12th June 2013

To whom it may concern,

Re: Draft Scope of Practice registration standard and guidelines

I am writing to provide feedback on the recent draft scope of practice registration standard and guidelines.

The National Board has asked for feedback on the following questions:

1) Will the revision of the standard provide greater clarity and certainty for dental practitioners to work within their scope of practice?
2) Will the introduction of guidelines further provide clarity for dental practitioners and the public?
3) Are there additional factors that could be included in the guidelines?
4) Does the preferred proposal balance the need to protect the public with the need to regulate the profession?

Question 1 – Standards

In response to the first question, I do not think the revised standard has provided clarity or certainty for dental practitioners.

First of all, the term 'dental practitioners' implies that the practitioners are doctors. In the area of medicine, only medical doctors are called medical practitioners, and other health practitioners fall into the category of nurses or allied health practitioners. In the area of law, 'legal practitioners' refers to lawyers, not paralegals. The same principle should apply to dentistry. Only dentists and dental specialists should be called dental practitioners; other team members should be called allied dental practitioners. If all dental members were called dental practitioners, the general public would be confused

about the different roles and skills that each member possesses. In sum, the use of the term ‘dental practitioner’ for all dental related members (i.e. hygienists and therapists) is deceiving.

Secondly, if the Board was to recognise the clinical leadership of dentists/dental specialists in a dental team (as suggested in the draft scope of practice point 3, under the section of requirements), then the word ‘supervision’ should not be removed in the description of dental hygienists, dental therapists and oral health therapists. Without use of the term ‘supervision’, the general public may mistakenly believe that dental hygienists and therapists can practise independent of dentists, and practise in all area of dentistry. How would the public possibly know whether the practitioner is qualified to provide certain treatments?

Under point 5 of the requirements in the draft scope of practice: **‘Dental hygienists, dental therapists and oral health therapists are members of the dental team. They practise in a range of activities included in the definition of dentistry which they have been formally educated and trained. They may only practice within a structured professional relationship with a dentist. They must not practise as independent practitioners.’** This proposed change has removed use of the term ‘supervision’. In my opinion, it is necessary to retain ‘supervision’ to reflect the leader-team member relationship between dentists and other team members. Again, the suggestion that dental hygienists and therapists can ‘practise in a range of activities included in the definition of dentistry’ is a misleading statement, as it implies that they can provide all types of treatment. The same problem exists in the amendment of the description of dental prosthetists.

The definition of ‘structured professional relationship’ in the draft scope of practice does not add any extra clarity to the existing standard.

In summary, the revised standard provides no extra clarity and certainty compared to the existing standard. The proposed change may lead to more confusion for dental practitioners and the general population.

Question 2 – guidelines

The aims of the proposed guidelines are to: 1) provide a description of the dental profession; 2) set out the standard of education and training requirements for oral health therapists and dental therapists; 3) clarify the changes in National Board approved programs which may extend a practitioner's range of practice. However, I do not think the draft guidelines achieve these aims or assist the standard in providing better clarity and certainty.

The descriptions of the dental profession are inaccurate, imprecise and misleading.

First of all, the guidelines ignore the importance of continuing professional development (CPD) courses. It is written in the guidelines that:

Within each division, registered dental practitioners must only perform dental treatment:

a) for which they have been formally educated and trained in programs of study approved by the Board, and

b) in which they are competent.

The CPD courses provide an excellent opportunity for practitioners to update and/or learn new skills even though the Board has no current accreditation system for CPD courses. If the new standard was to restrict practitioners to only performing treatments that are featured in 'programs of study approved by the Board' i.e. mainly university degrees and postgraduate courses, then there would be no practitioners willing to take on CPD courses and learn new skills. The word 'competent' is confusing, as it is such a subjective term. Section b should be eliminated.

I suggest point 2 should be rewritten thus:

Dental practitioners must only perform dental treatment for which they have been formally educated and trained in programs of study approved by the Board, or CPD courses that are compliant with the National Board CPD registration standards and guidelines.

In the section 'Dental practitioner divisions', it is stated that dental hygienists can provide treatment to patients of all ages, '**[t]his includes periodontal/gum treatment, preventive services and other oral care**'. What does it mean by other 'oral care'? Oral care services can be any type of treatments or services that promote better oral health.

In the section 'Dental therapists', it is stated that dental therapists can provided treatment including '**restorative/fillings treatment, toot removal, oral health promotion, periodontal/gum treatment and other oral care to promote healthy oral behaviours**'. Tooth removal can be simple extraction of deciduous teeth or adult teeth, sectional removal, or surgical removal of teeth. The guidelines should state which type of tooth removal dental therapists are allowed to perform.

In section 2 of the guidelines under the heading 'Education and training requirements for the treatments of patients for all ages', the Board is considering extending the scope of practice of dental and oral health therapists. The following questions should be considered carefully:

1) Knowledge in all aspects of dentistry is required to decide whether a restoration is simple, or merely appears simple. Do the therapists have the ability to differentiate between simple and complex restorations?
2) If the restoration turns out to be more complex than anticipated, do the therapists have the ability and knowledge to manage such situations e.g. providing immediate root canal treatment?

3) Do the therapists have any training in removable and fixed prosthesis? Unless therapists have sound knowledge and training in making fixed and removable prosthesis, they should NOT be treating patients with such problems.
4) If therapists are to treat medically compromised patients or polypharmacy in the adult population, shouldn't they have extensive knowledge in medicine and pharmacology? I believe this is not currently covered in the oral health or dental therapist program.

The guidelines provide details on how to assess a simple direct restoration. As mentioned above, it is extremely difficult to predict the complexity of restoration. Restorative and endodontic dentistry often overlap and practitioners must have extensive knowledge in both areas in order to manage an emergency situation. It is risky and irresponsible to allow therapists to provide restorations without adequate training.

Under section 3, it is proposed that the scope of practice for dental hygienists, dental therapists and oral health therapists be extended to include external tooth whitening, limited orthodontics treatments, direct restorations for adults, and stainless steel crowns. All of these treatments require advanced knowledge in dentistry, including tooth development, growth of children, a range of treatment options and basic crowns and bridges procedure, as well as medicine. Unless the hygienists and therapists have training in medicine and all aspects of dentistry – which may require an extra two years of university study – they should not be allowed to provide such treatments. The guidelines also propose that the scope of practice for dental prosthetists be extended to include implant retained overdentures, immediate dentures, and intra-oral appliances to manage sleep apnoea and snoring. Again, dental prosthetists do not have sufficient knowledge of implant dentistry and sleep medicine to provide such treatments. In terms of conscious sedation, dentists and dental specialists should not require the specific endorsement of the Dental Board, but should have undergone training that is approved by the Board.

If the Board was to standardise and enhance the quality of CPD courses, the Board should have official program to assess the CPD courses. As mentioned earlier, CPD is a valuable tool for dental professionals to update and learn new skills. CPD courses should be recognised as a type of formal training, and dental practitioners should be allowed to practise the knowledge and skills they learn from CPD courses.

In conclusion, the proposed standards and guidelines do not provide clarity and certainty for dental practitioners. These documents reflect an overly simplistic view of dentistry and fail to understand the interconnection of each type of dental treatment. They also fail to recognise the compulsory years of medical and dental training a professional must dedicate himself/herself to in order to provide safe and high quality dental care. The draft standard and guidelines will cause confusion if all team members are called dental practitioners. The attempt to remove supervision of dental hygienists and therapists, and to extend the scope of practice for dental hygienists and therapists, will simply cause further misunderstanding and loss of public confidence in the dental profession. There is no clear distinction of roles and responsibilities for dental hygienists, dental therapists and oral health therapists. The existing hygienist, therapist and prosthetist training programs lack extensive coverage of medicine and dentistry. As a result, allied dental practitioners do not have the ability to provide the extended treatment as proposed.

Question 3 – Additional Factors

In response to question 3, the following additional information should be included:

- A clear and precise outline of the educational and training program required for each division of dental practitioners should be attached to the standard. This is to ensure that the general public understands the differences in education, training and qualifications in each division.
- The age limit of patients that can be treated by dental and oral health therapists varies in different States and Territories. This should be clearly stated in the standard.

- If the National Board is to allow therapists to treat patients of all ages, then the Board needs to explain how they will add extra education and training to the existing programs in the guideline. The National Board also needs to explain how the training of dental prosthetists would equip them with adequate knowledge and training to provide implant over-denture and appliances for sleep apnoea.
- The guidelines should explain the role of CPD courses and whether CPD courses are approved programs that can extend the scope of practice for dental practitioners. This is a significant grey area at the moment.
- If the Board is to remove the 'supervision' restriction on dental hygienists and therapists (and is planning to remove the condition of a structured professional relationship in the future), the separation of liability should be carefully addressed in the guidelines, i.e. the principal dentist should no longer be liable for treatment carried out by hygienists or therapists. This is likely to increase insurance premiums for hygienists and therapists.

Question 4 – Protection of the public

In response to question 4, I think this preferred proposal does not provide any better protection for the general public than the existing standard. In fact, if dental hygienists, therapists and prosthetists are allowed to provide treatment in areas in which they have negligible training, this will have an adverse impact on the dental health standards of the community. The public would be very confused by all these divisions and overlapping roles. This proposal also does not improve the regulation of the dental profession, and it simply creates more grey areas.

In my opinion, the National Board should retain the existing scope of practice. The revised version is no better than the existing one.

Kind regards,

Dr Mandy Liu