Public consultation on a proposed revised *Scope of practice registration standard and Guidelines for scope of practice*

September 2018

Australian Dental Association template submissions with examples

The Dental Board of Australia’s (the Board) public consultation paper on a proposed revised *Scope of practice registration standard and Guidelines for scope of practice* opened for submissions on 22 March 2018 and closed on 14 May 2018.

As part of this public consultation process, the Board received over 1100 submissions. Among the individual submissions received, over 400 submissions (listed below) used an Australian Dental Association template (Attachment A) and included examples of lived experiences. These examples were intended to demonstrate the perceived risk of an adverse or unfavourable outcome to a patient in the event a structured professional relationship was not in place.

These submissions also contained personal information that gave rise to significant privacy concerns and therefore the Board has not published those individual submissions on its website. The Board has published this summation to provide a collective insight into the dominate issues raised by this group of submissions.

**Summation of issues**

These are:

- changes mean that dentists would be removed as the leader of the dental team which would place the public at risk
- expression of variations of the sentiment “You don’t know what you don’t know” as applicable to dental hygienist (DH), dental therapist (DT) and oral health therapist (OHT) and dental prosthetists (DP)
- where it is claimed that removal of the structured professional relationship between DH, DT and OHT’s and dentists degrade the team concept that underpins dentistry
- the proposals create a public risk from DH, DT and OHT’s who do not have the education and training to recognise and manage complex clinical situations, including patients with complex medical conditions
- allowing independent decision making and autonomous practice provisions will result in treatment planning that is not comprehensive
- concerns about DH, DT and OHT’s harming patients where performance is either below standard reasonably expected and/or outside scope of practice and not trained to perform and thereby placing patients at risk
- concerns about DH, DT and OHT’s performance such as failing to adequately assess/diagnose which may require referral to dentist/medical practitioner for further investigation and diagnosis.
• members of other dental divisions are not trained in advanced diagnostic (do not have the knowledge to interpret and diagnose more complicated disease manifestations) or treatment planning

• members of other dental divisions may not recognize the signs of oral cancer

• members of other dental divisions do not have advanced trauma skills

• members of other dental divisions may not make or inappropriately refer patients to specialist, dentist or other health practitioners

• members of other dental divisions may make adverse treatment outcomes involving periodontal care or removal of caries/decay

• assertions that some dental prosthetists have made and will make dentures for unhealthy mouths with untreated dental disease

• dentists are frequently approached by workplace DTs, DHs and OHT’s for assistance in the diagnosis of dental disease, developmental dental anomalies and radiographic interpretation

• members of other dental divisions do not possess sufficient competence to self-assess their own individual scope of practice

• some dentists lack knowledge and understanding of capabilities, understanding and experience of working with dental practitioners from other dental divisions

• general lack of acceptance of the professional status of other dental divisions and often referring these divisions as allied dental practitioners or mid-level providers

• patients will experience difficulty in identifying the qualifications of their treating dental practitioners resulting in confusion or delayed treatment

• members of other dental divisions are not eligible to have a Medicare provider number to enable processing of Medicare, Veteran Affairs and private health insurance claims for professional services rendered

• members of other dental divisions are not authorised by state and territory authorities to prescribe prescription medicines and in some jurisdictions are subject to holding or administering medicines under the authority of an authorised dentist

• members of other dental divisions are not eligible to have a prescriber number to enable access to the Pharmaceutical Benefits Scheme

• members of other dental divisions are not authorised to prescribe sedation through any route of administration

• unintended consequence of the dissipation of the oral and dental therapist workforce away from areas of need through commercial mechanisms

• greater potential for members of other dental divisions to hold out as dentists or specialists

• perceived over supply within the dental workforce

• speculation on the potential adverse business models that may members of other dental divisions
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Dr John Lockwood  
Chairman, Dental Board of Australia

Re: Scope of Practice Public Consultation

I write to express deep concern over the Dental Board’s proposed changes to the Scope of Practice Registration Standard. In my view, the proposed changes pose a significant risk to patients and undermine the foundations of the dental team.

Further, it is clear to me that the proposed changes have been considered in isolation and neglect to consider the broader context. Any changes to Scope of practice must also consider the legal limits to practice and the minimum competency set of all dental practitioners.

I wholeheartedly support the positions of the Australian Dental Association in its submission and while I will not reiterate those points I have provided examples of real-world situations where had a structured professional relationship not been in place, there was a risk of adverse or unfavourable outcomes to a patient.

[Use this space to provide examples of how being in a structured professional relationship prevented an adverse outcome for a patient. Below are some examples of situations you might have encountered. You should feel free to write as many examples as you wish and alter the format or length of this submission to best reflect your own views.]

- Where you doubted the ability of an allied dental practitioner to assess their own competency when they planned to perform a treatment and you had to intervene.
- Where an allied dental practitioner sought your professional input prior to treatment to ensure a positive outcome and minimise risk to the patient.
- Where an allied dental practitioner missed something critical and you had to intervene to ensure best outcomes for the patient.
- Where an allied dental practitioner has performed treatment you considered inappropriate or beyond their scope and had to intervene or re-do work.
- Where an allied dental practitioner was over or under conservative in their treatment approach and you had to adjust a treatment plan, intervene, or redo work.

I trust that these examples demonstrate a clear case for retention of the structured professional relationship and retain the requirements of ‘independent practitioner’. This will ensure that the best, quality dental care is provided safely to the Australian public. I strongly support maintaining the status quo (Option One) as laid out in the consultation.

Regards,