

June 18 2013

Executive Officer

National Board of Australia, AHPRA

GPO Box 9958

Melbourne, 3001.

The National Board seeks your feedback on the proposal. Please provide written submissions by email, to dentalboardconsultation@ahpra.gov.au by close of business on 19 June 2013.

Re: Comments on draft Scope of practice registration standard and draft guidelines.

Preamble:

I am of the view that the broad changes proposed do nothing to enlighten the public rather create confusion and less clarity. Principal among these is the use of the term “dental practitioner” to refer to Dental Therapists, Dental Hygienists, Oral Health Therapists and Dental Prosthetists, as well as Dentists and Dental Specialists. The recent introduction of Oral Health Therapist to the lexicon already distinguishes them from dentists and their titles are descriptive, logical and familiar to the public. To include Dental Prosthetists, Dental Hygienists, Dental Therapists and Oral Health Therapists under the blanket term “Dental Practitioner” is misleading when the public associates this term with Dentists and Dental Specialists. I can only be somewhat cynical that the reason is exactly to confuse and obfuscate, such that the public are not aware of the qualifications of the operator treating them. In light of some of the further proposed changes in this document, this has absolutely nothing to do with the “public good” or “clarity”.

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. The stated aim of the National Board to “extend a dental practitioner’s scope of practice by undertaking educational programs that the National Board has formally approved” is concerning. With the advent of a National Board it is imperative that educational institutions have standardised Australia-wide qualifications and competencies of allied dental professional programmes, and that these standards are set by an independent Australian Dental Council. The National Board should not be involved in the development of education standards, this is the role of the ADC. Similarly the National Board should not “grandfather” expanded scope of practice into the standard, simply on the basis that some educational institutions have done so prior to the formation of the National Board and at odds with the current 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

What the document fails to do is make clear why the revisions as proposed, are even necessary. It fails to tell us how these revisions make dentistry safer for patients. Indeed, this whole document fails to provide any emphasis on benefits to the public. The public seeking dental care deserve be sufficiently informed to enable an autonomous decision as to what care they receive. There is much in the document about the “autonomy” or lack of, for allied dental practitioners. That they are currently restricted by supervision requirements from making “autonomous” treatment decisions and that this is a bad thing. Why? How can a member of the public with no dental knowledge make an autonomous decision when they are unaware the allied practitioner treating them has limitations in skill-set and knowledge? More pertinent is once supervision is no longer a requirement, the least qualified practitioner is deciding whether to refer or undertake treatment. The revised standard emphasises a “team approach” but in fact the removal of supervision of less qualified allied dental practitioners can potentially allow the patient centred team approach, which is a collaborative model, to be replaced by a linear, sequential model as there is no compulsion for the allied dental practitioner to involve those more qualified or able to provide the patient with all the information and treatment options available. It is patient autonomy which is the critical issue NOT the practitioner.

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

No

The minimum requirement for the practice of dentistry is be a dental degree. Should an allied dental practitioner wish to expand their scope of practice to include independent practice and provide the public with a holistic overview of their dental needs, *which the public has a right to know*, then the allied dental practitioner must “add-on” an undergraduate dental degree.

With respect to the team approach to dental care, I agree no change to the standard is required as a team approach to dentistry is already enshrined in the current standard.

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?

No

For example, this consultation document goes into great detail of what constitutes a “simple restoration”- this is clumsy, wordy, and ask any competent lawyer, open to interpretation. The inherent danger of expanded scope of practice for allied dental practitioners: informed consent. To include the amputation or irreversible removal of tooth substance in patients of all ages, undertake so called “simple” restorations, allow all allied dental practitioners to take cone beam CTs is not in the public interest. A Dental Therapist undertaking unsupervised treatment on a child has consent from the parent who has made an autonomous decision on behalf of the child and currently within a “structured professional relationship” with a supervising dentist. Removal of the age restrictions for DT, DH and OHTs together with proposals for Dental Prosthetists to restore implant retained overdentures, carry with them responsibility to “do no harm”, where the risk to the patient is increased.

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

No

Public safety is not the focus of the changes proposed in this revision. There appears an emphasis on semantics such as including an overly long, wordy description of a “structured professional relationship”. This specific unwieldy paragraph appears to be included in the revision to pre-empt deregulation of the profession and as such in no way balances the need to protect the public with the needs of regulating the profession.

Additionally there is the potential for DT, DH and OHTs together with Dental Prosthetists, to be exploited in the workplace, used as “replacement cheaper dentists” and placed in untenable clinical situations where they may fear losing their job if they refuse to undertake increasingly complex treatment which, under Option 2 are easily pushed to their limit from an ethical and interpretation context. In no way does this benefit the public whose interests should be the central aim of any treatment decision.

Indeed I foresee the National Board’s proposed revisions overseeing the death of the small business, family dentist model. Replaced by corporate dentistry where the overriding emphasis is on fiscal return and not patient outcomes. This scenario will be even more detrimental to patient outcomes if the corporate owner is a Health Fund. It appears from the literature that the thrust of the revisions is intended to deregulate the provision of Dentistry, apparently in order to make Dentistry cheaper and more accessible. What is likely to result is the Coles and Woolies of Dentistry, little actual competition and declining standards of dental care. Where once there was a family dentist (or doctor) who knew your name, invested in treatment outcomes for patients because they live in the community, there is now a harassed professional who has to reduce patient time, increase output and possibly compromise ethics in order to maintain an income and comply with “throughput” in a “process driven, corporate entity.” Welcome to the unintended outcome of deregulation, less competition not more. The antidote to this is what Australians do very well: the small business.

Further Comments:

There is an overriding concern by the dental profession arising from the emphasis in the HWA¹ document on the restriction of DT, OHT and DHs scope of practice (SoP), which is: an underestimation of the complexity of providing quality dental services to the community.

Teeth and oral health are important to the well being, general health, self esteem and overall quality of life of an individual. Removal or amputation of tooth structure is a ***permanent, unalterable event, demanding that those undertaking such removal have the training, knowledge and understanding of all implications of their actions on patient outcomes. There is potential for disfigurement together with reducing the lifespan of the natural dentition, if inappropriate treatment is undertaken, particularly for young adults.***

The limited training at the university level of DT, OHT and DHs should not be simply “added to” as an apprenticeship. In the 21st century anything less than evidence based healthcare, is unacceptable. Formal University education, including examinations and the fulfilment of consistent, measureable criteria across all higher education institutions in Australia should be the minimum standard to protect the public. It appears glaringly obvious but rarely stated, that in order to address the complexity of oral diseases at the patient level demands significant university learning and post graduation continuing education. It is unreasonable for an DT, OHT and DH to be expected to upgrade skills without addressing these areas of curricula (diagnostic, pharmacology, pathology, the medically compromised patient, restorative skills, risk assessment, recognition of inter-relationships of oral and systemic disease and the need to refer before treatment is compromised, to mention a few) It is simply not possible in a 3 year degree to address these areas and to achieve the skills of a dentist, which is what independent practice demands in the adult population, contrary to what is being suggested by ADOHTA (Australian Dental and Oral Health Therapists’ Association).

A dental degree should remain the minimum requirement to undertake irreversible procedures in the adult population (such as the amputation of living tissue), with the dentist or dental specialist to have over-arching *responsibility for the treatment undertaken by DT, OHT, and DHs. This model recognizes the professional competencies of DT,OHT, and DHs within the dental team.*

I fear the National Board in revising the current scope of practice is undermining the gains achieved in dental education and delivery of dentistry over the past decades. Australian tax payers have invested hundreds of millions of dollars to build new Dental Schools and University infrastructure, with many more dentists graduating to address the unmet need for dental care in the community. Increased numbers of dentists will increase competition providing benefits for those less able to access care. Sadly the push by DT, DH and OHTs to extend their scope of practice to include destruction of tooth substance (I note restorative procedures are the focus of “add-on” courses advocated by the revised guidelines) is a significant move away from their primary role of prevention of Oral Disease, promotion of Oral Health and treatment and prevention of dental disease in children. The literature

reminds us^{2,3,4} we have an increased burden of oral disease in Australia borne by our most vulnerable members of the community but the key architects of prevention are considering becoming drillers and fillers. This is indeed an indictment of our National Board's priorities. Indeed Government is very short-sighted underutilising DT, DH and OHTs as preventive practitioners to address oral disease of Australian children and youth, reaping the benefits of reduced cost of disease as the population ages³.

1. Health Workforce Australia 2011, Scope of Practice Review - Oral Health Practitioners ISBN 978-0-9871920-7-3
2. ABS Health and Socio-economic disadvantage Australian Social Trends 41022.0 March 2010
3. Spencer J & Harford J, Improving oral health and dental care for Australians, ARCPOH, University of Adelaide, Adelaide, 2008
4. Report of the National Advisory Council on Dental Health 23 February 2012

Dr Heather K Kendall

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