



Associate Professor Leonie M. Short  
Head of Course, Bachelor of Oral Health  
CQUniversity Australia, Rockhampton, Central Queensland  
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**I support the Board's preferred Option two – proposed revised registration standard and guidelines**

Option two is to consult on a number of proposed changes to the current registration standard and guidelines. Under this option, the proposed revised registration standard and guidelines would continue to set out the Board's requirements for scope of practice however it would:

- remove reference to Programs to extend scope from the registration standard and guidelines giving effect to the Board's decision to phase out the approval process of these programs with a transition period until 31 December 2018
- clarify expectations around education, training and competence including revisions to the practitioner dental divisions and strengthening the link between an approved program of study and the relevant professional competencies
- reduce unnecessary regulation in light of well-established accreditation functions which have shaped practitioner training and competencies
- remove the requirements for dental hygienists, dental therapists and oral health therapists not to practise as independent practitioners
- further clarify the Board's expectations around the team-based approach and remove the requirement for a structured professional relationship, and
- improve readability and clarify current requirements by restructuring and re-wording the standard and guidelines.

**I support, as part of this option the Board has developed a new reflective tool for scope of practice** to help practitioners assess their individual scope and support continuous learning through reflective practice. Implementation of this tool would be supported by a broad communications strategy to deliver effective engagement and uptake.

## **Responses to Questions:**

### **1. From your perspective, how is the current registration standard and guidelines working?**

From the perspective of a person who has assisted in education oral health therapists at three universities – University of Queensland / Queensland University of Technology from 1997 to 2000, Griffith University from 2003 to 2010, and CQUniversity from 2011 to present, it has been commendable that oral health therapists have been able to adapt to, and work within, the confines of the current registration standard and guidelines. No other health profession who works with AHPRA has a ‘scope of practice’ registration standard – they only have a registration standard. There was never a rationale why the dental professions needed a scope of practice registration standard. A clear rationale why we needed this was never made in the first place– it was done because the Dental Board of Australia could do it. And we have worked within these regulations for eight years – safely and competently.

The inclusion of a words and phrases such as ‘not independent’, ‘structured professional relationship’ and in earlier documents, ‘supervision’ and ‘the dentist is the leader of the dental team’ have been included to reinforce the power and dominance of the dental profession over the professions of dental therapy, dental hygiene and oral health therapy. Again, no other health profession has words like these in their registration standards and guidelines. Nursing and midwifery documents do not include phrases that say that ‘doctors are leaders of the medical team’. Moreover, occupational therapists, physiotherapists and podiatrists documents do not include phrases that say anything about ‘not independent’, ‘structured professional relationship’ and ‘supervision’.

This subservient language embedded in the registration standard and guidelines has placed the professions of dental therapy, dental hygiene and oral health therapy in a subservient position in relation to dentistry and not equal to all allied health professions in Australia. The time has come for this anomaly to be changed and for us all to move forward in a truly supportive, collaborative and team-based manner.

I have never been a proponent of a dental therapist, dental hygienist or oral health therapist working as a single practitioner in a dental practice in Australia. I believe that a team-based approach is the only way to offer the full range of dental services to families. The fear or threat, that these proposed changes to the registrations standard and guidelines will result in many dental therapists, dental hygienists and oral health therapists setting up solo dental practices, is not a financially viable or practical practice model. Indeed, I am only aware of two such instances of this already in Australia. In one such instance, the oral health practitioner is across the corridor to the dentist with whom she has a structured professional relationship. The preferred dental practice model includes a dental team of dental specialists, dentists, oral health therapists, a dental prosthetist, a dental technician, dental assistants and a practice manager.

### **2. Are there any issues that have arisen from applying the existing registration standard and guidelines?**

Yes. As dental therapy, dental hygiene and oral health therapy were not assessed to be independent registered health practitioners, they were unable to apply for a provider number from Medicare nor from private health insurance companies in Australia. This

meant that all dental treatment and procedures which incurred a rebate from Medicare (Child Dental Benefits Scheme or Veteran's Affairs) or a private health insurance company (MBF, HCF, NIB or Teacher's Union Health) had to be processed with a provider number of a dentist with whom they had a structured professional relationship. Dentists preferred this gate-keeper role as it meant that every dental procedure by a dental therapist, dental hygienist or oral health therapist had to go 'through' a dentist. This maintained the power and control over what was seen as 'subservient' dental professions.

However, there were much wider issues and problems. One, dental therapists, dental hygienists and oral health therapists were not receiving acknowledgement for the dental treatment that they performed on a daily basis. Two, patients were confused as to why a dentist's name and provider number did not appear on their invoice when another person performed the dental treatment. Three, dental data from Medicare and the private health insurance companies were misleading as it showed that dentists performed all this work when, in reality, it was actually performed by dental therapists, dental hygienists and oral health therapists.

The issue of incorrect and misleading patient invoices and dental data must be resolved. The deletion of phrases such as 'not independent', 'structured professional relationship' and 'supervision' in the registration standard and guidelines is the first and necessary step in making all dental invoices and dental data true and accurate.

*As a University, the change to the 'Programs to extend scope from the registration standard and guidelines' giving effect to the Board's decision to phase out the approval process of these programs with a transition period until 31 December 2018 is the most needed. I could never understand why the Dental Board allowed dental specialists and dentists choose their own Continuing Professional Development (CPD) needs but made a clear distinction between CPD and 'Programs to extend scope of practice' for dental therapists, dental hygienists and oral health therapists. Again, there was never a clear rationale why the Dental Board of Australia made a distinction between CPD and 'Programs to extend scope of practice' for dental therapists, dental hygienists and oral health therapists. It was done because the Dental Board of Australia could do it.*

The adverse effects of this distinction, albeit intentional or unintentional, have been significant. Any courses to extend scope of practice needed to be accredited by the Dental Board of Australia – not the Australian Dental Council – but the Dental Board itself. Furthermore, the cost for accreditation of each course to extend scope of practice for dental therapists, dental hygienists and oral health therapists was \$10,000. This has meant that CQUniversity did not submit or offer any courses to extend scope of practice for dental therapists, dental hygienists and oral health therapists from 2012 to 2018. I'm assuming that the other stand-alone Bachelor of Oral Health courses at Curtin University of Technology and the University of Newcastle also did not submit any short courses for accreditation. This is because the workload and cost of accreditation outweighed the returns from participants in any proposed short courses.

However, as the Dental Schools are already accredited to cover the full scope of dentistry, they were allowed to offer short courses for dental therapists, dental hygienists and oral health therapists without the workload and cost of accreditation. This led to an unfair advantage for the Dental Schools, it inhibited competition between university providers and

fed the notion that 'extended scope of practice' courses could only be delivered by, and with, specialist dentists and dentists from a Dental School.

Unfortunately, the effect on the oral health workforce was damaging and detrimental, to say the least. As Queensland dental and oral health therapists who trained at the Yeronga School of Dental Therapy or the later named Oral Health Education Unit, they a more restricted scope of practice to those in every other state and territory of Australia and in New Zealand. The opportunity to bring all these Queensland trained dental and oral health therapists up to the national benchmark has been slow or non-existent over the last eight years because of the selective distinction between CPD and 'programs to extend scope of practice' from the Dental Board of Australia. The Board should be encouraging registered dental practitioners to be up-to-date and practice evidence-based dentistry in the best interests of the public. As an academic, I have watched the under- or de-skilling of the dental and oral health therapy workforce in Queensland – it has been heart-breaking. So the *change to the 'Programs to extend scope from the registration standard and guidelines' giving effect to the Board's decision to phase out the approval process of these programs with a transition period until 31 December 2018* is the most needed and overdue. It has held back the professions of dental therapy and oral health therapy for long enough.

### **3. Is the content and structure of the proposed revised registration standard and guidelines helpful, clear, relevant and more workable than the current registration standard and guidelines?**

Yes, the content and structure of the proposed revised registration standard and guidelines are helpful, clear, relevant and more workable than the current registration standard and guidelines. The Dental Board of Australia needs to be applauded for suggesting these much needed changes after eight years. As universities and registered dental practitioners, we need to work within the constraints of the registration standards and guidelines since the National Law came into effect. We have done that – when open forums were available or public consultation was requested, we had our say.

Furthermore, the evidence of our safe and competent practice as dental therapists, dental hygienists and oral health therapists is testament to the reason why a patriarchal top-down model of clinical practice is not warranted in Australia.

Another consideration for the Board is to respond proportionately to risks in order to protect the public. Notifications related to practitioners working beyond their scope of practice are exceedingly few. The Board's recent *Dental notifications classification of issues project* found that only two percent of dental practitioners were found to be practising in areas beyond their scope. Dentists, including specialists, account for about 90 percent of dental practitioner notifications annually. (**Dental Board of Australia** Public consultation – *Scope of practice registration standard and Guidelines on scope of practice* Page 6-7)

### **4. Is there any content that could be changed or deleted in the proposed revised registration standard and guidelines?**

No, again, the Dental Board of Australia needs to be applauded for suggesting these much needed changes after eight years of operating under the National Law.

**5. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?**

Yes, as dental therapists, dental hygienists and oral health therapists have proven to be safe and competent dental practitioners in Australia for over 50 years, a review period of at least every five years (rather than three) is appropriate.

**6. Do you have any other comments on the proposed revised registration standard and guidelines?**

No, again, the Dental Board of Australia needs to be applauded for suggesting these much needed changes after eight years of operating under the National Law.

**7. Is the content and structure of the new reflective tool helpful, clear and relevant?**

Yes, again, the Dental Board of Australia needs to be applauded for developing and providing us with the new reflective tool. The content and structure of the new reflective tool is very helpful, clear and relevant.

**8. Is there anything missing that needs to be added to the new reflective tool?**

No, I can't think of anything at this stage. Reflective practice is not something that was included or stressed in dental and/or oral health education in the past. Recent training of our academics and clinical supervisors at CQUniversity in reflective practice proved very beneficial. It was conducted alongside allied health practitioners including chiropractors, podiatrists, physiotherapists, speech pathologists, occupational therapists and social workers.