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# Response to the Dental Board of Australia Consultation on Scope of Practice review including Removal of a Structured Professional Relationship

I do **NOT** support the direction of the change proposed by the Dental Board of Australia. Removal of the requirement for a structured professional relationship with a dentist would be a retrograde step, and not in the interests of the safe practice of dentistry. As the body tasked with protecting the health of the public, the Dental Board must act to protect that interest as its first priority, yet nowhere in the proposal is this aspect addressed.

The following are my reasons for NOT supporting this proposal.

1. **Team concept of dentistry**

The proposal would allow dental hygienists (DH), dental therapists (DT) and oral health therapists (OHT) to work independently and without a structured professional relationship with a dentist. This **goes against** the concept of a dental team approach. To quote the Board's own description at http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Guidelines-Scope-of-practice.aspx "*The delivery of dental care **involves a team approach** across different types of health care settings. Each division of registered dental practitioner provides dental health care that is based on their education, training and competence*." "*A team approach between dental practitioners is encouraged, so that patients are assured of receiving the most appropriate treatment from the dental practitioner who is most appropriate to provide it*." I support collaboration rather than separation.

2. **The problem of a "one size fits all" approach**

As stated by the Board itself at http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Guidelines-Scope-of-practice.aspx

- *The education requirement for a dental therapist is a minimum **two years** full time.*
- *The education requirement for a dental hygienist is a minimum **two years** full time.*
- *The education requirement for an oral health therapist is a minimum **three years** full time **bachelor** degree.*

In the case of dental therapists, a number of these trained in special dental training facilities set up by state governments, where all work was under the supervision of the dentist. This training of school dental therapists was outside the vocational education

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system but is parallel to the Australian Qualifications Framework at approximately AQF level 6, with the emphasis on practical knowledge and skills for work (being trained to a specific set of tasks) with factual, technical, procedural and some theoretical knowledge, limited to the prescribed duties for school dental therapy. There was a clearly stated need for referral to a dentist for complex cases. Dental therapists who trained in special dental training facilities set up by state governments were not trained in how to work in independent practice, with all of the additional information and skills that requires.
In the case of dental hygienists, some of these have trained in the vocational education sector at AQF level 6, under the same constraints as school dental therapists above, with training in a set of prescribed procedural skills, and a referral pathway to a dentist for complex cases. There was no training for independent practice.
Some dental hygienists are now trained in university-based AQF level 7 (Bachelor degree) programs, as are oral health therapists. This means that across the three groups, there is enormous variation in the level and complexity of training, from 2 or 3 years, and from AGF level 6 to level 7. **It is therefore not logical to apply a "one size fits all" approach to dental hygienists, dental therapists and oral health therapists.**

### 3. Lack of clearly defined pathways for collaboration, consultation and referral

The Board's proposal is silent regarding the need for pathways that would need to be well and truly in place IF such changes were to occur.

The situation with midwifery is the relevant case in point. Until 2004 there was no single, nationally consistent and evidence-based tool to assist midwives to make decisions about when to discuss care and/or consult with other midwives or to refer a woman's care to an obstetrician or other suitably qualified health practitioner. The Australian College of Midwifery (ACM) guidelines were developed collaboratively with various stakeholders, including with significant input from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. These guidelines are now in their third (2013) edition, and have been used for the past 14 years to inform their clinical decision-making. They are designed to be relevant in all midwifery practice situations, to ensure the highest standard of safe and collaborative maternity care. They are consistent with the scope of practice of midwives practising in the Australian environment as referenced by the Australian Nursing and Midwifery Accreditation Council and the Nursing and Midwifery Board of Australia.

Three key aspects of the guidelines are below. These three aspects are themselves based on the Australian Health Ministers' Advisory Council (2012) Clinical Practice Guidelines: Antenatal Care – Module 1, and the Nursing and Midwifery Board of Australia (2007) National framework for the development of decision-making tools for nursing and midwifery practice.

*Collaboration refers to all members of the health care team working in partnership with consumers and each other to provide the highest standard of, and access to, health care. Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision-making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe health care.*

*Consultation is the seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It is dependent on the existence of collaborative relationships, and open communication, with others in the multidisciplinary health care team.*

*Referral is the transfer of primary health care responsibility to another qualified health service provider/health professional. However, the midwife referring the consumer for care by another professional or service may need to continue to provide their professional services collaboratively in this period.*

*The achievement of collaboration and co-operation between the professional groups involved in maternity care is of major importance for optimal care. This involves recognition of the particular expertise found within the various groups of healthcare providers.*

Thus, for the proposed changes from the Dental Board of Australia to occur, the same piece of work would need to be done to cover dental therapy, dental hygiene and oral health therapy. This would be a significant piece of work to be undertaken, to resolve the many scenarios situations where a DT, DH or OHT as a provider in their interactions with a dentist would need to either:

- Initiate a discussion with a dentist in order to plan or coordinate the patient's oral health care.
- Consult a dentist so that the dentist can then evaluate the patient's oral care needs (e.g. because the patient has conditions that the provider is unable to diagnose or identify).
- Refer the patient to a dentist for care (because of complexity of the patient or the conditions present).

**In the lack of such detailed guidelines**, this would expose the public to an AQF level 6 person undertaking invasive and irreversible procedures, in patients with increasing complex medical conditions, without the required professional support to provide pathways for referral of complex cases.

ADOHTA in their Position Statement 10 point out that "*Dental Hygienists, Oral Health Therapists and Dental Therapists must ensure that they practise dentistry <u>with the level and type of support</u> appropriate to the clinical circumstances and patient needs. The dentist, specialist or group of dentists must be available and able <u>to provide clinical support</u> and consultation to the Oral Health Therapist, Dental Hygienist or Dental Therapist. The level and specific nature of this support will depend on what is required for the safety and well-being of the patient, the treatment being provided, the type of practice and the education and experience of team members. These are matters for the professional judgement of the practitioners involved and may vary from case to case*." In so doing, they reinforce the principles behind the team approach to dentistry, and the need for professional support.

## 4. <u>Greater risks for medically complex patients</u>

The aging of the Australian population and the increasingly frequent presence of multiple complex medical conditions and the use of multiple medications means that for safe practice, the ability to assess these factors and determine their impact on the provision of care is essential. This aspect is one reason why having the relationship

with a dentist is so important for the safe treatment of patients. Dentists are trained to assess the patient's medical status and have the background knowledge in general medicine and pharmacology to determine how treatment can be provided safely for those with complex medical conditions. Removing the structured professional relationship increases the risk of serious adverse health outcomes for patients. **As a specialist in special needs dentistry, this aspect is very well known to me.**

The Australian Qualifications Framework definitions https://www.aqf.edu.au/aqf-levels clearly identifies level 6 as being "paraprofessional". In the same way, in the dental literature, DH, DT and OHTs are referred to as mid-level providers. It is inappropriate to allow mid-level providers to work directly with patients in an independent relationship, undertaking invasive and irreversible procedures (including administration of local anaesthetic), without the support of the structured relationship with a dentist.

## 5. Confusion of members of the public regarding roles in the dental team

What different members of the team do becomes even more important when there is no structured professional relationship. This is a major issue for members of the public and for other health professionals.

Following the public release of the Board's proposal, an April 7, 2018 media release from ADOHTA entitled "*ADOHTA supports Dental Board proposed new rules to modernize dentistry*" stated that *"Dental therapists, hygienists and oral health therapists are trained in the same universities as dentists*." Some dental therapists, hygienists and oral health therapists are trained in the same universities as dentists, however others are trained at universities that don't train dentists (such as CQU in Rockhampton, RMIT in Melbourne, or the University of Newcastle), while some are trained in the vocational educational sector (such as TAFE SA at Gilles Plains).

What the ADOHTA statement overlooks is that the educational programs are not the same for OHTs and dentists, even when they are both educated at the same university. If one takes the skill set of an OHT at the end of their 3 years at university, and a dental student after 3 years at dental school, those are not the same. Typically, a dental student at the end of their third year can perform many additional procedures such as (not an exhaustive list)

- interpret a complex medical history including the medicines used by patients
- diagnose complex oral conditions
- read a cone beam image set
- undertake endodontic treatment
- place more complex types of restorations including those with layering
- understand how to select dental materials and how they work
- design a partial denture (and wax up dentures, and make special trays)
- manage a medical emergency, and
- work out what dental procedures can be done with the aid of RA, conscious sedation and GA.

This difference arises because what OHTs study during their 3 years of university is not the same as the curriculum followed by a dental student. There is some shared content in the first year of dentistry, but the strong biomedical science core of dentistry is not found in OHT, therapy or hygiene. **As someone who has taught in dental hygiene, oral health therapy and dentistry programs I know this aspect extremely well**.

During their second and third year, dental students cover topics that are not in the curriculum for DT, DH or OHTs, such as:

- advanced biosciences including immunology, microbiology, physiology and pharmacology
- head and neck anatomy including surgical anatomy
- oral medicine
- advanced radiology
- endodontics and dental trauma
- removable prosthodontics
- oral and maxillofacial surgery, and
- prescribing drugs and medicines

This means that a significant missing element of the DBA proposal is a clear document, readily understood by members of the public, as to the differences between dental team members. Such a document must clearly state that a DT, DH or OHT can **not** do complex dentistry including the diagnosis and treatment planning of adults with dental or orofacial pain, or orthodontic or prosthetic dental problems, or requiring oral surgery. These patient problems can only be managed by a dentist. Likewise, procedure such as endodontics, crown and bridgework, surgical extractions and soft tissue surgery, or dental implant therapy can only be undertaken and done by a dentist (this is an indicative rather than exhaustive list).

The reasons for this are that during their fourth year, dental students study complex periodontal therapy, dental implantology, surgical periodontics, maxillofacial surgery, oral medicine, paediatric dentistry, special needs dentistry, molar endodontics, fixed prosthodontics, occlusion, and orofacial pain. They develop skills in comprehensive treatment planning.

Thus, it is essential for the identities of the members of the dental team to be clarified, for members of the public, rather than confused.

## 6. Sub-optimal use of dental team members

The final point relates to how the Board's proposal could lead to sub-optimal healthcare. There are no net benefits to the Australian health system. The Board's proposal will neither increase affordable access to dental care, nor will it reduce costs of dental care. In fact, the cost of professional indemnity insurance for DH, DT and OHTs may actually rise. The past claims history of these practitioners could well change if problems occur at the fringes of the scope of practice boundaries. The baseline costs of running a dental practice – rents, utilities costs, and front office and dental assisting staff – are the same regardless of who works in the practice. Formal assessments of the cost benefits of dental therapists and OHTs in the USA did not show reduced costs. The most comprehensive assessment (conducted in the US state of Minnesota) reported "*no evidence that the emergence of dental therapists has resulted in cost savings to the state, more equitable distribution of dental health professionals, or improved access to care for low-income, uninsured, and underserved populations*."

When the concept of OHTs was being developed, a key consideration was bolstering the preventive and health promotion components of this new team member – adding to rather than replacing dentists. OHTs within the team can help drive a shift towards disease prevention, because virtually all dental disease is preventable. This is a major

reason to keep the current dental team structure that we have – a team that works, and where the roles are known and defined.

Although an OHT can deliver clinical treatment, particularly restorative services for children, the core of their education and their knowledge and proficiency is in oral health and public health promotion. The current health system does not avail itself of the health promotion services that OHTs are already educated to deliver. Oral health therapists, dental hygienists and dental therapists should focus on disease prevention, both in the clinic and in the community.

Sincerely

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