



AUSTRALIAN & NEW ZEALAND ACADEMY OF PERIODONTISTS

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Re: Comments on draft *Scope of practice registration standard* and draft *Guidelines*

The Australian and New Zealand Academy of Periodontists (ANZAP) welcomes the opportunity to make a submission on the contents of the draft *Scope of practice registration standard* and draft *Guidelines*.

ANZAP is the peak body representing the speciality of Periodontics in Australia and New Zealand. ANZAP was established in 1987 and has 245 members, representing over 90 per cent of registered periodontists and periodontal postgraduate students in Australia and New Zealand. One of the main objectives of the Academy is:

2.1 To promote the dental and general health of the community through improved periodontal knowledge and care.

“Periodontal disease” is a broad term, encompassing a wide range of oral conditions from the very common and generally mild disease gingivitis, through to aggressive and advanced forms of periodontitis that can cause significant morbidity, including pain, infection and tooth loss. Further, the presentation of many malignancies of the oral mucosa and jaw bones, while rare, can mimic periodontitis, and many non-malignant disease entities that affect the mouth can greatly influence the periodontal status. Medical conditions, such as diabetes and blood disorders, and dermatological conditions affecting the oral mucosa, can also complicate the management of periodontitis and influence the response to treatment. Patient assessment and diagnosis can be complex. Dentists and dental specialists are trained to diagnose the different forms of the disease, and the extent and severity of



disease entities. Dental therapists, oral health therapists and dental hygienists are trained to examine a patient and recognise health and the absence of health, to allow them to carry out preventive periodontal care. However, it is important to acknowledge that they are not trained to **diagnose** the different forms of periodontitis.

Periodontal treatments encompass a wide spectrum of procedures. Gingivitis and mild periodontitis can be treated conservatively with scaling, root planing and behavioural modifications. More advanced forms of periodontitis will also require these treatments, but may also require surgical treatments, tissue regeneration, and other interventions, such as the judicious prescription of systemic antibiotics. Periodontal care also encompasses surgical procedures to modify tissue contours, biopsy of potentially pathological lesions, grafting of soft and bony tissue, regenerative surgical procedures, extraction of teeth, and the placement and maintenance of dental implants. The decision to carry out advanced treatment cannot be made in isolation of the overall complexity of the patient's restorative treatment needs or their medical conditions.

QUESTIONS IN CONSULTATION PAPER

In answering these questions, ANZAP recognises the assistance of the Australian Dental Association and has incorporated some the ADA submission in the responses.

- 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?)**

No.

Clarity is essential from the perspective of both practitioners and the public. This can only be achieved if there is clear specification of the scope of practice. Broad non-specific terminology defining scope, based upon attributes and competency can only create greater uncertainty. Individual teaching institutions have differing competencies, and this serves to increase the lack of clarity of permitted scope of practice.

ANZAP is of the view that the existing standard is clear and concise, covers every possible scenario and provides for the protection of the public. ANZAP understands the issues faced by the Board when developing the standard, in that the exit qualifications and competencies of ADPs from different institutions have been and to some extent currently are quite different. It should be that education providers ensure their programmes produce graduates with uniform competencies and attributes. ANZAP supports the ADC as being the independent accreditation body to set these standards.



To provide clarity for both health professionals and the public, the only solution remains that there be a very prescriptive scope of practice included in the Standard.

2. Do you agree that the introduction of the guidelines further supports this clarity for dental practitioners and the public? (Why or why not?)

No. ANZAP considers the wording of the scope of practice of dental hygienists and oral health therapists to be poorly worded.

The scope of practice of dental hygienists and oral health therapists has to be altered to reflect that they are **trained to provide non-surgical preventive periodontal/gum treatment, and other preventive oral care.**

The scope of practice of oral health therapists be worded to reflect that their training prepares them *for the prevention of oral disease* to bring their description of scope of practice into line with the scope of a dental hygienist, as their training is the same.

Rationale:

- The insertion of the words “**non-surgical preventive**’ will greatly help the public to distinguish the roles of the dental hygienists and oral health therapists in the provision of periodontal care.
- The focus on *the prevention of oral disease* clearly defines the scope of periodontal care that dental hygienists and oral health therapists are trained to provide. Their training in periodontal care is the same, so it is essential that the description of their scope of practice with regard to periodontal care is worded identically.
- The insertion of the term “**non-surgical preventive**” more accurately describes the training and competencies of dental hygienists and oral health therapists.
- This fits with the National Boards stated aim (page 4 of 23) of
 - Providing certainty to all divisions of dental practitioners on their scope of practice and
 - Providing protection and certainty to the public in recognising the divisions of dental practitioners and their scope of practice.



Clarity and certainty are required if the public are to have confidence in the respective skills of dentists and ADPs. The draft as provided by the Board goes some way to achieve this, and the ANZAP's suggestions create the certainty required. Without this clarity, there will remain potential for ADPs involved in providing periodontal care to misinterpret their scope to the detriment of public safety.

Additional material using plain language statements is required to demonstrate to the public:

- The role of the dentist or the dental specialist as a clinical team leader,
- The difference in qualifications between dentists, dental specialists and ADPs,
- Details about the difference between dentists, dental specialists and ADPs,
- Advice to the public about how to determine if the practitioner has formal education and training in a particular area of practice
- Accountability of each practitioner

It is misleading to state that the education requirement for a recent graduate dentist to be registered is a minimum four year full time formal education program. It is either a 5 year program, or a seven year program in those Universities who dictate that there must be completion of 3 year degree covering the basic biomedical sciences before commencing a 4 year postgraduate degree in dentistry (7 years in total). The document should clearly specify this when attempting to explain to the public the difference between the dental providers and contrast this extensive training of dentists to the limited training (as minimal as 2 years) for dental hygienists, and the limited three year training for oral health therapists.

The standards should also clearly point out that dental specialists undertake a further 3 year higher degree program (a doctoral level program) in research and advanced clinical care.



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

Yes.

As a starting point, every patient seeking dental care needs to be provided with enough information to make informed consent about the care they are to receive. Without a clear description of the limitations of each practitioner type with regard to ability to diagnosis and the limitations on treatment options, the patient's legal rights have not been met and the current document does not clarify this.

In relation to the matter of protection of the public, and the issues raised pertaining to training, scope of practice and supervision, the following points need to be considered.

The additional Guidelines as written do not clarify either to practitioners or the public the differences in services provided by the practitioners.

The education of ADPs, when considered in light of the Australian Qualifications Framework, is insufficient to prepare them for any degree of increased scope of practice and lack of supervision

Although the patient is at the very centre of the team approach, how will they know who is most "appropriate to provide it" if dental practitioners are not required to discuss this with them?

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?

If an allied dental practitioner wishes to practise with increased scope of practice and no supervision, then they need to train as a dentist. This means obtaining academic results in secondary school or at University which lead to acceptance into a dental undergraduate training program or a graduate level entry into a dental program, and then completing the level of education and training required to become a dentist.

This level of academic achievement is not a pre-requisite for entry into existing ADP training programmes, and following on from this, there is no basis for comparison between an allied dental practitioner and a dentist. Regarding this point, there can be no argument for the Board to support the changes being considered, especially considering the Board's role in



ensuring the protection of the public. It is inappropriate for political pressures to allow the Board's role to be compromised in such a manner.

For example – extension of scope of practice to all for Cone beam radiology:

ANZAP has strong objections, on the grounds of patient safety, on the extension of scope of practice to all for cone beam radiography. There needs to be clear distinction between training of ADPs in the physical setting up a patient into a machine and pushing a button to take the radiograph versus the highly specialised skills required to decide when cone beam imaging is appropriate, and the interpretation and reporting on the entire data set captured by 3D imaging. The wording of the current document does not clearly differentiate this. The current wording implies that all practitioners, including DPs in independent practice and then potentially all other ADPs in independent practice, could either make the independent decision to refer a patient for a cone beam image or could install a cone beam machine and use it to expose patients to the increased radiation. The ADPs simply do not have the skills necessary to interpret and report on the 3D dataset, let alone the diagnostic skills to determine whether a lower dosage, more simple radiological examination may suffice.

ANZAP is strongly of the opinion that injudicious exposure of patients to the increased radiation inherent in 3D imaging is a concern at a population level and it is inappropriate to extend the ability to expose patients to such a level of radiation to ADPs. If a patient is thought to need such an exposure on diagnostic grounds, that patient would automatically be classified as requiring complex diagnosis and care, and therefore, 3D imaging should be restricted to dentists and dental specialists. Interpretation of the images should be undertaken by dento-maxillofacial radiologists, oral and maxillofacial surgeons or head and neck radiologists for any FOV that involves any anatomical structures outside the dento-alveolar complex.

The New Zealand Dental Council tackled this issue last year, and in reference to their document, they specified that

- “For dento-alveolar CBCT images of the teeth, their supporting structures, the mandible and the maxilla up to the floor of the nose, a radiological report should be made by an adequately trained general dental practitioner or dental specialist,”
- “For all non-dento-alveolar small fields of view (e.g. temporal bone) and all craniofacial CBCT images, a radiological report should be made by a suitably trained specialist.”



5. Does the preferred proposal balance the need to protect the public with the needs of regulating the profession? (Why or why not?)

No.

The preferred proposal fails to protect the public. It fails to address the need for the revisions, it fails to address what outcomes are envisaged by the revisions, it fails to outline how the revised standards will be assessed. It muddies the role of the Dental Board of Australia and the Australian Dental Council – it now appears that the Dental Board of Australia has expanded its own scope to determine the contents of education programs run by our Universities. The current draft will allow an increase in scope of practice to be approved by the Dental Board rather than the ADC or the specialist academies who are in the best position to do this. It will allow the population to be exposed to increased levels of radiation, by extending scope of practice for 3D imaging to all. It will expose the public to receiving dental care without ensuring that such care is based upon a diagnosis. Rather than regulate the profession for the protection of the public, it does the exact opposite.

The Board's proposal eliminates the current public protection afforded by the current standard, and effectively will deregulate the profession to the detriment of public safety.

The inclusion of dentists and even more so, dental specialists, in the proposed extension of scope, fails to recognise the principles of a dentists' education which provides the foundational knowledge and competencies to incorporate innovation, techniques, procedures, materials and technology in a cost effective and safe manner.

ANZAP supports Option 1 – no change to the current Standard.

Additional comments:

Extension of scope of practice:

ANZAP recognises the Australian Dental Council (ADC) as the accreditation body in dentistry. As such, the ADC should be the body to accredit any program that is designed to extend the scope of practice of dental hygienists, dental therapists, oral health therapists and dental prosthetists. This should be clearly stated in the document. It is not adequate for the current document to simply state the "the approval of these programs by the National Board includes an external audit and accreditation process". Direct reference needs to be made to the ADC being the body to do the accreditation.



With regard to specialists, the recognised peak speciality body (eg ANZAP) should have the authority to set and expand the scope of practice of that speciality and set appropriate benchmarks for the training to extend the scope of practice within their speciality area. There is the analogy to this in the medical profession, where the Medical Board states that the scope of practice within a speciality is basically what the appropriate college recognises as the scope. ANZAP regards the current wording regarding scope of practice may have the effect of stifling the integration of new techniques within a specialty area, and as specialists, we are the group most highly qualified to assess these new techniques and to support expansion of scope of practice. We differentiate ourselves from dental hygienists, dental therapists, oral health therapists and prosthetists by the nature of our advanced clinical and research degrees, which enable us, as registered specialists, to utilise the analytical and clinical skills necessary to advance our profession in our speciality.

Independent Practice:

Many periodontists already work in a team care relationship with dental hygienists. A recent survey of ANZAP members revealed that about 50 per cent of members employ dental hygienists within their private practices. Depending upon the State, this has involved varying definitions of supervision. As such, ANZAP welcomes the use of the term, Team Approach, within the draft Scope of Practice registration standard. However, ANZAP does not support the independent practice of dental hygienists and oral health therapists. ANZAP regards that a three year period to reassess this is arbitrary and not based upon objective measures of how this will be assessed. The document needs to outline the way that this will be assessed. If the assessment is based on patient health outcomes, or on frequency/type of complaints about dental care providers to authorities, then three years is clearly insufficient for these factors to be measured. The argument put forth by bodies such as the DHAA highlighting the low level of complaints to regulatory bodies about hygienists or oral health therapists is a furphy. This is because the structured team relation, where the patient's care is overseen by a dentist, will result in the dentist "correcting" the poor workmanship of the DH or OHT employed in their practice, appeasing the patient and thereby diffusing the potential for a patient to complain. Without this important level of supervision in place, the potential for neglect of patients (due to misdiagnosis and providing a sub-optimal level of care) will become evident.

The 5 to 7 years of training that a dentist receives in all areas of dentistry enables the ability to carry out complex diagnosis, treatment planning, and the full range of treatments. Dental hygienists, dental therapists and oral health therapists are trained to recognise health and absence of health, but are not trained to diagnose. A patient who is examined and then treated without being given this full picture, and without being offered the full



scope of treatment options available, is receiving a sub-standard treatment and may not be made aware of this. This is clearly negligence.

Extraction of permanent teeth by oral health therapists:

ANZAP is strongly opposed to the extraction of permanent teeth by oral health therapists. This is an irreversible procedure, with significant morbidity if the procedure is not completed in one attempt. Roots fracture, roots displaced into the maxillary sinus, fracture of bone surrounding the tooth and bleeding and infection are common complications. It is beyond the scope of practice of an oral health therapist to deal with such complications. The widely accepted mantra of legal duty of care is never to start a procedure unless you have the capacity to cope with common complications. Oral health therapists do not have the educational depth of knowledge or training to do surgery. Dentists and dental specialists do. Extraction of permanent teeth should only be carried out by dentists and dental specialists.

Use of the term ‘Dental practitioner’

While outside the scope of this call for submission, ANZAP objects strongly to the use of the title “dental practitioner” other than by dentists and dental specialists. The public is rightly confused by the use of the term dental practitioner by dental hygienists, dental therapists, oral health therapists and dental hygienists. These 4 groups already have their own title to distinguish them and their role, in the eyes of the public. To add the umbrella title of “dental practitioner” to all is misleading the public, no matter what attempts are made to cushion the impact of this confusion by vaguely worded descriptions of the different roles that these groups play. ANZAP does not find the wording of the scope of practice of DT, DH and OHT to be at all helpful in guiding the public about the difference. ANZAP sees the analogy to the medical profession, where the term medical practitioner is used only by medical doctors and medical specialists, not by the other allied health professions that assist in the medical care of their patients, such as physiotherapists, speech pathologists, optometrists etc.



FINAL COMMENTS:

If Option 2 is adopted by the Board, then ANZAP is concerned that there is nothing in the document to ensure that the public is protected from receiving a substandard level of periodontal care. As a minimum, the following needs to be inserted into the Guidelines on Page 17 of 23 (In the education and training requirements for the treatment of patients of all ages):

ANZAP sees a need to recognise the additional training in provision of straightforward periodontal care to manage periodontal diseases in adults of all ages that dental therapists will require as part of their training and assessment. ANZAP greatly prefers the term “straightforward” to “simple”. Periodontitis is rare in adults under 25 years of age, let alone under 18 years of age. As such, dental therapists who have been educated to treat young patients will have had no clinical or theoretical understanding of the management of adult periodontitis, or the complexity of treatment planning decisions that need to be made when co-managing periodontal diseases and other dental treatment in adult patients.

The following two points need to be inserted in the paragraph:

The National Board expects the following uniform, minimum standard of modalities to be taught and assessed for dental therapists and oral health therapists when practising dental therapy on persons of all ages: :

Extension of clinical periodontal skills to the provision of straightforward non-surgical preventive periodontal treatment in the adult patient

Development of clinical judgement skills in identifying those individuals who require straightforward non-surgical preventive periodontal care and those who must be referred for diagnosis and more complex care

ANZAP recommends a separation of straightforward from complex periodontal care in the manner that the current document separates out simple restorative care from more complex restorative care.



The following outlines the criteria upon which a patient needs to be assessed and managed by a dentist or periodontist and distinguishes the complex patient from the straightforward patient:

A patient with the clinical signs leading to a possible diagnosis of aggressive or early onset periodontitis

A patient who has not responded to initial phase of periodontal treatment or who has relapsed after a period of response to treatment, must be regarded as complex and needs to be referred on to a dentist or periodontists for assessment and appropriate management

A patient with loss of attachment of over 4mm at four or more sites, and/or furcation involvement of the teeth must be assessed and diagnosed by a dentist or dental specialist

Inflammation of tissues surrounding an implant

Gingivitis or periodontitis complicated by medical or oral mucosal condition

The need for an extraction of a tooth due to periodontal disease

Patients with combined endodontic-periodontal lesion(s)

Patients with progressive gingival recession

Patients with any bony pathology of the jaws

ANZAP supports Option 1 – no change to the current Standard

Dr Louise Brown

President

ANZAP

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Council members:

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