Executive officer
National Board of Australia,
AHPRA

Dear Executive Officer,

I have viewed the Draft *Scope of practice registration standard* and guidelines (accessed from http://www.dentalboard.gov.au/News/Current-Consultations.aspx on 31/5/13). This has been the subject of much tension among the dental community and I feel compelled to comment on this issue, because I as a dental student will be more affected than anyone who has graduated before these adjustments are passed. Before writing, I consulted fellow dentistry and oral health students, whose expressions influence some of the content in my response.

I believe some changes, especially the team focus and the idea of a "structured professional relationship", will bring dentistry closer in line with the rest of the health profession. There really is no other relationship between qualified health professionals involving the silly, childish idea of "supervision". However, several changes, especially concerning dental hygienists (DHs) and therapists (DTs) and oral health therapists (OHTs), do not meet the HWA report recommendations – contrary to the DBA's claims. In addition, the lack of clarity and precision in the proposed guidelines is preventing any fair debate, because there is no solid definition on which to mount a case for or against change.

1. Do you agree that the revision to the standard will provide greater clarity and certainty for dental practitioners to work within their scope of practice? (Why or why not?)
While I applaud certain changes in wording that make the guidelines "less prescriptive" and much clearer (on pp.6-7 of the consultation paper), the revised scope of practice of DHs, DTs and OHTs utterly fails to provide clarity or certainty, because it fails to set any parameters concerning their scope of practice.

2. Do you agree that the introduction of the guidelines further supports this clarity for dental practitioners and the public? (Why or why not?)
Again, the "less prescriptive" parts have avoided unimportant, confusing specifics like "dental appliances for the treatment of sleep disorders" which the public will not understand.

However, the definitions of DHs, DTs and OHTs are either meaningless or very difficult for the public to understand. Key Change 2a (p.6) states: "Dental hygienists, dental therapists and oral health therapists are members of the dental team. They practise in a range of activities included in the definition of dentistry in which they have been formally educated and trained." This definition is weak and empty. This can be proved by a translation into layman language: "DHs, DTs and OHTs are members of the dental team. They practise some stuff within the field of 'dentistry' – any stuff that they've learnt about."

I understand there is a more detailed definition in the Guidelines – Scope of Practice (p.16). Although this has more substance, it is still weak and difficult for the public to understand. Since all three definitions have the same problem, I will only quote from the definition of a DH: "Dental hygienists provide… [list of medical jargon]. This includes… [list of dental jargon]." While this jargon may be part of the public's vocabulary, the public is not educated in the medical field and hence do not understand these words in the same way we do. This problem recurs in the definitions of DTs and OHTs, and hypocritically, is the same "prescriptive" listing that the DBA removed from the definition of a "dentist" (eg. "dental appliances for the treatment of sleep disorders"). Neither will a

DH describe their role to a patient by saying, “As a DH, I assess, diagnose, treat and manage teeth and give periodontal and gum treatment...” (Refer to HWA recommendation #4). I must clarify that I am NOT advocating the removal of this part of the guidelines. The problem is that this is the only place where a definition of any substance can be found, and its prescriptiveness renders it unsuitable as a decisive definition.

A similar problem exists with the definition of “dental prosthetists”, upon which I will not elaborate.

Consequently, the drafted changes have failed to meet the third and fourth recommendations of the HWA report, which respectively outline the need for the public to understand each clinician’s role, and the need for each clinician to be able to explain their role “simply” – note the word “simply”.

3. Are there additional factors which could be included in the guidelines to support the standard?

Changes to the Standard
As repeatedly emphasised, the DBA must clearly define the terms DH, DT and OHT.

I draw your attention to the definition of “dentists”, who are “independent practitioners who may practise all parts of dentistry included in the definition of dentistry. Where there is a structured professional relationship or referral relationship then the dentist… is the clinical team leader”. There are two elements of this definition which make it ideal. Firstly, it exactly stipulates what dentists may do and what they may not (the DBA has provided a precise definition of “dentistry” on page 16 which “cover the widest range of any procedures” possible). Secondly, it expresses their role within the dental team. Thus, this definition satisfies every relevant HWA recommendation (#1, 3 and 4).

To meet these three HWA recommendations, DHs, DTs and OHTs need to have similarly succinct, decisive definitions which 1) explain their role within the dental team and 2) based on this role, determine what they can and cannot do.

The proposed draft goes some way toward meeting the former by stipulating, “They may only practice within a structured professional relationship with a dentist. They must not practise as independent practitioners.” To fully satisfy HWA recommendation #1 and “reflect team based practice”, the DBA must also specify the role of the DH, DT and OHT in the dental team, just as it assigned the dentist the role of “clinical team leader”. Rather than being restrictive or unfair, this addition will give DHs, DTs and OHTs more significance and dignity within the dental team, having an exclusive role that dentists cannot fill.

From my personal understanding, and from the repetition of the phrase “preventive services” under all three sections in the Guideline on page 16, this role should relate to preventive dentistry. Thus, an example of a role-specifying, boundary-setting statement would be:

> *DHs, DTs and OHTs are members of the dental team **who focus on the prevention of oral disease**, and may practise a range of activities included in the definition of dentistry **to that end**. They may only practise within a structured professional relationship with a dentist. They must not practise as independent practitioners.*

The inclusion of the phrase, “to that end,” sets a boundary of practice that can then be elaborated upon in the guidelines.

Changes to the guidelines
Just as it is prescriptive to talk about dentists and sleeping appliances, it is prescriptive to list procedures like periodontal/gum treatment because the purpose of these lists is defeated by the inclusion of “other oral care” or “additional oral care” at the end of the lists.

The guidelines should begin by dividing “prevention of oral disease” into primary and secondary prevention, with this new medical jargon then explained in terms the public can understand.

The guidelines must also describe where each dental practitioner’s scope of practice ENDS, based on their role in the dental team. This is the most important point of my entire prose. While the guidelines covered “the widest range of any procedures” that dentists and specialist dentists can carry out, no corresponding parameter is set for DHs, DTs or OHTs. Yet, the DBA recognises that they can only practise a limited “range of activities included in the definition of dentistry”. Hence, the DBA does realise why dentists must undergo a gruelling five to nine years of university education as opposed to three years: a much broader foundation of knowledge is required in order to practise so many parts of dentistry at a level that respects patient welfare. Yet, my analysis concludes that only two differences separate dentists from OHTs: the title of “independent practitioner”, and the title of “team leader”. It is hypocritical to restrict the scope of practice of only dentists, the most heavily-trained members of the dental team, but no other dental practitioner.

Let me prove my highly subjective conclusion. As the standard and guidelines stand, it is technically possible for an OHT to legally perform endodontic treatment, provided they have received such education. This seems ludicrous as no such education exists, and the DBA would probably never permit such a program. However, the simple fact is that there is no clause in the Standard or the Guidelines on which basis to reject such a program if one was soundly put together. One may argue that I am violating common sense here, but one cannot deny that it is nothing less than the purpose and responsibility of the Standard and the Guidelines to preclude such possibilities. That such possibilities still exist only reflects their failure.

This failure can be rectified by drawing a line in the Guidelines, differentiating what dentists can do that DHs, DTs and OHTs cannot do – based on their role within the dental team. Just as the Socceroos cannot have eleven goalkeepers, this line is crucial to the success of dental teamwork, as described in HWA recommendation #1, and its presence is absolutely critical to public safety.

4. Do you agree with the list of skills in the guidelines relating to programs to extend scope? Are there additional skills which the National Board should consider adding to the list?
With the failure to properly define DHs, DTs and OHTs, it is impossible for anyone to mount a solid argument against the proposed expansions. Had a strong, precise and sensible definition been provided, I would have been happy to support any number of changes which agree with the definition, regardless of any consequences I suffered. As the standard and guidelines stand currently, the National Board has the ability to extend the scope of practice as far as its whim, because there is no boundary in the standard or guidelines to stop it. Not only does this endanger patients as explained previously, but it depreciates the dignity of OHTs into cheap labour replacements for dentists – a trend that angers me and my colleagues.

If, however, the DBA specified DTs as having a preventive role, it would need to seriously consider whether it would be consistent with this definition to expand the scope of practice to all adults.

5. Does the preferred proposal balance the need to protect the public with the needs of regulating the profession? (Why or why not?)
Again, this question is too subjective to build a serious answer without a strong definition.

In summary, I agree with the much of the new diction in the draft standard and guidelines, and I agree with the idea of a structured professional relationship.

However, the many inconsistencies in the draft reflect the reality that changes are being rushed on mere pretence that they are being based on the recommendations of Health Workforce Australia, when I have clearly proven they are not. Rather, these changes intimate a disgusting view of oral health therapists as nothing more than cheap substitute dentists. To truly apply these recommendations with consistency and without hypocrisy, the definitions of the dental hygienist, dental therapist and oral health therapist must be redefined with a view to public understanding and public safety. Most of all, the National Board must acknowledge, then clarify, each member's significance in the dental team by definitively delineating the boundaries of each scope of practice.

Until these major flaws are rectified, there is no providence for transparent, fair polemics. More startlingly, neither is there a foundation to justify the proposed extensions of the scope of practice. Instead, I urge you to reserve major changes in the scope of practice until definitions have been refined acceptably. Although a two-stage approach would take much longer, it must not be forgotten what is at stake: not only the welfare of patients, but the welfare of dental practitioners and those who, like me, have dreamt for many years to become a dental practitioner.

Yours earnestly and fervently,

Mr. Joshua Zheng
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