Dr Rachel Mascord
Level 5, 84 Pitt St
SYDNEY, 2000, NSW
T; (02) 9232 2800
[redacted]

Friday 11th May, 2018

Response to the Dental Board proposed revised Scope of practice registration standard and Guidelines for scope of practice

Dear Sir/Madam,

I must preface this letter by stating my concern that the Dental Board will pay little heed to the comments I will make below. To date, nothing in the actions of this Board has demonstrated obvious gestures of concern for the state of the dental profession nor its practitioners.

These concerns, however, will be laid aside, as the proposed changes call for such urgent consideration, that silence on the issue will not serve.

Each will be addressed below, in turn.

- Remove the requirement for a 'structured professional relationship'. The Board considers that the *Code of conduct* for dental practitioners details more appropriately the important standards for dental practitioners in understanding the expected ways of working. This includes that dental practitioners must work within the limits of their competence and scope of practice and refer patients for care that is outside their scope of practice.

  A superficial reading of this point cannot be argued with. Of course, a dentist must operate within the "limits of their competence" and within their "scope of practice". The Code of Conduct has been the benchmark for my entire time in practice, and those of my peers and colleagues who value our profession and seek in every way to uphold exemplary standards.

  I am unaware that this requirement has changed in the 26 years in which I have worked in this profession. I am also more than aware of unscrupulous and greedy practitioners who adopt questionable and ethically dubious practices, such as the provision of intrusive facial cosmetic work as part of their general dental practice. I am aware of practitioners whose ambitious claims exceed their technical and moral capabilities.

  I am however, not aware of what action is being undertaken in some of these cases, nor how this proposal will effectively manage the issue. In fact, I cannot fathom what the board means by the phrase 'Remove the requirement for a 'structured professional relationship'.' *In simple terms, what are you actually proposing, and by what means are you going to enact it?*

- Remove the requirements of 'independent practitioner'. At the time of the last review in 2014 the Board agreed that it would incrementally remove the bar on independent practice from the registration standard. This approach was adopted to effectively recognise the professional roles, responsibilities of all dental practitioners and their regulation.

  Again, this statement is clouded with obfuscation. I have been led to believe by my professional association that by this change, you intend to allow Dental Hygienists and Therapists to practice dentistry independently and presumably in their own practices. *For what reason do you propose to do this? What are the benefits (to the profession, to the Board and to the people of the public we serve) you seek to gain by such an action? Are you intending to expand their scope of practice, and to what degree?*

If you are using this as a mechanism to make dental services more accessible and affordable to the general public, how do you propose to qualitatively and quantitatively measure the outcomes? How do you propose to balance reduced costs (if indeed they do occur) against quality of care received?

And have the members of the Board taken into consideration the costs of establishing and maintaining a dental practice (barely less for a hygienist than a dentist), and how a hygienist could manage such costs in the provision of dental hygiene services. It is naïve and entirely non-reflective of clinical and financial reality to imagine that 'scales and cleans' will cover the costs of the rental of premises, purchase of capital equipment, employment of staff, insurances and the cost of materials to name but handful of the running costs of a private clinic.

How are hygienists to handle emergency care? Or are you anticipating a complete revision of their scope of practice, such that they are able to treat dental emergencies? What training do you propose to make available to them to master clinical diagnosis and management of emergencies?

It is contingent upon you as the Board to make clear what you mean by this statement and include:

- Proposed changes to scope of practice for all dental staff,
- An estimation of impacts on patient access to treatment and costs of care (understanding that these would be entirely theoretical therefore not necessarily reflective of actual outcomes),
- The relationship of your proposal to the relationships between providers and health funds,
- Any role to be attributed to Medicare in the funding of dental care under this new regime,
- How you propose to measure all outcomes, both qualitatively and quantitatively,
- And how you propose to recognise and manage adverse outcomes when the changes are implemented.

Without such clarity it is impossible to rationally and reasonably understand your intent, hence make a studied and practical response.

- Remove reference to *Programs to extend scope* giving effect to the Board's decision to phase out the approval process of these programs. Going forward, these programs can continued to be delivered as continuing professional development (CPD).

Is this a means of limiting the scope of practice of general dental practitioners, and funnelling them into specialist training programs? In other words, a dentist may participate in training but cannot claim "specialist" capacity in the area of training they have undertaken.

Clarity about your intent is essential for members of the dental profession to make a response that is cogent, relevant and based on making change that actually benefits professionals and the public.

- Clarify expectations around education, training and competence. As accreditation standards, competencies and processes for approving programs of study are now well established under the National Scheme[1], the Board proposes to remove the prescriptive terminology from each division description outlined in the guidelines.

As stated in earlier points this statement is so vague as to be meaningless in its current form. It is clear that the Board has an intent 'to remove the prescriptive terminology from each division description outlined in the guidelines', but what terminology exactly, and to what end? Are your proposals in line with current levels of training of the different professionals within the field? And how are we, as members of the profession to make the determination of how to

respond when we do not have sufficient information about the precise terminology you intend to remove.

If you are serious about receiving the feedback of the profession, then make your intentions absolutely clear and detailed so that we understand exactly what we are agreeing to and make determination of what it might mean. It is also essential that you are responsive to the outcomes of these changes and develop a contingency plan if they fail to achieve your desired outcomes, or more importantly fail the people of our community and our profession.

The Dental Board has proven itself to be unresponsive to concerns and problems flagged by the profession. Your history does not assure us that your proposals have the interests of the dental profession, nor the public at heart. I would urge you to consider this deeply, as much as any change you are proposing to the structures of the profession.

Yours truly,

Dr Rachel Mascord BDS