Dr John Lockwood
Chairman, Dental Board of Australia

Re: Scope of Practice Public Consultation

I write to express my opposition to the Dental Board's proposed changes to the Scope of Practice Registration Standard. Any changes to Scope of practice must also consider the legal limits to practice and the minimum competency set of all dental practitioners.

It seems like the push to weaken registration standards of the dental board is driven by vague, hand-wavy notions of "increased accessibility" and "flexible care models", and is presented without any clear business models or strategies on how this is to actually be achieved. My presumption is that there is a belief amongst the Ministerial Council that the proposal might have the effect of pushing the cost of dental treatment down. I am here to assert that there is no reason to believe this is likely to occur. Each and every dental practice has fixed and significant costs in order to establish the physical facilities, equipment, and appoint staff. ***These costs will not be less on an auxiliary with a narrow scope of practice than they are on a dentist!*** All these costs will be passed onto the consumer. The effect will be to create a second tier of less trained practitioners charging at the same rates as dentists.

I also feel the proposal seems to have lost sight of the original purpose of dental auxiliaries. The entire point of having auxiliary staff is to extend the capacity of a dentist in providing care to a community. Creating auxiliary staff who practice independently but with limited scope will induce a fracturing of the care model for the public, without any guarantee of effective workforce distribution and collaboration. Who is accountable if an auxiliary does not recognise/manage a complex case in an appropriate fashion, particularly if the scope of practice of a dental professional is so individualistic as in the proposed changes? Or if a patient's care needs exist predominantly outside the scope of that auxiliary group?

The only standard that makes sense and is understandable by the public is that of the independent dentist, and the staff working for that dentist. If flexible care models are truly felt to be an important step towards the future, then they need to be designed, from the beginning and at a foundational level, with consideration of how they interface with current clinical care. Without the support and involvement of dentists (as leaders in their development and deployment), and without any clear advantage or value proposition to the public, there will be no take up of such services and the purpose of the regulatory changes is defeated. All that will have occurred is cost to the taxpayer.

I am extremely sceptical of the capacity of dental auxiliaries to learn entirely new skillsets via short, day course CPD programs when they were not taught in a structured learning environment of an accredited university program. We already have seen rising litigation when even qualified general dentists attempt advanced surgical treatments after weekend courses. On the other hand, I strongly support the ability of employing dentists to train staff in additional skills either in-house or via professional CPD courses, so as to enable enhanced care ***within the structured and controlled care of a dentist's overall supervision***. This model of care replicates the medical system but with the benefit of tight integration within a practice and preserves clear lines of accountability.

I strongly support maintaining the status quo (Option One) as laid out in the consultation.

Regards,

Dr Ramon Baba

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