interest in carrying out their mandate...the professions do not appear to have fully accepted or understood what it means to act in the public interest. They still believe, perhaps because it is the members who elect the governors and pay for the college's operations, that the colleges are there primarily to protect the interests of the members.'⁷⁵
- 6.2 I have observed that on the CDSBC Board and committees discussion about protecting the interests of dentists rather than of the public remains an underlying theme. But I also recognise the changes of attitude and action that are being brought about by the Board, committees and senior staff. This significant shift towards prioritising public protection is strongly expressed in the new CDSBC Strategic Plan 2019-22.
- 6.3 It is my conclusion that the Board of the College has not always in the past put fully into effect its role in ensuring the safety of dental patients and in protecting the public. Some dentists both on the Board and on College committees continue to believe that the College should protect dentists. This was explicit in the statement on Governance and Operations in the 2017/18 Annual Report which reads, 'Board, committees, registrants and staff understand the role and limitations of the College with respect to regulatory vs. advocacy functions'.⁷⁶ The College in fact has no advocacy functions and the only limits to its regulatory functions are those set out in its legislation or which it has chosen to apply to itself.
- 6.4 Nowhere in the summary of the former Strategic Plan set out in the 2017/18 Annual Report do the words 'patient safety' or 'public protection' appear. The College, it says, 'supports the professional rights and responsibilities' of dentists but it is silent on the rights of patients. A former staff member told me, '*Elections lead to the sense of entitlement over the College's operations that registrants hold. They hold it very dearly. You ought to see, if you haven't seen already, many examples of vitriolic correspondence from registrants saying that it's so unfair that a dentist agreed to something to resolve a complaint. That there was a gun to their head. That there was excessive pressure. It's truly pathetic.*'⁷⁷
- 6.5 A concern for the well-being of dentists rather than a single-minded focus on patient safety and public protection is still a part of College culture. A member of the Inquiry Committee wrote to me, '*The College should not conduct itself to protect the public at the expense of the dentist's physical and mental well-being...*'⁷⁸ For this Inquiry Committee member, responsible for complaints and discipline, the welfare of dentists comes before the welfare of patients. Another dentist wrote to me in

⁷⁵ *Acting in the Public's Interest? Self-Governance in Health Professions: The Ombudsman's Perspective*, 2003 p 3.

⁷⁶ CDSBC Annual Report 2017/18, p2-3

⁷⁷ Public Board member, interview, July 2018

⁷⁸ Written evidence submitted to the Inquiry, July 2018

support of a colleague who had accepted a MAU restricting their practice, *'The most substantial concern is that the CDSBC...have put 77 members of the public and their families through an inappropriate anxiety ridden experience. This pales in comparison to the horrendous ordeal that the Registrant has had to endure.'*⁷⁹ I don't think these perspectives are typical but for dentists who are active in the College and dental community to express them suggests a profound misunderstanding of the purpose of professional regulation and lack of concern for the safety and well-being of patients.

- 6.6 The College is in practice far from being dismissive of the well-being of dentists and CDAs. It seeks to check if health issues underlie problems with performance and then actively tries to agree with them voluntary withdrawal from practice. It has established a health and well-being programme for those unable to practise though drug or alcohol abuse or issues with mental health. It is a worthy objective, compassionate in intention and desirable to achieve. But why is the regulatory College rather than the membership Association running it? The welfare of dentists in trouble should surely be the concern of their Association and it would be a proper collaboration for the College to refer dentists who needed help for whatever reason to the Association which exists for their benefit. I don't doubt the needs of this group of unwell dentists and CDAs but I do doubt that it is a regulator's role to arrange and sometimes pay for healthcare for them. There is no comparable rehabilitation service provided by the College for the patients whose health and well-being has been damaged by dentists.
- 6.7 I asked the board officers who were in post from 2016/18 what 'protection of the public' meant to them and how during their period in office the College had improved patient safety. One told me, *'I know, the things that we were upset about didn't have a lot to do with patient's safety.... The Board has been stuck, we have accomplished virtually nothing because of this issue.'*⁸⁰ The minutes of board meetings provide little evidence of an organisation focussing its attention on public protection. As a dentist Board member said, *'A lot of time had to be spent in the last two years just sorting out the Board, rather than focusing on protecting the public.'*⁸¹
- 6.8 The former President however strongly defended their track record.⁸² He shared with me *'the things we were able to accomplish as a board, things I was really proud of.'* He cited the standards for sedation and anaesthetic dentistry, the establishment of a national programme through CDRAF (Canadian Dental Regulation Authorities Federation) for specialty recognition of dental anaesthesia, the development of the College's new Quality Assurance process, the change to Bylaw 12 so that it allowed advertising compliant with the Canadian Charter of Rights and Freedoms⁸³, new standards for dentists to provide and advertise Botox and facial fillers and the wellness programme for dentists. *'Our focus was on harm reduction and rehabilitation'*, he told me.
- 6.9 The former President described the 'listening sessions' with dentists which he had instituted. *'That was a big push of mine. I developed blogs for the College so that I*

⁷⁹ Submission to the Inquiry dated November 2018

⁸⁰ Interview, July 2018

⁸¹ Interview July 2018

⁸² Interview November 2018

⁸³ The Constitution Act 1982

could talk to dentists, I wanted them to be aware of what was going on. I would go out and talk about issues or concerns so that we were seeing what they were seeing, to minimise harm to people in the Province.’ The former President gave examples of what these listening sessions identified; *‘loss of public trust through unethical advertising’, ‘over-supply of dentists because the National government is encouraging foreign trained dentists to come in’, inadequate training at dental school, ‘new graduates don’t have the competency, skill and knowledge to adequately treat patients and have inadequate ethical standards’.* He said the new QA programme would help to address the last.

- 6.10 *‘In one ethnic area, he said ‘the community, a south-Asian community, has made a universal decision not to accept co-payments from patients. This does not really affect the public except that it cuts the cost but it is not compliant with the College regulations and bylaws and puts the College at risk... We also addressed risk to the public of corporate entities, this was part of my platform, determining patient treatment to maximize income; putting the public at risk of unnecessary treatment.’* Having identified these issues, he told me, the Board worked with the ethics committee to improve the Code of Ethics and developed ‘Patient-centred Care and the Business of Dentistry’. *‘These are all things that we’ve done to show we are working in the public interest and protecting the public,’* he said.
- 6.11 I recognise that many of the issues as highlighted by the former President do indeed have possible adverse outcomes for patients; either under-treatment through lack of access or over-treatment because of over-supply and the need for dentists to make an income. However, they are all issues of dental ethics, advertising, commercialisation, and dental fees rather than patient safety issues in themselves. They arise out of the economics of dentistry in the Province.
- 6.12 It seems to me that CDSBC’s underlying cultural resistance to being fully focussed on the safety of patients, despite the efforts of many people to move it in that direction, derives in part from a number of problems with the Health Professions Act. The first is the defined purpose of the legislation, the ‘Duties and Objects of a College’, which is no longer sufficient to protect the interests of the citizens of BC, the second, which I have dealt with in paras 3.1-3.3 above, is the electoral system and the confusion of membership with registration; third there is a curious caution about creating and publishing unequivocal Standards of Dentistry, against which dentists can be held to account; fourth, the complaints process is over complicated and open to protracted negotiation by health professionals and their lawyers; and fifth the College’s commitment to voluntary consent and remediation as an outcome of complaints has tipped the balance so far that it has become sometimes both unsatisfactory for dentists and to the detriment of public protection. I comment on possible changes to the HPA in Part 2 but also I set out some ideas for improving public protection within the existing legal framework.
- 6.13 Professional regulators promote safety and protect the public in three ways; they only register and allow to practise those who meet the requirements for registration; they set clear, mandatory standards for competence and conduct; they hold professionals to account for observing those standards and may restrict or remove practise rights from those who breach them.
- 6.14 In the assessment against the Standards of Good Regulation the College failed to meet two out of five Standards for Standards and Guidance. When proposals from

committees to strengthen standards or guidelines do come forward some Board members have argued how inconvenient and expensive implementation will be for dentists. *'The first board meeting I went to, the dentists all spoke as dentists. They did not speak as members of the College Board whose responsibility was to protect the public. They spoke from, 'Yeah, but if we do that, it's going to cost the dentists \$1,400 to buy a defibrillator and we don't want to spend the money.'* Well, sorry guys, if you have people having heart attacks in your office, you need to be able to help them' (Former public board member).

6.15 The HPA says that amongst the committees a college may establish is a 'Patient Relations Committee.' The CDSBC chose not to do this. The Governance Manual does not have any reference to a patient relations committee nor any terms of reference of such a committee. In addition to a patient relations committee, the HPA also refers to a 'patient relations program'⁸⁴. The duty and objects of a college require it:

'(f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;'

6.16 The Dentists Regulation designated CDSBC as a College that had to establish a patient relations program. The College patient relations program is also included the bylaws:

'Patient relations program

13.03 (1) The board must establish a patient relations program to seek to prevent professional misconduct, including professional misconduct of a sexual nature.

(2) For the purposes of the patient relations program, the board must

(a) establish and maintain procedures by which the college deals with complaints of professional misconduct of a sexual nature,

(b) monitor and periodically evaluate the operation of procedures established under paragraph (a), and

(c) develop guidelines for the conduct of dentists, dental therapists and certified dental assistants with their patients.'⁸⁵

6.17 The CDSBC has failed to establish either a Patient Relations Committee or a patient relations programme. It has however taken action against dentists who have violated sexual boundaries with their patients if it has received a complaint.

6.18 The only area where the College has issued guidance on patient relations permits dentists to treat their own spouses, children and close friends. The rejection of the College's original draft standard on patient-practitioner boundaries in 2015 was based on outrage that conjugal relations could be characterised as sexual misconduct. The suggestion dentists might not treat their own family members was considered insulting, inconvenient and costly. In allowing dentists to continue to treat family members and leaving the ethical application of autonomy, consent and objectivity to personal judgement, the College is out of step with the medical profession. For example, the College of Physicians and Surgeons of BC has adopted a standard that reads, 'Physicians must avoid treating themselves or family

⁸⁴ HPA S16

⁸⁵ CDSBC, Bylaws 3.03

members unless the medical condition is minor or emergent and no other physician is readily available⁸⁶.

- 6.19 Sedation and anaesthesia are a highly dangerous area of a dentist's possible work. The College should take very seriously breaches of its standards in this area of practice. In 2015 a College disciplinary panel made the disturbing decision not to cancel the registration of a dentist who had permanently brain damaged a young woman through his own deliberate acts. The dentist provided deep sedation when he was not permitted to do so, failed to follow College guidelines, published false claims that he was authorised to provide sedation, failed to exercise the level of skill and care necessary and failed to monitor his patients. It appears from the penalty decision summary⁸⁷ that apart from ruining this young woman's life and no doubt the happiness of her family, he put other patients at risk. He received a three month suspension and a fine. The handling of this case by the CDSBC raises questions about its commitment to upholding standards of the profession and surely failed to give the public confidence that the CDSBC had either their safety or their interests at heart.
- 6.20 Recently the CDSBC has reviewed and strengthened its Standards and Guidance for sedation and anaesthesia, which have been in place since 2008 and continues to update them. The Standards require dentists to be qualified to be registered and for dental offices to be inspected 'If you own a dental office and intend to administer general anaesthesia to your patients, you must register your qualifications with CDSBC and must apply to have your facility inspected by the College'⁸⁸. Of course, all these and others were ignored by the dentist who brain damaged a girl but has been allowed by the College to continue to practise.
- 6.21 The inspection regime put in place by the CDSBC involves an annual self-assessment by the dentist provider with a tri-annual independent inspection. The consequent reports are considered by the Sedation Committee.⁸⁹ The College says that it is short of inspectors and that reports and therefore approvals may be delayed. It only covers the provision of deep sedation and general anaesthesia not light or moderate sedation.
- 6.22 This inspection regime was criticised by the College of Physicians and Surgeons of BC (CPSBC) in its submission to this Inquiry. The CPSBC wrote:

Both the College of Physicians and Surgeons of BC and the College of Dental Surgeons of BC accredit private facilities in which advanced procedures requiring some level of sedation or general anaesthesia are provided... These private facilities are subject to accreditation requirements whether by the College of Physicians and Surgeons, or the College of Dental Surgeons.

'We bring to your attention that the accreditation standards for the two programs are significantly different. For example, the College of Dental Surgeons does not assess facilities that only provide light or moderate IV

⁸⁶ CPSBC, Practice Standard Treating Self, Family Members and Those with Whom You Have a Non-professional Relationship, 2017

⁸⁷ Discipline Panel decision summary of Dr. Bobby Rishiraj, CDSBC, 2015.

⁸⁸ CDSBC, General Anaesthesia.

⁸⁹ CDSBC, Current Authorization Process for Deep Sedation and General Anaesthesia Facilities, 2018

*sedation. In contrast, the College of Physicians and Surgeons requires accreditation standards to be met for any level of IV sedation*⁹⁰

- 6.23 I am not in a position to assess the difference in thoroughness of the two approaches but given the demonstrably serious risks to patients of sedation and anaesthesia, I suggest that both Colleges meet to agree a shared approach and inspection regime and to ensure mutual confidence in the safety of patients.
- 6.24 Dentists and patients would benefit if the College adopted a more structured and consistent approach to the revision of current standards and the identification, writing and approval of new standards. I suggest that the Ethics Committee be renamed the Standards and Guidance Committee and that it is charged, on behalf of the Board, with overseeing a programme of regular checks on existing standards, the risk-assessment and determination of which new dental practices require new standards or guidance or information to be published, the establishment of expert groups to develop those standards or guidance and their approval and submission to the Board. The College should build on and systematise learning from complaints, professional concerns and horizon scanning in determining risks and its priorities. The College should adopt a consistent taxonomy of 'standards', 'guidance' and 'information' and criteria for how potential harms fall into which category. In published documents these terms should be used obviously and repeatedly. The College should stop calling standards and guidance 'policies' and reserve that term for internal College policies, such as the Finance Policy or the Safe & Respectful Work Place policy. The current 'policy development process' could readily be adapted as a standards and guidance development process. A possible structure for this more coordinated approach is set out in the diagram below.

⁹⁰ Letter from the CPSBC dated September 24, 2018

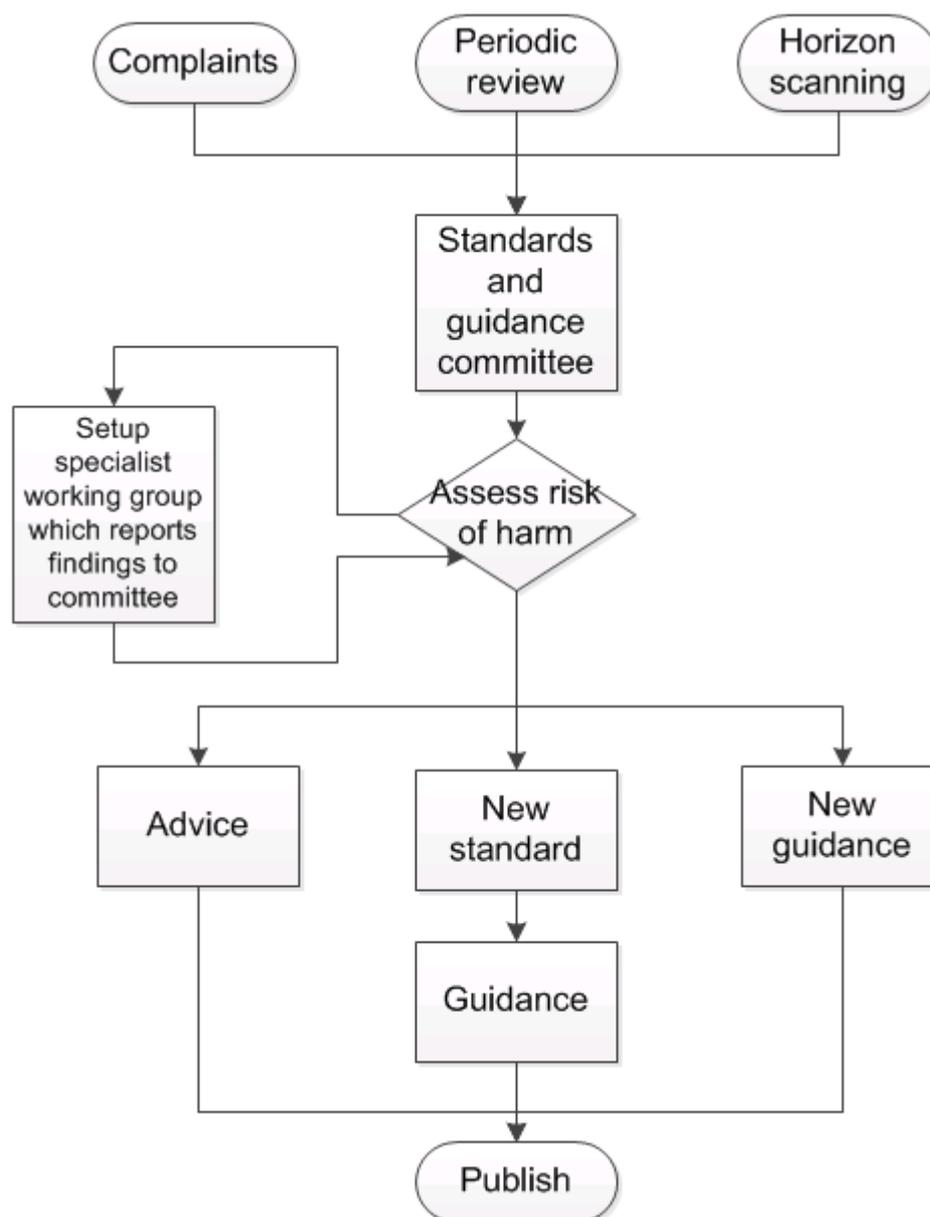


Table 5: Standards and guidance development process

6.25 The Duties and Objects of the College as set out in the HPA are:

- (a) to serve and protect the public, and
- (b) to exercise its powers and discharge its responsibilities under all enactments in the public Interest.⁹¹

6.26 These overarching duties are followed by 16 regulatory objects which are quite specifically about registration, standards of practice, discipline and the proper governance of the College.

6.27 The phrase ‘to serve and protect the public’ is broad and therefore open to a wide range of interpretations. This has led I believe the College and perhaps other Colleges to interpret its role as playing a wider part in the health system in British Columbia than is strictly warranted as a professional regulator. A regulator’s role is

⁹¹ HPA s16.1

maintaining patient safety, upholding the standards of the profession, maintaining public confidence. The HPA does not ask regulators to be responsible for public health or for access to health professionals. Of course, regulatory actions have an impact on supply (raise standards and you reduce supply, lower standards and you increase supply) but that should not influence the regulator in setting the appropriate standard. In July 2018 the BCDA wrote to the Chair of the Bylaws Working Group of the College about the 'supply' of Certified Dental Assistants⁹². They complained that the supply of CDAs had not matched the increase in the number of dentists and suggested that the College might reduce the registration requirements for CDAs especially in relation to their returning to practise. Supply is not the responsibility of a health regulator; it is a matter for the government of British Columbia to ensure supply and to intervene in the workforce market if necessary.

6.28 The process for receiving, investigating complaints and for the determination of disciplinary action as set out in the HPA is inadequate for a modern regulator, its requirement that all complaints be examined, its reliance on volunteers, its convoluted opportunities for delays and appeals are not helpful to either health professionals or patients. The College needs to work within the legislation but I suggest there are some things it can do at the present time to speed up the process, increase transparency and improve public protection.

- Build on the recently introduced risk assessment for complaints and use the Registrar's power to dismiss trivial and vexatious complaints more regularly. At the same time, based on assessed risk of harm, refer to an interim order hearing when there is a continuing risk to patients
- Stop assuming that remediation works in every case when the evidence shows it does not. Dentists who have a second complaint having previously signed an MAU should not be allowed to do so again. Stop hoping that dishonesty can be remediated by an ethics course
- Move towards professionalising the Inquiry Committee by paying members properly for attendance in person and introducing mandatory training and appraisal on an annual basis. Separate membership of the Inquiry Committee from the Board of the College so that it is clearly independent, ensure that legal advisors only give advice and do not direct the decision-makers. Publish reasons for all decisions⁹³. Always put the interests of patients before the interests of dentists or the College
- Publish guidance on triage, Inquiry Committee and Discipline Committee processes and outcomes. This would clarify for the public, dentists and Committee Members/Registrar the approach to be taken to decisions and the factors to be taken into account at the relevant decision-making stages
- Set out a Case Management Protocol – to address matters causing delay by clearly setting out the expectations for case preparation and listing by both the College and the Dentist

6.29 The New Strategic Plan agreed by the Board in November 2018 is a significant step forward. It shows the valuable influence of the new public board members, a recognition by the Board that change is necessary and a re-energised senior staff

⁹² Letter from the President of the BCDA to the Chair of the Bylaws Working Group, June, 26 2018

⁹³ See page 3 of the Annual Report of the HPRB, July 2018

team. This Strategic Plan places patients at the forefront of the College's activities for the first time.

6.30 Very many of its objectives parallel the recommendations I have made in this report. Its objectives include:

'Ethical, open and transparent'

'Patient-centred and engaged with the public'

'clearly stated standards of competence and conduct'

'An effective process for development, review and revision of standards'

'Using data and risk-assessment to enhance regulatory effectiveness'

'A risk-based framework to prioritize complaints'

6.31 These are just a few of the objectives set out in the plan which will take the College forward if it is properly used to test the decisions of the Board and delivery by the staff. If the College can really integrate this plan into its thinking and decision-making it should be a powerful tool for achieving what I believe, the officers, board members and staff all want; a genuinely patient and public focussed College.

6.32 Who owns the College? Well, the truth is that the citizens of British Columbia own the College; though through their government they have given dentists self-regulatory powers but only as long as the College serves the public, the Board serves the public, the staff serve the public and dentists serve the public. I am not convinced the elected leadership of the CDSBC understands this. In December 2018 the President in a message to all Board members thanked them '*On behalf of the College of Dental Surgeons of BC and the profession of Dentistry.*'⁹⁴ Not, I note, on behalf of patients and the public.

6.33 An independent, effective, efficient, fair and patient focussed regulator, accountable to the citizens of British Columbia is good for the dental community as a whole. It is especially good for the majority of skilled and honest and public serving dentists.

⁹⁴ Email to all Board members, December 2018

7. Recommendations

7.1 On the basis of the report above I make the following recommendations to the College. They are split into the sections to which they relate:

Governance, conduct and probity

1. That the Board continues with its plans to reduce its size, increase the representation of public members and to appoint its officers from within its membership. An induction programme should be required of those dentists and CDAs wishing to stand for election before they do so. This will help ensure that those entering the Board fully understand the role that it is expected of them and how they should undertake it.
2. That no one who has held an officer position in the British Columbia Dental Association (BCDA) or any other representative organisation for dentists should be allowed to stand for election until at least three years has passed since they held that office.
3. That no dentist about whom a complaint is under investigation should stand for election or be appointed to a committee until the complaint has been resolved in their favour. No dentist against whom a complaint has been upheld should be a member of the Board or any committee of the College.
4. Any dentist who is a member of the Board or a committee of the College who has a complaint under investigation should stand down until the complaint is resolved.
5. That the Board should review its committee structure and the number of committees it has with the aim of reducing them and making the College's decision-making more stream-lined and effective. The Governance Committee should be abolished. A new Standards & Guidance Committee should be created out of the Ethics Committee and taking on certain functions of the Quality Assurance Committee which should focus its work on Continuing Professional Development. The College should decide if a Remuneration Committee to deal with confidential HR matters requiring oversight of the Board should be created.
6. The Board officers, the Registrar and College staff should be more assiduous at monitoring progress on workstreams and recording the implementation of decisions. The introduction of an action log attached to the minutes of a meeting would enable Board members and staff to keep track of decisions and outstanding actions.
7. The College should create a risk register which should be maintained by the senior staff and monitored by the Audit Committee and reported to the Board.
8. The Board should continue in its current trajectory of increasing transparency around as much of its business as possible to public scrutiny and being ready to be held accountable to the public whom it exists to serve. The Board

should limit the number of meetings held without any staff present to those dealing with HR matters. It should always make, approve and retain formal minutes of those meetings.

9. The College should renew its commitment to proper procurement policies and should conduct its legal contracts through its General Counsel and not through individual Board officers. It should consider introducing an internal audit function to support the Audit Committee. Board officers should not attend the Audit Committee except when invited to do so. In reviewing its committee structure the Board should consider if there is any value in continuing with the Finance and Audit Working Group.
10. The Board must recalibrate its relationship with its expert staff team. The Board must stop seeing itself as the College and recognise that its role is to govern the College and oversee its performance but that the College is run and managed by its professional staff. The Board and staff need to form a constructive and respectful partnership. Despite good intentions on all sides this is far from being achieved.

Performance of the College

1. The College significantly improves its internal data collection and performance management so that it knows how it is performing against its own procedures and can demonstrate that it is effective in all areas of its work.
2. I strongly recommend that the College sorts out and codifies its documents to assist both dentists and patients. Standards should be gathered together into a single document, perhaps called 'Standards for Good Dental Practice'. These should be clearly mandatory. Similarly, all guidance should be gathered into one place or publication. What 'policies' are is completely unclear and why some things are policies but not guidance or information I do not understand. I suggest the word 'policies' is reserved for internal College 'policies and procedures'.
3. The board should remove itself from involvement in the complaints process and should not attempt to influence or interfere in complaints in any way.

External Relationships

1. As part of its new Strategic Plan the College should develop a stakeholder mapping and communications strategy to ensure that proper attention is paid to all its stakeholders and in particular to engagement with patients and the public through a public engagement strategy.
2. The College should work to improve the reach and response rate of its annual complaints survey. It should consider how it could use the patients who contact it as a resource for learning and engagement.

3. The College should continue with its plan to open part of its Board meeting to questions and comments from members of the public
4. The College should aim to build a different relationship with its dentist registrants; one of both mutual respect and distance. Its thorough approach to consultation should aid this over time
5. The College should commit greater time, respect and interest to both CDAs and Dental Therapists
6. The CDSBC should encourage better and more regular engagement with the three other dental colleges to promote the safety of patients and public protection
7. When collecting fees the College should inform dentists more clearly what part of the fee goes to the College and what part to the Association. The College should also report that the Association pays it a sum of money for that collection and how much that is. The Annual Report of the College should show more clearly how much each dentist pays to the College and to the Association. The College should implement this recommendation with immediate effect
8. The College should resolve to stop collecting fees for the BC Dental Association. It should do so in a phased manner as the purpose is not to damage the Association but to strengthen the regulatory independence of the College. I suggest a transition period of no more than three years for the two organisations to separate.⁹⁵

⁹⁵ NOTE: As part of this Inquiry I asked the BCDA in writing for its most recent annual accounts. It did not provide them. Financial Statements dated February 2015, which I have seen, show realisable assets in cash or securities in excess of \$4.6m. The BCDA would appear to have the resources to manage a phased transition to collecting its own fees.

8. Introduction to Part 2

- 8.1 This is part 2 of the report of an Inquiry into the College of Dental Surgeons of British Columbia commissioned by the Honourable Adrian Dix, Minister of Health under section 18.1 of the Health Professions Act RSBC 1996 c183 and conducted under the provisions of the Public Inquiries Act.
- 8.2 The terms of reference for this Inquiry can be found in annexe 1 of this report.
- 8.3 The Inquiry began in May 2018 and concludes with the submission of this report to the Minister of Health in December 2018.
- 8.4 In the Introduction of Part 1 of this report I set out the activities undertaken in order to carry out my Inquiry. I will not repeat them here.
- 8.5 This Part of the report deals with the statutory framework for the regulation of health professionals in British Columbia. In particular it relates to the purposes of the inquiry 2 (a)-(d) as set out in the Terms of Reference.
- 8.6 I consider first, changes that might be made to the Health Professions Act to improve public protection and create a more efficient and flexible statutory framework without changing the structures by which regulation is currently delivered. Second, I suggest wider reforms which would require the creation of a new Act and different functions and component parts to the regulatory system.
- 8.7 In preparing this part of the report I have been assisted by many conversations with regulators, lawyers, health professionals and patients in BC. The meetings of the BCHR that I have attended have been particularly useful, as have the written submissions of some colleges to this Inquiry. I am grateful to all of them for sharing their time and expertise.
- 8.8 I have also drawn on the work done by the Australian Health Practitioners Regulation Agency⁹⁶ and the Professional Standards Authority in the UK⁹⁷. I have learned much from reviews carried out for the Royal College of Dental Surgeons of Ontario, the College of Registered Nurses of BC, the Engineers and Geoscientists of BC and work with regulators across Canada. Officials in the Ministry of Health in BC have been unfailingly helpful but scrupulous to never compromise my independence.
- 8.9 I have been assisted throughout this Inquiry by Michael Warren, Policy Manager, at the Professional Standards Authority. I could not have completed this report without his diligence and attention to detail. Simon Wiklund, Senior Solicitor, has helped my thinking about reform of the HPA.

⁹⁶ See for example, [Health Practitioner regulation in Australia: using the right-touch](#), Fletcher, Interligi & Robertson in *Right-touch regulation in practice, International perspectives* PSA 2018

⁹⁷ In particular, *Regulation Rethought; proposals for reform*, PSA 2016

9. Reforming or replacing the Health Professions Act

Context

- 9.1 The framework for the regulation for health professions in British Columbia was developed thirty years ago and brought into law through the Health Professions Act in 1979. The risks and benefits of healthcare practices have changed hugely since then. The status and diversity of health professions has changed, public expectations and requirements have changed, the health needs of our populations have changed. Quite simply the Health Professions Act is no longer adequate for modern regulation. That does not mean it is wholly without merit, but it does mean that significant change is needed if it is to meet future requirements for the safety of patients and the protection of the public of British Columbia.
- 9.2 Healthcare systems around the world are facing similar challenges. These are:
- Aging populations
 - An increase in multiple long-term health conditions
 - The increasing cost of health technologies
 - Rising public expectations and consumer demands
 - A global shortage of healthcare workers
- 9.3 Canada is little different from other developed countries; infant mortality is low and life expectancy increasing. Over 18% of the population of BC is over 60 years of age⁹⁸. Diabetes and Alzheimer's disease are on the increase. Obesity in adults has been estimated at 64% across Canada as a whole but BC has the lowest obesity rate of any Province. Nevertheless, over the next twenty years and more health systems will be competing for resources and will need significant workforce reform, greater flexibility and the ability to obtain advantage from new technologies including artificial intelligence (AI). The regulatory implications of AI alone are only just beginning to be considered.
- 9.4 A regulatory framework that will last another twenty years needs to be effective to protect patients, flexible to adapt to change, efficient to provide value for money to registrants, and reliable to promote public confidence.
- 9.5 In setting out some proposals both for reform within the current regulatory framework and wider legislative changes I have been aware of the invitation from the Ministry of Health to the British Columbia Health Regulators (BCHR) to submit their own ideas for change. I welcome that invitation and the different perspectives BCHR will bring. My ideas and theirs are in no way in competition. BCHR have already shown themselves as a forward looking and constructive group and I hope that the Minister will find our contributions complementary if not

⁹⁸ Public Health Agency of Canada, Tackling Obesity in Canada, 2018

necessarily aligned. I have not of course shared this report with any of the Colleges.

- 9.6 I am also aware of the reforms to professional regulation being proposed by the government of BC in the areas of real estate and most recently in environmentally significant occupations as set out in the 'Professional Reliance Review'⁹⁹ and in the subsequent Professional Governance Act¹⁰⁰. The structural changes being made in these sectors provide a context for the government's possible thinking about health regulation although I note it is specifically excluded from the Professional Reliance Act.
- 9.7 I am also mindful that the recommendations I make here follow immediately from my review and assessment of the CDSBC. I have been careful not to let the particular difficulties that the CDSBC has experienced colour my proposals for reform except where I consider the HPA contributes to those difficulties. There are 21 separate Colleges, with no doubt their own strengths and weaknesses. That there must be significant variation given their very different size and resources is part of the problem with the HPA, which is overarching legislation applied to very different professions and colleges. I have tried not to generalise from the CDSBC to the colleges as a whole.
- 9.8 That there are 21 regulatory Colleges in British Columbia does raise questions about the durability and indeed common-sense of setting up separate regulators for every occupation regardless of its numerical strength or its risk profile. The colleges in BC cover about 118,000 registrants. The smallest has only 78 registrants (podiatric surgeons), the largest, BC College of Nursing Professionals, 55,000. The highest annual fees are paid by registrants of the smaller regulators'; optometrists (805) pay \$1390, midwives (228) pay \$2340, while Nursing Professionals pay between \$450 and \$650. This is in line with research findings for both the UK and Australia which show that the larger the register, certainly up to 100 thousand registrants, the greater the economies of scale¹⁰¹. Another less direct factor in a multiple college system is that, on balance, the lower paid occupations pay a higher proportion of their income to be registered than higher paid occupations. Well paid physicians and surgeons pay \$1685 to their College, while low paid denturists \$1249 each year.
- 9.9 The economic consequences of professional self-regulation are regularly ignored. As the figures above indicate regulation is a tax on work; a payment for the privilege of working. The consequence of course is an increase in the price of that occupation's services. Self-regulation also hands control of supply to the occupation. As Adam Smith the 18th century social economist put it 250 years ago, 'People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in

⁹⁹ *Final Report of the Review of Professional Reliance in Natural Recourse Decision-Making 2018*

¹⁰⁰ Professional Governance Act SBC 2018

¹⁰¹ *Review of the cost effectiveness and efficiency of the health professional regulators, PSA, 2012 and cost-effectiveness and efficiency review of the Australian National Registration and Accreditation Scheme, PSA, 2014*

some contrivance to raise prices.¹⁰² Professional regulation has as its public intention the maintenance of quality; in practice it may create a cartel or monopoly.

- 9.10 Professional regulation is not scientifically based, it is a social construct. This can easily be seen by comparing which occupations are or are not regulated in different jurisdictions. Very frequently whether a profession is regulated by statute or not will depend on history, geography and politics. Rarely does it depend on a proper assessment of risk of harm or an evaluation of the costs and benefits to the public.
- 9.11 An example of the weakness in public protection of fragmented self-regulation may be seen in the case of a BC naturopathic physician who breached their College's standards on vaccination and reportedly treated an autistic child with a homeopathic remedy containing saliva from a rabid dog¹⁰³. A complaint was made to the College of Naturopathic Physicians by the BC Naturopathic Association. They stated, 'We take no pleasure in filing a complaint against a registrant with our college, but we do so, first and foremost, in the public interest to protect our profession's reputation and to ensure that safe, competent and ethical care is delivered to all patients'. The Association may have been more committed to safe ethical care than the regulatory college.¹⁰⁴ According to the brief Public Notification on the website of the College of Naturopathic Physicians of BC, in November 2018, after 'a collegial discussion' the registrant was allowed to resign from the College with no action taken on the grounds that they said didn't agree with the standards¹⁰⁵. This renders the purpose of professional regulation meaningless. If it is a defence to say after the event, 'I didn't agree with the standards' then both registration and standards are pointless.
- 9.12 Patients I have spoken to do not have great confidence in the colleges or in health regulation generally. It should be a matter of concern to all colleges and health professionals that a patient who provided evidence to this Inquiry concerning a regulatory complaint asked to remain anonymous because of fear of rejection or retaliation by other health professionals treating them in the future. They told me, 'It could have repercussions if I was known to be someone that tried to put a dent in this culture they seem to have'¹⁰⁶. It is unacceptable that patients lack confidence in the ethics of health professionals.
- 9.13 In considering possible changes to the wider framework of professional regulation in BC I have made a number of assumptions. I set them out here so that my proposals may be assessed against them. If my assumptions are wrong, it may be that my proposals are not credible. My assumptions are:
- That the Ministry of Health is serious about reform and open-minded about the possibilities

¹⁰² Adam Smith, *An Enquiry into the Nature and Causes of the Wealth of Nations*, 1776

¹⁰³ [A 4-year-old was 'growling like a dog.' A B.C. naturopath's cure? Rabid dog saliva](#), Global News, April 2018.

¹⁰⁴ [Uproar in Canada after homeopath gives boy pill made from rabid dog's saliva](#), Guardian, April 2018.

¹⁰⁵ [Public notification](#), College of Naturopathic Physicians of British Columbia,

¹⁰⁶ Email December 2018

- That the colleges share a desire for change but may disagree about what is necessary or desirable
- That the present legal framework is not adequate for protection of the public
- That the present legal framework does not have the full confidence of either health professionals or of patients
- That improvements can be made to the current legislation
- That those improvements will not be sufficient in the longer term
- That significant reform is both desirable and achievable.

9.14 The overall objectives of reform of health professional regulation should be:

- To protect the safety of patients, to prevent harm and to promote the health and well-being of the public
- To provide a framework for safe, competent and ethical professional practise
- To have the trust of the public and the confidence of regulated occupations
- To be able to adapt to change and respond to new risks and opportunities
- To be efficient and cost effective in the interests of all citizens

9.15 I have kept these objectives in mind in setting out my proposals. First, I suggest changes to the Health Professions Act itself. These would change the way in which the Act directs and enables the colleges but would not change the overall structure of professional regulation except insofar as the colleges chose, as the nursing colleges have done, to amalgamate. Second, I set out a different framework for health professional regulation. This would involve the replacement of the Health Professions Act with new legislation governing how professional regulation is delivered in the public interest. Many of the proposals I make for reform of the HPA itself should be incorporated into the wider reforms.

Reforming the Health Professions Act

A new mandate

9.16 The Health Professionals Act charges the colleges established under it with the duty to 'serve and protect the public'. Despite the 15 objects which fall under this general duty, none of which, incidentally, include the word 'safety', I consider it too vague to ensure that a regulatory college is fully accountable for the wellbeing of patients. 'Serving and protecting' the public can be widely interpreted in ways that meet the interests of a profession. In particular it can be interpreted as supporting the availability of an occupation. It may for instance, include not

raising standards if that might affect the supply of a profession, raising standards if that would reduce the supply and therefore increase the exclusivity of a profession, not taking action to remove someone from practice because there would be a shortage of the profession, resisting innovation because that would affect the current arrangements or promoting innovation because that will increase market share.

- 9.17 Colleges need a clear mandate prioritizing patient safety and the clinical competence and ethical conduct of registrants. The duty of regulatory Colleges should be amended to give priority to the safety of patients. I propose:

'It is the duty of a college at all times;

To protect the safety of patients, to prevent harm and promote the health and well-being of the public.'

A mandate of this nature would ensure that regulatory colleges were focused primarily on safety, on standards of clinical care and on the health needs of patients.

Governance

- 9.18 The HPA is ambiguous in its use of 'members' and 'registrants'. The concept of membership has led to many misunderstandings about the nature of professional regulation. The idea of membership should be discarded and replaced throughout with 'registrant.' If Colleges do not have members, then there is no need for an Annual General Meeting not indeed any of the other trappings of a club such as award ceremonies and gifts to volunteers. Some will protest that this removes the principle of professional self-regulation. It does. Unlimited self-regulation has in general proved itself unable to keep patients safe or to adapt to changing healthcare provision and changing public expectations. Professional regulation needs to be shared between the profession and the public in the interests of society as a whole.
- 9.19 The construction of boards for colleges is unsatisfactory. This is not a reflection of the competence or motivation of the individuals who are elected or appointed but on what is an inadequate process for determining who should run these important public institutions.
- 9.20 It would be beneficial to move to fully appointed boards combining health professionals and members of the public in equal parts. However, the appointment process as currently operated in British Columbia is not independent, transparent, competency based. It cannot be relied upon at the present time to take on a broader role.
- 9.21 I suggest as an interim measure that colleges introduce an effective nominations process for professionals standing for election to the board. The colleges should publish the competencies they are looking for and candidates for election should demonstrate they have the right skills and competencies to be a board member before standing for election. The chair should be elected by the Board. Public members should be eligible for election as chair. The audit chair should continue to be nominated though the public appointment process. There is no need for a

- treasurer if a college is no longer a club. The choice of having a vice-chair or not should be left to each board. Vice-chairs, like chairs should be chosen by the Board.
- 9.22 The Government should consider the process for the appointment of public members so that it is more transparent, with public criteria and competencies for appointment and attention paid to the skill mix on individual boards.
- 9.23 Boards should be reduced in size; the most effective size for a board is generally agreed to be between eight and 12 people. This aids engagement and discussion and promotes corporate decision-making,¹⁰⁷
- 9.24 Terms of office should be extended to three years, renewable for a further three years, to provide continuity and the expertise which comes with experience. This should apply to elected as well as appointed members. The current structure encourages amateurism and short-term planning. Regulation is a long-term business.
- 9.25 The number of statutory committees should be reduced; Audit and Risk, Registration, Inquiry and Discipline are probably essential. Otherwise colleges should be free to manage their own functions and involve registrants in the most appropriate way for each task. Appointment to committees should be based on competence and merit.
- 9.26 Colleges should be given greater freedom to change their own rules and bylaws. Current arrangements are too cumbersome to allow them to respond to change (see para 10.19 below).
- 9.27 Colleges should separate themselves entirely from professional associations. They should not collect fees for professional associations or give them grants. Of course, such associations or unions have a role to play and are often key stakeholders for colleges, but they should not be accorded special privileges or special influence on college decision-making.
- 9.28 If a higher performance is to be expected of board and committee members, they should be adequately rewarded. Board and committee members, both professional and public should be paid for the time they give and the expertise they provide. This is particularly relevant to the inquiry and discipline committees which in the larger colleges may have too many cases for them to give the level of independent scrutiny and decision-making that they require. If the size of boards and the number of committees is reduced the cost of adequate payments to members will not be large and will be offset by gains in efficiency.
- 9.29 The Board should be removed from any involvement in complaints and discipline. inquiry Committees and disciplinary panels should be independent, separately appointed and should have regular training and appraisal. They should be paid for their significant responsibilities.
- 9.30 Part 2.01 of the HPA sets out arrangements for the amalgamation of colleges. The Ministry of Health should actively encourage and facilitate mergers,

¹⁰⁷ PSA 2011, *Board size and effectiveness*.

especially of the smaller less well-resourced colleges. The joining together of the three nursing colleges is an example to others. I do not think that mandating mergers at the present time would be good for public protection as the colleges vary so greatly in size and competence. The result might be to damage a smaller college which performs well by merging them with larger college which performs badly. Fewer, larger colleges with resources adequate to do their job should be the objective. This should also reduce fees to registrants.

- 9.31 It is possible to envisage groupings of colleges around particular services such as dentistry (currently four colleges) or by creating a multi-occupation college, as has been done in Ireland¹⁰⁸ and the UK¹⁰⁹. These regulators have provided effective and efficient services to both patients and registrants of multiple smaller occupations. I await with interest the views of the British Columbia Health Regulators on how the reduction in number of regulators should be progressed.
- 9.32 The Ministry of Health should as a matter of policy place a moratorium on creating any new colleges and should consult on how any occupations currently under consideration for regulation could be registered with an existing College.

Clarity of language and meaning within the HPA

- 9.33 Just as the HPA uses 'members' and 'registrants' interchangeably there are other terms with more legal significance which are ambiguous or poorly defined. This is unhelpful to registrants, complainants and colleges.
- 9.34 The HPA defines 'professional misconduct' as including 'sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession'¹¹⁰. Separately it defines 'unprofessional conduct' as 'including professional misconduct'. The word 'including' suggests there are other behaviours which might constitute unprofessional conduct, but which are not professional misconduct. This is unclear and open to interpretation.
- 9.35 The definition of 'serious matter' is even more problematic. The HPA says a serious matter 'means a matter which, if admitted or proven following an investigation under this Part, would ordinarily result in an order being made under section 39 (2) (b) to (e)'. This is a somewhat circular definition since before an investigation is complete it is not truly possible to know what the appropriate outcome will be. Colleges are therefore left guessing the likely outcome and of course having made a decision at an early stage that the matter is or is not 'serious' based on its possible outcome are likely to work towards that end. The characterisation of something as a 'serious matter' or not has very significant consequences because of its link to publication.
- 9.36 The test is problematic as the decision as to whether a matter is 'serious' can determine whether or not publication of the outcome is required. Consent or undertakings in relation to 'serious matters' may be published, if matters are not 'serious' they can be kept secret. Publication is a difficult part of the process for registrants and is often contested. The controversy and perverse incentives

¹⁰⁸ [CORU](#)

¹⁰⁹ [Health and Care Professions Council](#)

¹¹⁰ HPA s.26

created by the link between serious matter and publication of consent orders or undertakings creates unnecessary cost, delay, and uncertainty. Overall, it is difficult to discern any benefit to the public.

- 9.37 The HPA would also benefit from the clarification of the terms ‘fitness to practise’, ‘ability to practise’, and ‘competence to practise’. A standard term used consistently would be preferable or clear distinctions of meaning be established. Steps towards this have been taken in the new Professional Governance Act.

Complaints and discipline

- 9.38 The purpose of the investigation of complaints and the disciplinary process is to protect patients and reduce harms, to secure public trust in professions and to promote professional standards. These objectives need to guide the outcome of all complaints.
- 9.39 There needs to be a common entry route for all types of complaints or referrals so that all are prepared in the same way and sufficient information gathered before consideration by the registrar or Inquiry Committee.
- 9.40 The HPA complaints process needs significant revision to make it more efficient and effective, transparent and fair. Table 6 below sets out the current complaints and disciplinary process in the HPA.

Health Professions Act

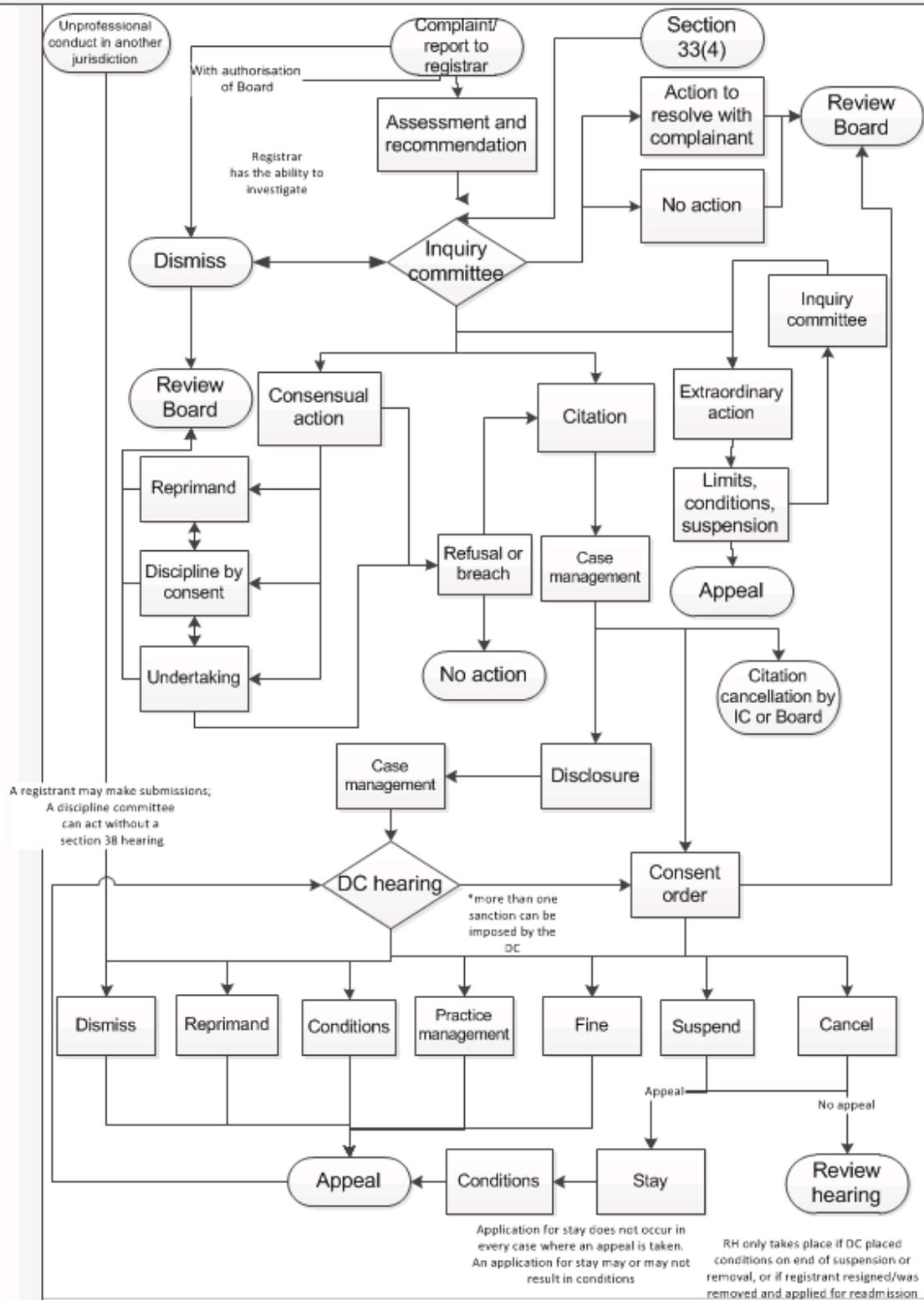


Table 6: Health Professions Act

9.41 Table 7, below, sets out an alternative process, more clearly linear. There are three clear stages; triage, investigation and adjudication. The first two would be private the third open to public scrutiny

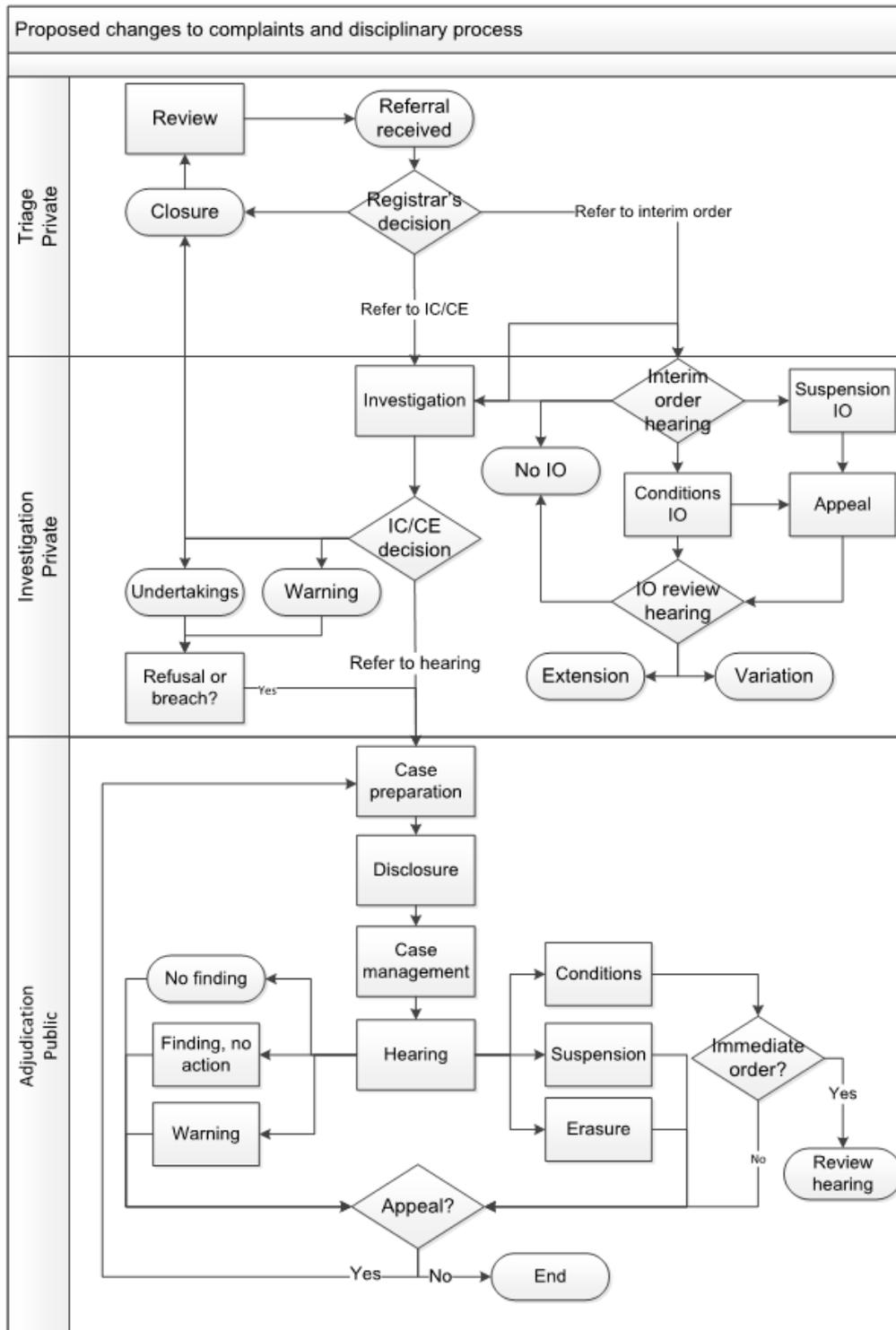


Table 7: Proposed changes to complaints and disciplinary process

- 9.42 This revised process (Table 7) would establish a clearer separation between the various stages; complaint acceptance (steps taken prior to and including decision by Registrar), investigation (steps taken by Inquiry Committee) and adjudication (steps taken by Discipline Committee).
- 9.43 The HPA does not establish a complaints resolution system, but rather a disciplinary regime. Section 33(6)(b) however creates an option for the Inquiry Committee to take action to resolve a matter between the complainant and registrant. This has been removed in the process proposed in Table 7 as matters not raising issues of competence or conduct, such as complaints about poor service or price, should be dealt with in an alternative way and not by a regulator¹¹¹.
- 9.44 The ability of the registrar to dispose of complaints as set out in section 33(2)(c) of the HPA is unsatisfactory. The HPRB in its written submission to this Inquiry¹¹² explains the complex problem succinctly:
- 'Unfortunately the statutory language by which registrars must decide whether they have jurisdiction is extremely complex both in operation and application. This is most acutely the case under Section 32(3)(c) authorizes the registrar to dismiss a complaint or make a request under 36(1) only where the complaint, 'contains allegations that if admitted or proven, would constitute a matter other than a serious matter, subject to investigation by the inquiry committee under section 33(4).' Applying this section requires the registrar (a) to take the allegations as given, (b) to consider the definition of 'serious matter' in section 26 and then (c) to cross reference to section 39 of the HPA and make an assessment as to whether, if the allegations were admitted or proven the disciplinary committee's remedy would 'ordinarily result' in a fine or a reprimand (in which case the registrar has jurisdiction) or would 'ordinarily result' in a license suspension, revocation or 'limits or conditions' on the respondents practice....These are unnecessarily complex and unsatisfactory provisions on which to base what should be a simple jurisdictional test.'
- 9.45 I agree with the HPRB
- 9.46 The difficulty created by the term 'serious matter' has already been noted. Colleges need defined thresholds at each stage of the process, for registrar closures, which outcomes are appropriate when considered by Inquiry Committee. For example, when a case will raise issues of competence or fitness to practise, when a case will be closed, when a case will be resolved with the complainant, when a case will result in a reprimand or remedial action and when a case will result in citation.
- 9.47 Another concern is the lack of clarity about the consideration of a registrant's past history. A history of upheld complaints is clearly relevant to sanction, particularly if remediation has previously been prescribed but has failed to improve

¹¹¹ The BCDA which provides a fees schedule for dentists could also provide an arbitration service for patient disputes over fees

¹¹² Written submission from the HPRB, December 6, 2018

performance. As, again the HPRB point out, 'The consideration of past conduct history appears to be discretionary (HPA s39.2). College complaint dispositions rarely if ever, explain the basis on which decision-makers exercise their discretion even to consider this information, or how it was considered if it was considered.'¹¹³ The HPRB recommended that the colleges should develop a shared policy on past regulatory history. I support the view of the HPRB in this regard and recommend that changes along the line of those already implemented in Ontario¹¹⁴ are adopted.

- 9.48 The Registrar should have the option to refer a matter for extraordinary action before and separate from consideration by the Inquiry Committee (which should maintain its power to refer for extraordinary action). This is necessary for protection of patients. The need to take extraordinary action should be determined by an adjudicatory panel separate from the Registrar or Inquiry Committee to maintain separation between investigation and adjudication.
- 9.49 Defined and consistently applied thresholds at each stage will be fairer to registrants and clear to complainants. They will make it harder for registrars to use the 'summary dismissal' in cases where there has been a serious harmful outcome - even if they are legally entitled to do so. Such decisions undermine public confidence in the regulation of the professions.
- 9.50 When the Registrar or the Inquiry Committee conclude that a registrant should undertake remedial education or training they are limited to a 'request' that they should do so. If the registrant declines, the only option for the college is to institute disciplinary proceedings. As the HPRB points out, in practice this rarely happens. Colleges need the power, when appropriate, to mandate remediation. A further issue with remediation is the apparent lack of a requirement that a registrant shows insight before accepting remediation. Without insight remediation is morally and educationally vacuous.
- 9.51 There needs to be clarification that once a citation has been issued, the outcome of the case will be published, even if a consent order is agreed, because it has passed a threshold of seriousness/risk to the public.
- 9.52 Under section 53(1)(b) of the HPA the board of a college may authorize disclosure of information in the public interest. In the interests of speed and efficiency this power should be extended to the Registrar.
- 9.53 Inquiry committees should have wider powers to dispose of matters under section 33 of the HPA. This could enable more matters to be dealt with proportionately.
- 9.54 The option for a registrant to make a proposal to the inquiry committee after the discipline committee has 'assumed jurisdiction' should be removed. (s37.1(5)). There should be no settlement once a matter is referred to a hearing by citation unless that settlement is considered and agreed by the Discipline Committee at a hearing and public protection and the public interest taken into account.

¹¹³ HPRB written submission to the Inquiry December 2018

¹¹⁴ Ontario, Regulated Health Professions Act, 2007

- 9.55 The imposition of Discipline Committee actions such as suspension or conditions should be able to be imposed immediately pending resolution of any appeal to the Supreme Court. The option to stay a Disciplinary Committee action to cancel or suspend a registrant should be removed as this undermines the Committee's decision.
- 9.56 The role of fines should be reconsidered. They have no contribution to make to patient safety. They may be a disincentive to wrong actions but do not improve clinical practice in the incompetent professional. The use of fines should be reserved for financial misdemeanours or for failure to co-operate with the regulatory process or for deliberate delaying tactics during the disciplinary process.
- 9.57 The statutory time limit for complaints should be removed and other means of ensuring case are dealt with as rapidly as possible while ensuring fair process are imposed. Section 50.56 of the HPA should be repealed.
- 9.58 I recognise that there may be other improvements and simplifications of the HPA which a more thorough legal analysis could suggest, and that consultation on such changes will be needed to ensure clarity and avoid unintended consequences.

Increase transparency

- 9.59 Colleges need to increase the openness and transparency of their work. There is considerable variation in practice and the BCHR should encourage best practice to be adopted by all. Board meetings should be open to the public and time should be reserved for visitors to ask questions or to comment. The assumption should be that business will be done in daylight. Boards, if voting, should not have secret ballots; board members are accountable for their decisions.
- 9.60 Some regulators have very good, informative and easy to navigate websites others are lacking in content, a few have pages 'under construction'. All colleges should aim to emulate the best and to learn from each other. Colleges should publish the maximum information possible within the legislation about complaints.
- 9.61 The HPA builds secrecy into the complaints process. In doing so it protects registrants but not the public. Only a small number of outcomes from complaints are published. The HPA limits publication to decisions
- Concerning conduct that, if proven or admitted, would normally result in the imposition of practice restrictions, a suspension or cancellation of registration, or a fine;
 - Where discipline is applied after a citation is issued for a hearing before the Discipline Committee; or
 - That involve the imposition of practice restrictions, or the suspension or cancellation of registration.
- 9.62 It is not possible for patients to give informed consent to care if they do not know that their health practitioner has had a complaint upheld against them. It should

be recognised as a fundamental right of a patient to know about their healthcare provider's competence and conduct.

- 9.63 All colleges publish an annual report. They vary considerably in quality and content. The Minister to Health should specify the information and performance data that should be published by each college annually to inform registrants and the public and to allow for direct comparison between them.
- 9.64 The minimum dataset to be published by all colleges, as well as financial data required by law, should include for the reporting period;
- Information on the revision of Standards and Guidance and any new Standards and Guidance published
 - Information on current registrants, new registrants, international registrants and any registrant appeals
 - The number of complaints received, the number progressing to Inquiry Committee, the number progressing to a disciplinary panel
 - The median length of time taken to resolve complaints
 - The outcome of complaints including remediation and sanctions imposed
 - The College's approach to learning from complaints and what it has learned
 - The College's information security and data protection policy and any breaches
 - The College's commitment to diversity and equalities and to First Nations healthcare
- 9.65 The Colleges should work together to agree, a consistent way of reporting this data so that they can assess their own performance and benchmark themselves against others. Developing a framework that both regulators and government agree on will make Annual Reports more useful and support future performance improvements. Effective and comparable reporting of data will improve transparency and accountability.

Develop the role of the Health and Professions Review Board

- 9.66 The Health Professions Review Board is a check and balance within the current regulatory model. Its role in relation to the adequacy of investigations and reasonableness of dispositions is valuable, as is its power under application to review registration decisions. Its role in reviewing a college's adherence to the statutory time limit is bureaucratic and since I propose removing the statutory time limit will become redundant. It is not that the time taken to progress complaints is not important but statutory time limits take no account of reality (complexity of cases, actions by the registrant, actions by lawyers, circumstances outside the college's control, resources available) and there are other better ways of improving timelines.
- 9.67 I suggest two additional roles for the HPRB. First it should be able to publish guidance for all the colleges on improving their complaints performance and

learning from good practice. The HPRB has a wealth of data that could be analysed qualitatively as well as quantitatively to generate learning.

- 9.68 Second, I consider that the HPRB should be empowered to review decisions of the colleges in relation to complaints on its own account and without receiving a referral. I imagine it might exercise this power rarely but consider it would be beneficial to public protection if a college has made a perverse or transparently lenient determination and the patient complainant is not in a position, for whatever reason, to take the matter further. The HPRB could act on behalf of the public interest by initiating its own review.

10. Replacing the Health Professions Act; professional regulation for the future

A framework for the future

- 10.1 The current model of professional regulation will not be adequate to protect patients and the public or to represent the interests of citizens in the future. Reforming the HPA will improve the ability to prevent harms, promote patient safety and hold the confidence of professions but it will not be sufficient to create a regulatory framework fit for the future of healthcare. New legislation will be necessary to achieve structural reform.
- 10.2 In numerous jurisdictions self-regulation of the liberal professions has shown itself slow to adapt to the expectations of consumers. In healthcare in particular it has struggled to adapt to the changing needs and expectations of patients, to new technologies and to new business and delivery models. Regulation based on the supposed uniqueness of individual occupations runs counter to contemporary practice through effective team-based inter-professional collaboration. It also protects existing occupational boundaries against new roles and ways of working, putting up barriers to desirable developments in the expansion of the health workforce.
- 10.3 There is a lack of relentless focus on the safety of patients in many but not all of the current colleges. Their governance is insufficiently independent, lacking a competency framework, a way of managing skill mix or clear accountability to the public they serve.
- 10.4 Lack of Public trust in the current regulators is reflected in media headlines such as
- 'College of Dental Surgeons oversees 'secret world of discipline' ¹¹⁵**
- 'Vancouver chiropractor resigns from College Board over anti-vaccine video'¹¹⁶**
- 'The disturbing record behind one of B.C.'s top billing doctors'¹¹⁷**
- 'College of Naturopaths under investigation for offering treatment to 'eliminate autism'¹¹⁸**
- Such reports undermine the self-regulatory model and deservedly so.
- 10.5 The objectives of a new regulatory framework should be:
- To deliver safe and good quality care provided to patients and the public.
 - To restore public trust and professional confidence in regulation

¹¹⁵ *Pain 'started the day he worked on me' says B.C. woman now suing dentist, along with 7 other ex-patients*, CBC, 2016

¹¹⁶ *Vancouver chiropractor resigns from college board over anti-vaccine video*, CBC, 2018

¹¹⁷ *The disturbing record behind one of B.C.'s top billing doctors*, Globe and Mail, 2018.

¹¹⁸ *B.C. naturopaths under investigation for offering treatment to 'eliminate autism'*, Global News, 2018

- To be risk-based and proportionate
 - To be fair and consistent
 - To be efficient and effective
 - To be open and accountable
 - To be agile and adaptable
 - To promote collaboration between occupations
- 10.6 In order to meet these objectives while working with the strengths of the existing arrangements in British Columbia I suggest the following new structures and arrangements.
- 10.7 Reconstitute the colleges as bodies responsible for setting standards and licencing health professionals who are within their jurisdiction. This might cover two or more occupations within a single college.
- 10.8 The colleges should agree a single code of ethics and conduct for all health professions. There is no reason why the ethics of doctors, say, should be different from those of dentists or of chiropractors. If an occupation presents risk of harm that warrants statutory intervention, then it should adhere to high and shared ethical standards
- 10.9 The colleges should remain responsible, as now, for setting Standards for clinical competence and practise and for issuing guidance to their registrants.
- 10.10 The colleges would issue a licence to practise for individuals who met the good character and clinical competence requirements for registration.
- 10.11 The colleges would remain responsible for assuring continuing competence and for assessing registrants prior to annual renewal of their licence.
- 10.12 Colleges would investigate complaints but not adjudicate on them.

Establish a single register and adjudication body for all health professionals

- 10.13 The names of all registrants should be held on a single register. When the colleges issue a licence to a practitioner they should upload their information in consistent format to the shared single register. The register should include the name, recognised qualifications, place of work and all or any sanctions imposed in relation to complaints. The register must be open to the public and to potential patients or employers.
- 10.14 A new body should be established to do this; a professional registration and adjudication agency. It should hold a single register of all regulated health professionals. As it holds the register it should also manage the adjudication process for imposing conditions of practise on registrants and ultimately for removing them from the register. It should therefore be responsible for establishing inquiry committees and disciplinary panels to adjudicate on complaints. This will create a proper independence from the licencing and

investigatory functions of the colleges and remove conflicts of interest from the membership of the committees and panels. It will enable recruitment, training and appraisal of both professional and public members and promote consistency of approach and decision-making. Separation of investigation from adjudication is a common principle of law which currently does not apply under the HPA.

- 10.15 A single register should make it easier for members of the public, patients, employers and registrants to identify individual health professionals. It will help to build trust in the public that their complaints are being considered independently and openly. It should mitigate concerns by registrants that decisions by inquiry committees are unduly influenced by college investigators. A single register and adjudication body will create economies of scale and consistent disciplinary decisions, which should benefit the public, patients and registrants.
- 10.16 The shared code of ethics and conduct jointly agreed by the colleges would be required of all registrants and would be the standard against which unethical behaviours or unprofessional conduct was judged by an inquiry committee or disciplinary panel. Matters of clinical competence would as now be judged against standards established by the relevant college for that profession. Committees and panels would as now be composed of public and professional members the latter drawn from the relevant profession if clinical competence was the issue under consideration. Such members should not be serving board members of any college. Members of committees and panels should be appropriately paid, appraised annually and removed if their performance is unsatisfactory.

A new oversight body for the regulatory framework

- 10.17 If such a different regulatory framework were to be established, with greater transparency and accountability the question arises as to whether further oversight or supervision might be necessary. Full disclosure of all licencing bodies and the register and tribunal and HPRB of performance data to the public to registrants and to the government might be sufficient to hold the components accountable. However, the consolidation, analysis and interpretation of the data would remain desirable. As would action to improve performance. The registration and adjudication body would need to be brought into the framework for data collection and publication.
- 10.18 The Health Professions Review Board already has oversight of some small part of the complaints and discipline process. It has as I suggest in paragraph 9.67 above capacity to add further value to the existing regulatory system. The new model I propose however requires a greater and somewhat different level of oversight. I have considered whether the UK's Professional Standards Authority* is a form of oversight that would be useful in BC. I have concluded that while some of the functions of the Authority¹¹⁹ could be usefully replicated, its role and

¹¹⁹ The Professional Standards Authority is the oversight body of nine statutory professional regulators in healthcare in the UK.

*NOTE: As the Authority's former Chief Executive I declare an interest.

structure was a response to particular regulatory failures in the UK at the time and that British Columbia would benefit from its own somewhat different approach.

10.19 I propose the following functions for an oversight body for health professional regulation in BC

- Approval of the shared Standards for Ethics and Conduct and imposition of that Standard if all colleges are unable to agree (see 3.17 above)
- Approval of the range (although not the content) of Standards for professional practice developed by colleges to ensure they cover all the necessary areas of practice
- Approval of a revised and more flexible arrangement for colleges to change their rules and bylaws
- Establishment of performance Standards of Good Regulation to be applied to both the colleges and to the registration and adjudication body
- Establishment of the dataset to be reported on by all colleges and for the compilation, analysis and publication of that information with the purpose of comparing performance, improving patient safety and reducing harm.
- Encouragement and support for the voluntary amalgamation of colleges
- Absorbing the functions of the HPRB to review on request certain registration decisions by the colleges and Inquiry Committee dispositions by the adjudication body
- Conducting reviews and investigations into the performance of colleges at the request of the Minister
- Advising, but not directing, colleges and the Minister on improvements in regulatory practice
- Assessing the risk of harm to patients and the public of healthcare occupations and to make recommendations to the Minister as to whether or not statutory regulation is necessary and if it is which college should be responsible
- Creating and overseeing an independent appointment process for both professional and public members of college boards based on open competition, published competencies and relevant experience and to make recommendations to the Minister

10.20 This new oversight body would absorb the functions of the HPRB. This implies no criticism of the HPRB but I consider its functions need to be part of a wider remit. The proposed Office of the Superintendent of Professional Governance¹²⁰ to be

¹²⁰ BC Ministry of the Environment and Climate Change, 2018, *Regulations Intentions Paper consequent to the proposed Professional Governance Act*, pgs. 8-10

established under the Professional Governance Act in British Columbia may provide a model for the oversight of health professional colleges as described above.

Introduce a risk assessed model for determining who should be regulated

- 10.21 In order to make progress on reform of the professional regulatory framework there should be a policy commitment that no new colleges are created. There should be active encouragement existing colleges to follow the lead of the nursing colleges and to seek partners for amalgamation. The smaller colleges are a priority and are likely to benefit most from the economies of scale and increased capacity arising from mergers.
- 10.22 An evidence based occupational risk assessment process should be developed and implemented to identify the potential risks of harm from occupations within the health sector and to consider the appropriate mitigations¹²¹. Only if statutory regulation is necessary should it be proposed. Other levels of assurance may be sufficient to manage the risks. The new oversight office should make recommendations to the Minister including as to which college new occupations should be allocated.
- 10.23 The occupational risk assessment should be the responsibility of the new oversight office. The decision as to which occupations should be regulated should remain with the Minister.
- 10.24 Table 8 below summarises the changes in responsibility for regulatory functions here proposed and where those functions will be carried out under different arrangements. The table is complemented by a diagram 9 beneath it showing the suggested roles of the Ministry of Health, Oversight Body, Registration and Adjudication Body, and the Colleges.

¹²¹ See, for example, *Right-touch Assurance*, PSA, 2016

Body	Retains	Loses	Gains
Colleges	Standards and Guidance	Adjudication of complaints	Publication of dataset
	Registration and Licencing	Holding register	
	Continuing professional development		
	Investigating complaints		
Health Professions Review Board		Reviewing timelines	Functions transferred to oversight body
		Review registration appeals	
		Reviewing determinations	
Registration and Adjudication			Holding a single register
			Adjudication of complaints
			Removal from register
Oversight body			Reviewing determinations
			Review registration appeals
			Publication of performance data
			Oversight of appointments process
			Approval of bylaw changes
			Risk assessment of occupations
			Investigations and reviews
Ministry of Health	Control of legislation	Appointments process	Independent advice
	Appointments to Boards		
	Decisions on regulation		Reviews and investigations

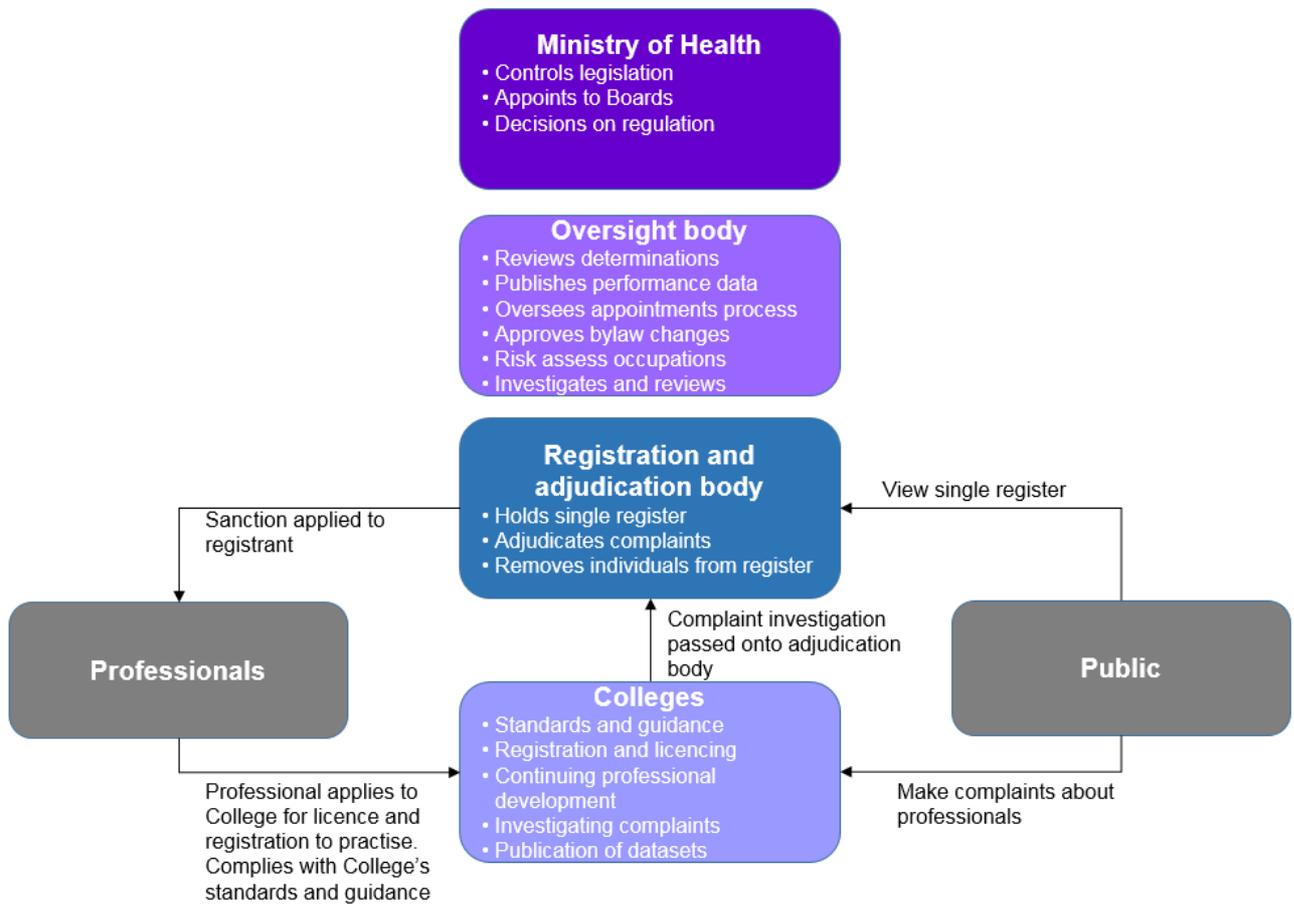


Table 8 and diagram 9: Both explain the different arrangements for professional regulation proposed in this Inquiry

11. Conclusions

- 11.1 There are many amendments and improvements that could be made to the Health Professionals Act to make it fairer to both registrants and complainants, clearer and easier to operate for Colleges and more transparent to the public. I have suggested some of the improvements that could be made in this report.
- 11.2 If the HPA is to be amended a full consultation on changes and a careful consideration of how they would actually work out on practice will be needed. Right-touch regulation warns us of the importance of considering the unintended consequences of regulatory changes as well as their benefits.
- 11.3 It is my conclusion, however, that changes to the HPA alone will be insufficient to create the flexible, public focussed, team-based and efficient regulatory system needed to support the delivery of safe healthcare in the future.
- 11.4 A complete overhaul of the way health professional regulation is conceived and delivered is required. I have set out a new structure to improve governance, performance, fairness, efficiency and cost effectiveness. I hope that the Ministry of Health, with the support of the colleges and, importantly, the health professions themselves, will seize the opportunity created by this review to work together to shape reform in the interests of the citizens of British Columbia.

Appendix 1 People and organisations that provided evidence

The following organisations provided written evidence to the Inquiry:

British Columbia Dental Association
Dental Technicians Association of British Columbia
College of Denturists of British Columbia (responded but with no comments)
College of Dietitians of British Columbia (responded but with no comments)
College of Massage Therapists of British Columbia
College of Opticians of British Columbia (responded but with no comments)
College of Physicians and Surgeons of British Columbia
College of Physical Therapists of British Columbia
College of Psychologists of British Columbia
College of Speech and Hearing Health Professionals of British Columbia
College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia
Health Professions Review Board

The following people provided evidence to the Inquiry¹²²:

Dr Don Anderson
Dr Deborah Battrum
Gurdeep Bains
Dr Ben Balevi
Dr Richard Busse
Greg Cavouras
Dr Larry Cheevers
Dr Ken Chow
Dr Susan Chow
Dr Doug Conn
Melanie Crombie
Dr Heather Davidson
Dianne Doyle
Dr Andrea Esteves

¹²² I also spoke to several staff members. With the exception of Dr Chris Hacker, I have not included them in the list.

Dr Michael Flunkert
Kenneth Glasner QC
Dr Ray Grewal
Dr Chris Hacker
Barb Hambly
Megan Hasselbach
Terry Hawes
Dr Patricia Hunter
Dr Erik Hutton
Oleh Ilnyckyj
Dorothy Jennings
Cynthia Johansen
Jocelyn Johnston
Jennifer Lawrence
Rick Lemon
Dr Peter Lobb
Jerome Marburg
Elaine Maxwell
Sherry Messenger
Kristine Mulligan
Dr Heidi Oetter
Dr Neeta Popat
Dr Wendy Rondeau
Carl Roy
Dr Masoud Saidi
Dr Mark Spitz
Neal Steinman
Dr Lynn Stevenson
Dr Peter Stevenson-Moore
Dr David Tobias
Dr Ash Varma
Carmel Wiseman
Dr Ivy Yu
Dr Ron Zokol

Appendix 2 Standards of good regulation

Below, are the Standards of Good Regulation which the college used in this Inquiry's review of the performance of the College. The Standards of Good Regulation were adapted to reflect the particular context and statutory responsibilities of regulators in British Columbia.

Type	Standard
Registration:	Only those who meet the regulator's requirements for registration or certification are registered
	Through the register, everyone can easily access information about dentists, dental therapists and CDAs, except in relation to their health, including whether there are restrictions/conditions on their practice
	The public and others are aware of the importance of checking a dentist's, dental therapist's or CDA's registration. Patients and members of the public can easily find and check a registration and certification
	Risk of harm to the public, and of damage to public confidence in the profession, related to non-registrants using a reserved title or undertaking a restricted activity, is managed in a proportionate and risk-based manner
Standards and Guidance:	Standards of Practice and professional ethics reflect up-to-date practice and legislation. They prioritise patient safety and patient-centred care
	Additional guidance helps registrants apply the regulators' standards to specialist or specific issues, including addressing diverse needs arising from patient-centred care
	The regulator has an effective process for development and revision of standards and guidance, the regulator takes account of stakeholders' views and experiences, external events, developments in provincial, national and international regulation, and best practice and learning from other areas of its work
	The standards and guidance are published in accessible formats. Registrants, potential registrants, educators, patients and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed

	The regulator has a systematic approach to ensuring dentists, dental therapists and CDAs are up to date and able to practise safely
Complaints and discipline:	Anybody can raise a concern, including the regulator, about a registrant
	Information about complaints is shared with other organisations within the relevant legal frameworks
	The regulator will investigate a complaint, determine if there is a case to answer and take appropriate action including the imposition of sanctions. Where necessary the regulator will direct the person to another relevant organisation
	All complaints are reviewed and risk assessed on receipt and serious cases are prioritised
	The complaints process is transparent, fair, proportionate and focused on public protection
	Complaints are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of all individuals involved. Delays do not result in harm or potential harm to patients
	All parties to a complaint are kept updated on the progress of their case and supported to participate effectively in the process
	All decisions at every stage of the process are well reasoned, consistent, protect the public and maintain confidence in the profession
	All final decisions, apart from matters relating to the health of a dentist, dental therapist or CDA, are published in accordance with the legislation and communicated to relevant stakeholders
	Information about complaints is securely retained

Appendix 3 Standards of Governance

The table below lists the Standards for Governance used in this Inquiry's review of the performance of the College.

Governance:	The regulator has an effective process for identifying, assessing, escalating and managing organisational risks, and this is communicated and reviewed on a regular basis by the senior staff and the Board.
	The regulator has clear governance policies that provide a framework within which decisions can be made transparently and in the interests of patients and the public. It has clear terms of reference for committees and working-groups and effective reporting mechanisms
	The regulator has effective controls relating to its financial performance, so that it can assure itself that it has the resources it needs to perform its statutory functions effectively, as well as a financial plan that takes into account future risks and developments.
	The regulator engages effectively with patients and the public
	The regulator is transparent in the way it conducts and reports on its business.
	The Board has effective oversight of the work of the senior staff and effective reporting to measure performance
	The Board sets strategic objectives for the organisation
	The regulator's performance and outcomes for patients and the public are used by the Board when reviewing the strategic objectives of the organisation
	The Board works cooperatively, with an appropriate understanding of its role as a governing body and members' individual responsibilities.

Annex 1 Terms of Reference

PROVINCE OF BRITISH COLUMBIA

In the Matter of an Inquiry under section 18.1 of the Health Professions Act R.S.B.C. 1996 c. 183

I, Adrian Dix, Minister of Health, further to my authority under section 18.1 of the *Health Professions Act* R.S.B.C. 1996 c. 183 (“Act”), having considered the public interest, appoint Harry Cayton to inquire into the administration and operation of the College of Dental Surgeons of British Columbia (“College”), in accordance with the following terms of reference.

TERMS OF REFERENCE

Purposes of Inquiry

1. Harry Cayton is to inquire into, make findings of fact, and provide advice and opinions respecting whether the College adheres to best practices for governance of regulated professions and whether the College is fulfilling its mandate under section 16 of the *Act* including, but not limited to,
 - (a) the effectiveness of the College in ensuring:
 - (i) members of the Board discharge their duty to act in the public interest and fulfil their duties in accordance with the Oath of Office set out in 17.11 of the *Act* and section 4 of the Health Professions General Regulation B.C. Reg. 275/2008;
 - (ii) persons appointed by the Board to committees of the Board and College discharge their statutory duties under the *Act*, in the public interest;
 - (iii) there are mutually respectful relationships between Board members and professional staff of the college;
 - (iv) senior staff of the College treat each other and all College staff with respect and professionalism; and
 - (v) the College has established clear and appropriate policies and procedures to resolve conflicts or disputes between Board members or between Board members and College staff or amongst College staff;
 - (b) whether, to carry out its statutory mandate respecting the handling of complaints about registrants pursuant to Part 3 of the *Act*:

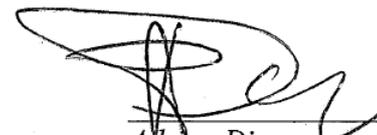
- (i) the College bylaws, standards, practices and procedures respecting complaints are in accordance with the Act and are focused on and effectively protect the public safety and the public interest; and
 - (ii) investigations and complaints are processed in a timely and effective manner;
 - (c) whether the College bylaws, guidelines, standards of practice and policies established by the Board to guide registrant conduct are in the public interest and ensure public safety;
 - (d) whether the College has an effective program to monitor and enforce bylaws, guidelines, standards of practice and policies that ensure the protection of the public interest; and
 - (e) whether the College practices respecting public notification and reporting are consistent with the Act and show appropriate transparency including the reporting of college activities, bylaws, finances and decisions to registrants, government and the public.
2. Harry Cayton is make recommendations respecting changes to the Act and regulations made under the Act which he considers necessary or appropriate in order to enhance:
- (a) the effective administration and operation of a college to assist in carrying out the duties and objects of a college under section 16 of the Act;
 - (b) the ability of a board of a college to utilize best practices for governance of regulated professions;
 - (c) the transparency and accountability of a college; and
 - (d) the public interest and public safety generally.

Conduct of the Inquiry

3. Without limiting the powers of Mr. Cayton under section 18.1 of the Act:
- (a) For the purposes of the inquiry into the matters described in paragraph 1(b), Harry Cayton shall review a sampling of complaints including their handling and disposition by the College. The manner of the selection of the sample of the complaints for this purpose shall be determined by Harry Cayton.
 - (b) The report to the Minister respecting shall not
 - (i) include any information that would identify any complainant or any registrant who is the subject of a complaint; and

- (ii) make any finding or allegation of misconduct with respect to any person.
- (c) Investigation or adjudication of any specific complaint submitted to the College pursuant to Part 3 of the Act by Harry Cayton is outside the scope of the inquiry.
- (d) Harry Cayton may observe Board meetings of the Board and meetings of any committee of the College or the Board and may observe any aspect of the administration and operations of the College.
- (e) Harry Cayton may consult with such individuals and organizations as he considers necessary or desirable.
- (f) Harry Cayton may engage other persons to assist him with the inquiry as he determines necessary or desirable.
- (g) Harry Cayton shall submit a report to the Minister of Health no later than December 1, 2018.

April 11, 2018
Date


Adrian Dix
Minister of Health



