



**AUSTRALIAN DENTAL  
ASSOCIATION INC.**

**Australian Dental Association Inc.**

**With**

**Australian Dental Association (New South Wales Branch) Limited**

**Australian Dental Association (NT Branch) Incorporated**

**The Australian Dental Association (Queensland Branch)**

**Australian Dental Association South Australian Branch Incorporated**

**Australian Dental Association, Tasmanian Branch Incorporated**

**Australian Dental Association Victorian Branch Inc.**

**Australian Dental Association (WA Branch) Inc.**

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**Draft scope of practice registration standard and guidelines**

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**19 JUNE 2013**

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**Draft Scope of Practice registration standard and Guidelines Submission**

**Authorised by**



**Federal President**

**Endorsed By**



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President ADA NSW**



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President ADA NT**



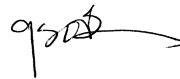
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*BDS*, *MDS* (*OralMed OralPath*), *MRACDS* (*Oral Med*), *FRACDS*, *FICD*  
President, Oral Medicine Academy of Australasia

13 June 2013

Mr Robert Boyd-Boland  
Chief Executive Officer  
Australian Dental Association Inc.  
14-16 Chandos Street, St Leonards NSW 2065  
PO Box 520, St Leonards NSW 1590

Dear Robert,

**Re: DBA's review of the Scope of Practice Standard and Guidelines.**

Thank you for the opportunity to view the Australian Dental Association submission in response to the Dental Board of Australia's Scope of practice Standard and Guidelines.

As an Affiliate of the Australia Dental Association, and the peak body representing oral medicine in Australia and New Zealand, the Oral Medicine Academy of Australasia agrees with the content and position of the submission.

Sincerely,



Anastasia Georgiou



The Dental Board of Australia

18 June 2013

The Australian Society of Implant Dentistry (Inc) fully supports the Australian Dental Association (ADA) submission in response to the DBA's review of the Scope of practice Standard and Guidelines

If you have any queries please don't hesitate to contact me on [gunyahdental@bigpond.com](mailto:gunyahdental@bigpond.com)

Thanks and best regards

Tony Collins AM BDS BA Mast Clin Prac (Implants) FASID FICOI

Federal President, ASID (Inc).



The Dental Board of Australia

The Australian Society of Periodontology (Federal Branch) fully supports the Australian Dental Association (ADA) submission in response to the DBA's review of the Scope of practice Standard and Guidelines

If you have any queries please don't hesitate to contact me on [president@asp.asn.au](mailto:president@asp.asn.au).

Thanks and best regards

Vijay Tumuluri BDS MSC(Med) MSc FRACDS (Periodontics)

Periodontist, Specialist Clinical Associate, The University of Sydney.

President of the Australian Society of Periodontology (Federal Branch) 2012-2014.

## Draft Scope of Practice registration standard and Guidelines Submission

### Introduction

The Australian Dental Association Inc. (ADA) welcomes the opportunity to further contribute to the development of the revised Dental Board of Australia's (the Board) Scope of practice registration standard (the Standard) and draft *Guidelines – Scope of practice registration standard* (the Guidelines).

The ADA understands that the impetus for the review is the request from the Australian Health Workforce Ministerial Council (Ministerial Council) that the Board assess whether the current Standard has had any unintended and negative impacts on the scope of practice of dental hygienists, dental therapists and oral health therapists.

With the release of the "Scope of practice review – Oral Health Practitioners" report by Health Workforce Australia (HWA Report)<sup>1</sup> the Ministerial Council also requested the Board to provide advice to Ministers on scope of practice and new models of care and training as part of its review of the Standard.

The ADA has been extremely disappointed that the feedback provided by the Association in relation to this matter has been substantially ignored. Therefore, many of the comments previously made are repeated in this submission.

As the peak body representing dentists in Australia the ADA strongly urges the Board to consider carefully the views of the Association. The Association has consulted its members and its affiliate societies extensively to ensure that the views presented here are those of the profession. For example, a recent survey of members conducted at the Australian Dental Congress held in Melbourne in April 2013 indicated that 98% of dentists surveyed would not support the Board's proposed removal of the requirement for supervision of allied dental practitioners [ADPs].

It is worth reporting one particular conversation that occurred at Congress. This is a common story that is reported to the ADA.

*A current dentist student who was asked to complete the survey indicated that he was currently registered as a dental hygienist with an additional qualification in dental therapy. He remarked that he was surprised that the Board would seek to remove the requirement for supervision because, as a current ADP, he did not feel confident that his training had prepared him to work without supervision. More importantly, he commented about how little detail had been provided in his initial qualifications, in comparison to the depth of knowledge incorporated into his dentist training programme.*

The ADA also receives regular calls from members and the general public seeking advice on what ADPs can and cannot do in the clinical environment. Below are some examples of the type of enquiries that are received on a regular basis.

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<sup>1</sup> Health Workforce Australia 2011, Scope of Practice Review – Oral Health Practitioners

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Dentist: *“I am intending to employ a dental hygienist, dental therapist or oral health therapist and am seeking advice on what I can allow a dental therapist to do. Before national registration, the state act provided advice on what duties they could perform. The current information from the Board is vague and provides no guidance and I am relying on the individual to tell me what they can do.*

*I have checked the university website but none of them have the same curricula and it seems that their scope of practice is different depending on where they are trained.”*

Dentist: *“A patient has refused to pay for an examination performed by my hygienist. The hygienist tells me that they are trained to do examinations. Where can I find out if they are trained to do this or not? The scope of practice standard on the Board's website does not provide advice on the types of things they are competent or registered to perform.”*

Parent: *“Can you please advise me if it is correct that a dental therapist can remove my son's tooth without him ever having seen a dentist? I have worked in the dental industry for many years and I do not believe that this person has adequate training to perform this type of treatment. Also can she do this without my son having seen a dentist?”*

The ADA represents almost 15,000 stakeholders, 80 % of whom work in the private sector. Many of these practitioners work within structured professional relationships with ADPs. The proposed changes as worded have the potential to deconstruct these existing structured professional relationships.

In deconstructing the team to its component parts the provision of seamless appropriate dental services for patients is lost. It is clear that HWA has been given information that did not adequately deal with the complexities of the provision of dental services and has formed what we believe is an erroneous and misguided position in relation to ADPs. In doing this one of the aspects of that same report was to assist the public to understand the roles of the various dental practitioners. Under the Board's proposed changes, the public have no assistance in determining their own needs and then relate them to a service provider appropriate for those needs.

There is no support from within the profession for the changes proposed.

Therefore, of the options presented in the Consultation paper, the ADA supports option 1 and as outlined below, there is capacity for the Board to provide further guidance on the interpretation of the Standard.

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### HWA Report

Given that the HWA Report has been used as the catalyst for the proposed changes to the Standard this submission will also provide details of the ADA's concerns with the findings of the HWA Report.

The HWA Report is neither balanced nor objective, and is based on assumptions that are grossly incorrect. There can be no doubt that the HWA Report was prepared with a predetermined objective in mind. The methodology and analysis provided to justify the findings and recommendations were unscientific, biased and flawed.

A desired outcome seems to have been identified and, by the use of selective data and supposition, the report has attempted to justify the recommendations made. In particular, attention is drawn to the following deficiencies in the HWA Report:

#### 1. Non engagement with the Australian Dental Council

The approach said to be taken to the project included consultation with the community, dental professionals, peak bodies, government providers, regulatory bodies and dental educational institutions. The described approach creates the impression that the project team left no stone unturned in seeking to understand fully the extent of the issues being considered. This was not the case.

For example, the HWA Report does not list the Australian Dental Council (ADC) among the groups it consulted. Had the ADC been consulted, the project team would have discovered that the requirement for supervision of such personnel is founded in the knowledge that their education and training is limited. To have not consulted with the ADC and recognise this key element of supervision demonstrates a fundamental flaw and undermines any recommendations made.

#### 2. Methodology adopted.

The review adopted an unusual methodology.

Firstly, the survey sought to gather information from two cohorts, dental health professionals and consumers. The response rate was extremely low (n=702) as a percentage of all registrants (n=19769). The survey responses from dental professionals were predominantly from dental therapists, dental hygienists and oral health therapists and therefore not representative of the dental profession, which is made up of 80% dentists.

Secondly, most consumers are unlikely to know the difference between the scope of practice of a dental hygienist and a therapist (dental or oral health). In many cases, consumers think they are being treated by a dentist and thus would be unable to provide informed comment in the survey. This theme of confusion in the minds of the public will underpin some of the key recommendations of the ADA in this submission.

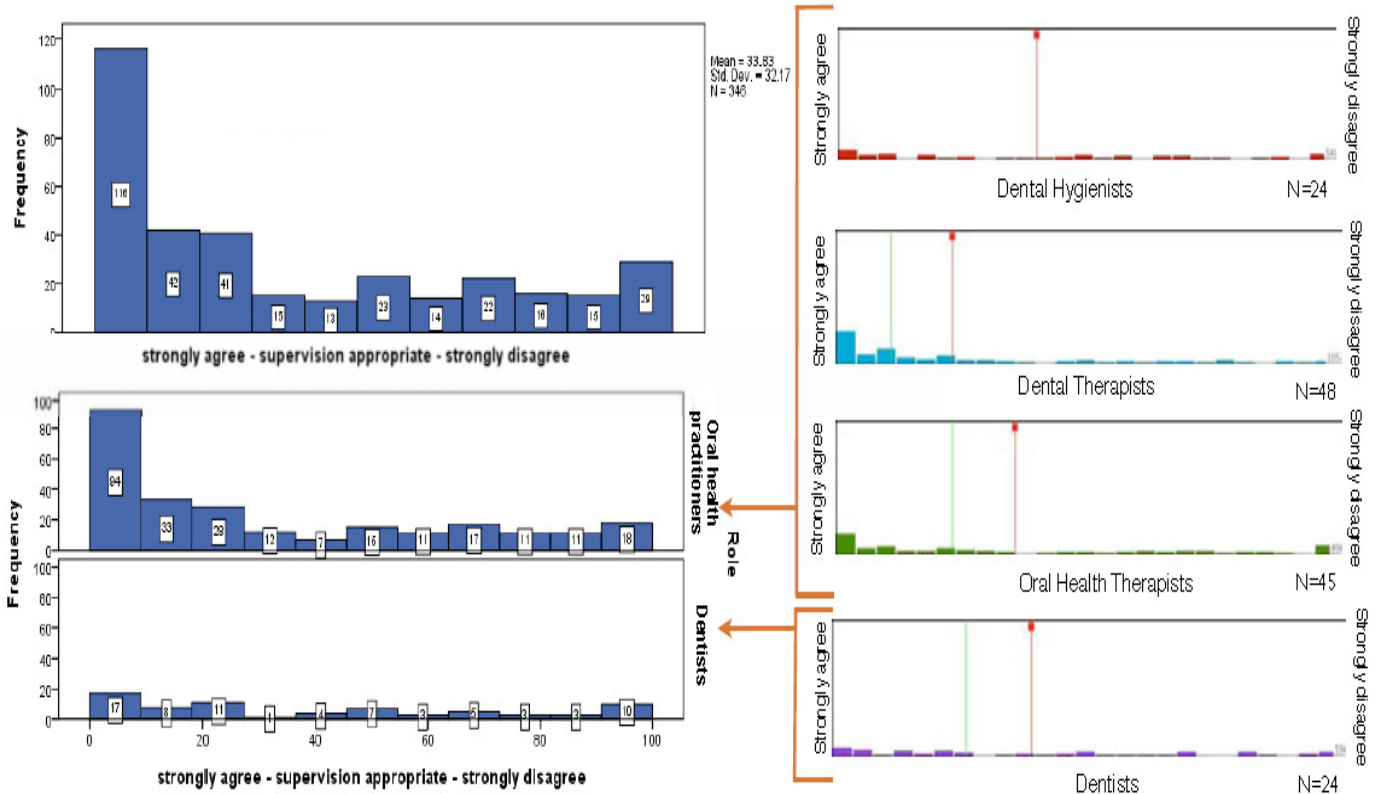
Furthermore, the conclusions in the HWA report are not consistent with the results of the survey conducted. For example, the graphs shown on page 48 of volume 2 of the HWA Report, which HWA has failed to publish on their website, in response to the question "*Is the current level of supervision I give or receive adequate for the services I deliver?*" clearly shows that the majority of dental practitioners, including dental hygienists, dental therapists and oral health therapists, think that their level of supervision



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is appropriate. As this HWA report is being used as evidence to support the removal of the supervision requirements from the registration standard, HWA should have reported this as a finding of the study.

**Dyad 6: The current level of supervision for oral health professionals I give or receive is appropriate for the services I deliver?**



Source: Scope of practice review – Oral Health Practitioners. Volume 2: Oral health workforce scope of Practice study – Narrative Analysis Report

If the Board is conducting a review on the premise of the HWA report then the Board must undertake further analysis of the survey findings so as not to be influenced by a conclusion which does not reflect the findings.

**3. Incomplete literature review**

The literature review undertaken as part of the project (Volume 3 of the HWA Report - also not yet published by HWA) was strongly biased to papers that supported the use of ADPs.

The ADA was invited to contribute relevant material to this process and did so. However, having provided a series of papers to be considered these papers were not referred to in the final report, possibly because they provided only qualified support for use of ADPs.

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Where contrasting research has been reported, the literature review provided only selective quotes, all of which supported the predetermined outcome and recommendations. Therefore, little credibility can be given to the report's findings in these circumstances. If necessary, the ADA would be willing to make available to the Board the ADA's feedback on the literature review.

### 4. Workforce shortages

"Oral health practitioners", as defined by the HWA Report, represent 18.7% of the total registered dental practitioner workforce [dental hygienists (1267), dental therapists (1135), dually qualified and oral health therapists (1286)]<sup>2</sup>. Dental Prosthetists, although not captured in the HWA Report, represent a further 6%. The remaining 75.3% of registrants are dentists. Yet the recommendations in the HWA Report give the impression that as a result of the new national registration standard, the scope of practice of ADPs is limited and this is having a significant impact on the delivery of oral health services to the Australian community. Supposed limitation of scopes of practice of less than 20% of the workforce cannot realistically impact significantly upon delivery of care. There is no logic to this claim and it is an unsubstantiated claim for which no evidence has been produced.

Further, the HWA Report assumes a shortage of dentists and ADPs is impacting on dental care delivery.

This is not correct. In their report, HWA rely on the 2006 workforce data from a report by the Australian Institute of Health and Welfare Dental Research Unit (AIHW DRSU) to justify workforce shortages<sup>3</sup>. A further report, available from the AIHW DRSU during the time the HWA Report was being prepared, reported that there had been an increase in the supply of dentists in the decade to 2009 from 46.9 to 54.1 practising dentists per 100,000 population, with a very substantial increase of 40% in remote/very remote areas<sup>4</sup>.

The HWA Report also claims that ADPs are often more available in rural and remote areas and that increasing their scope of practice will address any shortfall in those regions.

This suggestion is based on two false assumptions:

- a) That an oral health practitioner can replace a dentist, and
- b) That there is a shortage of dentists in Australia.

Any suggestion that ADPs can provide the same overall level of service and care to patients as dentists ignores the significant differences in education and training between dentists and ADPs.

Since the 2006 data was released, there has been a significant increase in the number of dentists entering the workforce both from Australian dental schools and through the Australian Dental Council pathway for overseas qualified dentists. There has also been a concurrent and significant increase in the number of graduates from ADP programmes.

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<sup>2</sup> Registration Data Table – March 2013. Dental Board of Australia available at <http://www.dentalboard.gov.au/About-the-Board/Statistics.aspx> - accessed 14 June 2013

<sup>3</sup> Australian Institute of Health and Welfare Dental Statistics Research Unit: AIHW (2011). Oral health practitioner labour force projections, 2006–2025: research report series no. 52. Canberra: AIHW. [DEN 209]J

<sup>4</sup> Chrisopoulos S & Nguyen T 2012. Trends in the Australian dental labour force, 2000 to 2009: Dental labour force collection, 2009. Dental Statistics and Research Series no. 61. Cat. No. DEN 218

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There is now compelling evidence of an oversupply of dentists, and hence no shortfall exists to justify the expansion of scope of another provider<sup>5</sup>.

The particular premise upon which the HWA Report has based its workforce shortage conclusion is not founded in fact, and hence any conclusions and recommendations are not credible and must be ignored.

The real issue is one of accessibility, particularly for remote and very remote areas and more critically for Indigenous communities. This needs to be addressed by all levels of government through adequate funding of oral health promotion and prevention in the first instance, and until there is such a commitment, the oral health of Australia's population will not improve. By investing in the oral health of future generations from an early age (as is being attempted in the "Grow Up Smiling" (GUS) Scheme), there will be a reduction in the demand for oral health services in the future. This highlights the continuing importance of prevention, which is the very role for which ADPs were developed.

### 5. Diversity in educational preparation

The HWA Report provides some commentary on the education and training of ADPs. However, it does not disclose the fact that most of the registered dental hygienists and dental therapists have been trained under a different model of education to the current one. While the current programme is set at a baccalaureate level, dental therapist education and that offered for dental hygienists have been, and in some cases are still provided, at advanced diploma level. The Report is silent on this significant issue, and on the historical nature of the development of the two modalities as briefly outlined above.

The ADA supports the HWA Report's call for greater clarity and prescription of duties by the Board. As it currently stands, the revised Standard proposed under Option 2 will do nothing to clarify the skills and competencies of ADPs. In fact it is likely to make things even more confusing for ADPs, employers and more importantly, patients. The Board is not implementing the changes required to meet the HWA recommendations 2, 3 and 4. The ADA proposes that the scopes of practice listed later in this submission be used to provide direction as to the duties of both groups. This fulfils recommendations 2, 3 and 4.

### 6. Supervision

The Consultation paper indicates that the Board is seeking views on particular issues and poses a number of questions. The next section responds in turn to each of the questions raised.

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<sup>5</sup> Insight Economics: Review of Dental Workforce Supply to 2020. Available at <http://www.ada.org.au/members/Publications/adapubmem.aspx>

**Draft Scope of Practice registration standard and Guidelines Submission****QUESTIONS IN CONSULTATION PAPER****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.

Clarity is essential from the perspective of both practitioners and the public. This can only be achieved if there is clear specification of the scope of practice. Broad non-specific terminology defining scope, based upon attributes and competency can only create greater uncertainty. Individual teaching institutions have differing competencies, and this serves to increase the lack of clarity of permitted scope of practice.

The ADA understands the issues faced by the Board when developing the Standard in that the exit qualifications and competencies of ADPs from different institutions have been, and to some extent currently are, quite different. Education providers should ensure their programmes produce graduates with uniform competencies and attributes.

Any notion of confusion in the current Standard has been manufactured by those with a political agenda and used as an argument to effect change. If one examines the arguments about the so-called lack of clarity, they stem solely from political motives to gain a back door entry to expanded scope of practice and independence despite a lack of proper academic training or qualifications.

The Board seems to have accepted the arguments from groups representing ADPs that the standard is “confusing”. It is doubtful that a practitioner subject to a complaint could justify using a defence of “confusion” or not understanding the scope of practice standard. Further, for any type of practitioner to not have a clear understanding of the extent of their training and capabilities demonstrates that they are more of a threat to public safety. To provide further clarity for both health professionals and the public, there must be a prescriptive scope of practice included in the Standard, as was the case before national registration.

The inclusion of a definition of dentistry in the Standard does not provide greater clarity or certainty for dental practitioners, rather it introduces ambiguity. The extension of the scope of practice discussion to limit the practice of dentists is unnecessary and regressive. Further commentary on the definition is provided later in the document under “Proposed changes to the draft Guidelines”.

**Draft Scope of Practice registration standard and Guidelines Submission****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.

The Board seems to be advocating that there be a merging of the scope of practice between dental hygienists and dental therapists. A survey of privately employed ADPs conducted in 2009 by the Queensland branch of the Australian Dental Association indicates that dental hygiene services constituted 80% of the services provided by ADPs in the private sector.

Clarity and certainty are required if the public is to have confidence in the respective skills of dentists and ADPs. The draft as provided by the Board goes some way to achieve this, and the ADA's suggestions create the certainty required. Without this clarity, the potential remains for ADPs, dentists and patients to misinterpret their scope to the detriment of public safety.

Additional material using plain language statements is required to demonstrate to the public:

- The role of the dentist as a clinical team leader,
- The difference in qualifications between dentists and ADPs,
- Details about the difference between dentists and ADPs,
- Advice to the public about how to determine if the practitioner has formal education and training in a particular area of practice
- Accountability of each practitioner

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

Yes.

The modifications suggested by the ADA provide the solution as to how the guidelines can support the Standard and thus provide the degree of certainty and clarity required to best serve the interests of ensuring safety and quality in health care delivery.

In relation to the matter of protection of the public, and the issues raised pertaining to training, scope of practice and supervision, the following points need to be considered:

- The additional Guidelines as written do not clarify either to practitioners or the public the differences in services provided by the practitioners and who is most appropriate to provide the service, and the fact that the education of ADPs, when considered in light of the Australian Qualifications Framework, is insufficient to prepare them for any degree of increased scope of practice and lack of supervision.

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- 4. Do you agree with the list of skills in the guidelines relating to programmes to extend scope? Are there additional skills which the National Board should consider adding to the list?**

No.

The protection of the public is paramount.

If an allied dental practitioner wishes to practise with increased scope of practice and no supervision, then they need to train as a dentist.

There can be no argument for the Board to support the changes being considered.

It is inappropriate for political pressures to allow the Board's role to be compromised in any manner.

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

No.

The Board's proposal eliminates the current public protection afforded by the current standard, and effectively will deregulate the profession to the detriment of public safety.

The inclusion of dentists in the proposed extension of scope erodes established practices and fails to recognise the principles of a dentist's education, which provides the requisite foundational knowledge empowering dentists to identify and introduce innovation, techniques, procedures, materials and technology in a cost effective and safe manner.

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**ADDITIONAL COMMENTS IN RELATION TO THE CONSULTATION PAPER**

**Potential benefits and costs of preferred option**

The Board suggestion that there will be no additional costs to dental practitioners or the public as a result of the changes to the existing standard is incorrect.

Allied dental practitioners currently experience the benefits of reduced professional indemnity (PI) premiums because of the requirement for them to be supervised by a dentist.

The current supervisory requirements are recognised by insurers when developing professional indemnity premiums. For example, one of the largest providers of professional indemnity insurance to dental practitioners calculates the premiums for dental hygienists based on the knowledge that the supervising dentist will be vicariously liable for actions of the hygienist. This has resulted in the professional indemnity insurance premiums for dental hygienists being significantly lower than that of dentists.

Under the proposed changes, any dentist working in a structured professional relationship will seek to restrict their indemnity cover to exclude any vicarious liability for the ADP and to ensure that their cover is reduced to take account of the independent cover that will be required of the ADP. Rather than achieving a saving this alteration will impose an additional significant financial burden on the ADP.

Increases in costs for indemnity cover will be passed on to patients in the long term.

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### PROPOSED CHANGES TO THE DRAFT SCOPE OF PRACTICE REGISTRATION STANDARD

While supporting retention of the current Standard (Option 1 – no change to the current Standard), Option 2 can only be considered if the changes and recommendations outlined in the next section of this submission are adopted. In addition, the ADA has made a number of recommendations as to how the Guidelines should be altered to reflect a revised Standard. These changes are proposed with public safety in mind.

The ADA proposes that the following text replace the current wording at relevant points. Explanations about the proposed changes to the Standard are outlined further in the section on the Guidelines.

#### Requirements

1. *Dentists and/or specialist dentists work as independent practitioners who may practise all aspects of dentistry. Where there is a structured professional relationship or referral relationship then the dentist and/or specialist dentist is the clinical team leader.*
2. *Allied dental practitioners (dental hygienists, dental therapists, dental prosthetists and oral health therapists) are members of the dental team who work within their particular areas of education, training and competence, to provide the best possible care for their patients.*
3. *Allied 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 preceding statements have been modified to recognise the distinction between the level of education of dentists and ADPs.

The introduction of clause 3(a) into the Dentists division would result in unwarranted restriction or constraint on the scope of practice of dentists and dental specialists. Within the Dentists division, unlike the other divisions within the dental profession, dentists and dental specialists are specifically trained to identify research, analyse and successfully introduce new materials, technology and techniques safely into their practice.

The following comment from an orthodontist demonstrates the unintended consequences of the changes on the practice of dentists as proposed by the original clause 3(a).



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*“If the restrictions on dental practitioners only performing treatments for which they were educated and trained applied to dentists and dental specialists, then I as an orthodontist, trained in the 1970s, would have to use bands and not bonded brackets, stainless steel wires and not modern wires; aligners, temporary anchorage devices or perform combined orthodontic and orthognathic procedures. This would also prevent me from teaching these techniques in a postgraduate programme in which I currently teach and my experience and expertise would be lost.”*

*Comment from a Practising Orthodontist*

4. *Dental prosthetists are members of the dental team. They work as independent practitioners in a defined range of activities.*
5. *Dental hygienists, dental therapists and oral health therapists are members of the dental team. They practise in a defined range of activities. They must only practise within a structured professional relationship with a dentist. Where there is a structured professional relationship or referral relationship then the dentist and/or specialist dentist is the clinical team leader. They must not practise as independent practitioners.*
6. *A dental practitioner must not direct any person, whether a registered dental practitioner or not, to undertake a dental service or provide advice outside that person’s education or competence.*

These revised points separate out the difference between a dentist who is educated to perform all aspects of dentistry and ADPs who have a defined range of activities. To leave it as it is currently worded does not provide any further clarity than the previous standard, and may add to confusion and have unintended consequences on the practice of dentists and dental specialists.

**Definitions**

*Independent practitioner means a practitioner who may practise without a structured professional relationship or workplace agreement.*

*Structured professional relationship means the arrangement established between a dentist\* and an allied dental practitioner (ADP\*\*) to provide professional advice, oversight, guidance and direction in relation to the management of patients. It provides the framework for the referral of patients from the dentist to the ADP and referral to the dentist when the care required falls outside of the scope of practice and/or competence of the ADP.*

\*Dentist includes specialist dentists or a group of dentists

\*\* ADP includes dental hygienist, dental therapist, oral health therapist, and dental prosthetists.

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### PROPOSED CHANGES TO THE DRAFT GUIDELINES

The Guidelines should act as a plain language statement to assist the public in understanding the various roles within the dental team as already exists in the current practice environment. Consistent with the views expressed earlier in this submission, the following revised text to the Guidelines is recommended to achieve this outcome.

#### Description of the dental profession.

*Where there is a mix of practitioner types in a clinical setting then a team approach, with the dentist as the clinical team leader, is required so that patients are assured of receiving the most appropriate treatment. The Board expects that the level and specific nature of the dental care provided will depend on:*

- *what is required for the safety and well-being of the patient*
- *the treatment being provided, and*
- *the type of practice and the education, experience and competence of team members.*

*While each individual dental practitioner exercises autonomy within their scope of practice, it is the supervising dentist who is responsible for the decisions, advice and treatment that is provided.*

The existing Standard supports the notion of team care arrangements because it carefully delineates the levels of responsibility in a structured hierarchical manner. The current demand for ADPs is for prevention orientated services.

The proposed changes to the standard have the potential to deconstruct the existing team concept. As mentioned previously, this is a matter of public safety, and no amount of word-smithing of legislation can alter the fact that ADPs are not dentists and hence are unable to practise in the manner proposed.

#### Other legislative /regulatory frameworks

*In addition to complying with the scope of practice requirements set by the National Board, services provided by dental practitioners may be further defined in accordance with workplace agreements. Practitioners must also comply with other regulatory requirements.*

#### Dental Practitioner divisions

##### Dentists

*Dentists work as independent practitioners and may practise all aspects of dentistry.*

*Education and training leading to registration must be to degree level in a programme conducted by a tertiary institution in the higher education sector and accredited by the Australian Dental Council (ADC).*

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### Specialist Dentists

*Dentists must undertake additional formal education, research and training to be recognised as a Specialist Dentist. Specialist dental training must be of at least three years additional duration and should be consistent nationally.*

The ADA recommends that the Board review the Dental Specialist Registration Standard to reflect this requirement.

### Dental Hygienists

*As part of the dental team dental hygienists provide oral health assessment and limited examination, treatment, management, and education for the prevention of oral disease to promote healthy oral behaviours to patients of all ages. This includes periodontal (gum) treatment, preventive services and other oral care. Dental hygienists must work within a structured professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate dental hygienist to be registered is a minimum two-year full-time or dual-qualified three-year full-time formal education programme.*

*The duties of a dental hygienist should be directed towards oral health education and the prevention of dental diseases, including dental caries and periodontal disease.*

*Treatment services provided by a dental hygienist must be provided in accordance with a written treatment plan which has been signed and dated by a dentist who has personally examined the patient, and:*

- such treatment plan shall be effective for not more than 12 months; and*
- the need for a further examination of the patient by the dentist after completion of the treatment plan by the dental hygienist will depend on the needs of the patient, the treatment provided and the experience and competency of the dental hygienist.*

*The range of duties which a dental hygienist is permitted to perform includes:*

- a. established procedures associated with chair side assisting and practice management;*
- b. oral health education;*
- c. instruction in monitoring and recording of plaque control routines and recording of periodontal disease;*
- d. prophylaxis;*
- e. polishing of restorations;*
- f. fluoride therapy, application of remineralising solutions and desensitising agents;*
- g. debridement to remove supragingival deposits from teeth;*
- h. debridement to remove subgingival deposits from teeth;*
- i. application and removal of rubber dam;*
- j. application of non-invasive fissure sealants;*
- k. taking of alginate impressions other than for the fabrication of prosthetic appliances;*
- l. removal of periodontal packs;*
- m. taking of dental radiographs;*
- n. orthodontic band sizing;*
- o. removal of orthodontic appliances including orthodontic cements and resins;*
- p. placement and removal of non-metallic separators and alastic modules; and*
- q. administration of local anaesthesia by infiltration and mandibular nerve block.*

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The inclusion of generic descriptors such as those listed above will satisfy recommendations 2, 3, 4 & 5 of the HWA Report as outlined in the Board's consultation paper.

### Dental prosthetists

*Dental prosthetists work as independent practitioners in the assessment, treatment, management and provision of patient removable dentures; and flexible, removable mouthguards used for sporting activities. The education requirement for a recent graduate dental prosthetist is at least a three-year full-time formal education programme (including a dental technician course).*

*Dental prosthetists must be formally educated and trained in a programme of study approved by the National Board. They may construct various types of intra-oral appliances, and may only provide patient removable prostheses for the purposes of replacing missing teeth, and mouthguards for protection against sporting injuries. They may construct, but not provide, prostheses supported by implants.*

The revised statement above has been rewritten to reflect the clinical issues which are beyond the scope of dental prosthetists and which are implicit in the training of dentists. This is discussed in further detail later in this submission.

*The range of services which a dental prosthetist may provide includes:*

- a. fabrication, provision, maintenance and repair of complete and partial patient removable dentures, and*
- b. fabrication and provision of mouthguards,*

The inclusion of generic descriptors such as those listed above will satisfy recommendations 2, 3, 4 & 5 of the HWA Report as outlined in the Board's consultation paper.

### Dental therapists

*Dental therapists provide oral health assessment, treatment, management and preventive services for pre-school and school aged children. This includes a limited range of restorative treatments, primary tooth removal, additional oral care and oral health promotion. Dental therapists must only work within a structured professional relationship with a dentist and/or specialist dentist. The education requirement for a recent graduate dental therapist to be registered is a two-year full-time or dual-qualified three-year full-time formal education programme.*

*The range of duties which a dental therapist may perform should be restricted to prevention of dental diseases and control of dental caries in pre-school and school children namely:*

- a. established procedures associated with chair side assisting and practice management;*
- b. oral health education;*
- c. oral health examination;*
- d. taking of dental radiographs;*
- e. application and removal of rubber dam;*
- f. pre- and post-operative instruction;*
- g. irrigation of the mouth;*
- h. fluoride therapy, application of remineralising solutions and desensitising agents;*

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- i. debridement to remove deposits from teeth;*
- j. taking of alginate impressions other than for the fabrication of prosthetic appliances;*
- k. application of fissure sealants;*
- l. direct coronal restoration of primary and the permanent teeth of school children;*
- m. pulpotomies in vital primary teeth;*
- n. administration of local anaesthesia only by infiltration and mandibular nerve block; and*
- o. forceps extraction of primary teeth under local anaesthesia.*

The inclusion of generic descriptors such as those listed above will satisfy recommendations 2, 3, 4 & 5 of the HWA Report as outlined in the Board's consultation paper.

### Oral health therapists

*Oral health therapists are dual qualified as a dental therapist and dental hygienist and can provide the range of services as detailed above. However, the core of their education and knowledge is based in oral and public health promotion<sup>6</sup>. They must only work within a structured professional relationship with a dentist and/or specialist dentist. The education requirement for an oral health therapist to be registered is a three-year full-time bachelor degree formal education programme.*

The inclusion of generic descriptors such as those listed above will satisfy recommendations 2, 3, 4 & 5 of the HWA Report as outlined in the Board's consultation paper.

### **Definition of dentistry**

The ADA does not support any reference to a definition of dentistry within the Standard or Guidelines.

The definition of "restricted dental practice" was included in section 121 of the National Law to ensure that only registered practitioners can perform these acts. However, activities related to the practice of dentistry are broader than the list of restricted practices referred to in the National Law.

The ADA believes that a definition is not required as it is important that dentistry continues to encapsulate the wider scope of dental practice and the potential for growth and development of the profession in response to changing models of care, new technologies, treatment modalities and the burden of oral disease.

To place a definition in the Standard may potentially restrict the utilisation of other dental personnel. For example, dental assistants with Certificate IV qualifications are skilled in the application of dental radiography and digital dental photography techniques. The inclusion of the proposed definition of dentistry in the Standard would not permit this and may therefore have unintended consequences beyond the registered dental practitioner workforce.

The ADA supports the use of all members of the dental team in the provision of services to patients and therefore recommends that the Board does not include a definition of dentistry in the Standard.

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<sup>6</sup> Int J Dent Hygiene. DOI: 10.1111/j.1601-5037.2012.00564.x Ford PJ, Farah CS. Oral health therapists: what is their role in Australian health care?

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### Education and training requirements for the treatment of patients of all ages

The Board has outlined what it believes should be the uniform, minimum standard of modalities to be taught and assessed for dental therapists and oral health therapists to practise dental therapy on persons of all ages.

This section will respond to the proposed modalities.

Underpinning these comments is the view of the ADA that:

- a. Education and training of dental hygienists should be directed to preventive services;
- b. Education and training of dental therapists/oral health therapists should be in alignment with the need for simple restorative treatments in pre-school and school age children, and
- c. All patients should be examined by a dentist prior to treatment by an ADP.

### ***“Extension of clinical restorative skills to the provision of simple direct tooth restoration in the adult patient”***

The demand for dental therapy services is in the government sector and in particular, for dental care of pre-school and school aged children. The proposal to expand the scope of practice of ADPs into areas of more complex restorative treatment and exodontia, does not meet demand. There is therefore no justification to expand the scope of practice of ADPs into these areas of practice.

The scope of practice should be limited to pre-school and school aged children only in line with their current education and training. This is consistent with the demand for dental therapy service in the government sector.

The Guidelines go on to provide a list of suggestions as to what constitutes a simple direct tooth restoration as opposed to one which requires the attention of a dentist. This list includes the suggestion that a simple direct tooth restoration is one that has four surfaces or less, does not include cusps or require pins or complex retentive features. This is not easily assessed from the outset so should not form a basis for an ADP scope of practice.

Similarly, the Guidelines suggest that a simple restoration is one that does not involve the pulp when assessed radiographically. Again, experienced dentists and specialist endodontists cannot assess pulpal involvement of a tooth just from radiographic assessment alone; so an ADP will not be able to make this decision based on radiographic evidence alone.

The ADA is also concerned about advice that suggests that a simple restoration is one that is easily accessed and simple to isolate at the gingival margin. This cannot always be assessed accurately pre-operatively and often manifests itself into a much more complex restoration.

Under the principle of patient centred care a practitioner should not commence treatment they are unlikely to complete. To have a requirement that every patient undergo radiographic examination before commencing a filling (to ensure caries is well clear of the pulp) is also contrary to patient centred care.

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The role of the dental therapist was specifically created to focus on the delivery of preventive services and dental care for children, and their education and training reflects this. While some of the services provided to children and adults may be similar, the dental treatment of adults is far more complex than the treatment of children. Treatment of adults requires significant diagnostic skills and involves a wide range of dental treatments to overcome problems presenting in adulthood that do not exist in children.<sup>7</sup>

The educational preparation and training required to produce a practitioner with the skills, competence and knowledge for this type of potentially complex diagnosis and treatment would be equivalent to that required to produce a dentist. If this treatment is to be provided, it should be confined to the practitioner with this level of training - the dentist, who can also deal with any complications as they arise.

With the current oversupply of dentists entering the workforce from Australian programmes and overseas universities there is no workforce imperative to support such an expanded scope of practice.

***“development of clinical judgment skills in identifying those teeth which require simple direct restoration and those which must be referred for more complex care”***

The Guidelines provide a list of suggestions as to what constitutes a simple direct tooth restoration as opposed to one which requires the attention of a dentist.

As previously indicated a direct restoration which presents as what might appear to be a simple procedure can be anything but “simple”.

Example 1:

Given the Board defines a simple restoration as being of 4 or less surfaces, all too often an occlusal carious lesion in a permanent molar can present with a mesio-distal fracture line. This often requires the removal of cusp[s] and/or can easily lead to pulpal involvement. It is inherently reckless to expect the ADP to restore such a tooth and it is inherently inappropriate for the patient not to have the procedure dealt with efficaciously “there and then” by a dentist.

Pulpal involvement with "simple" buccal pit caries is not uncommon especially in the elderly and often may involve the pulp [nerve] of the tooth necessitating root canal treatment or extraction. Root canal treatment is entirely out of the scope of practice of ADPs and extraction of such teeth eroded by decay can be extremely challenging.

To not complete the treatment in the above 2 cases, as would happen under the care of the dentist, and ensure the patient is pain free and does not require an extra appointment, defeats the entire objective of providing patient centred dental care.

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<sup>7</sup> The Scope of Practice of Oral Health in Dental Hygiene, Dental Therapy and Oral Health Therapy: A Literature Review-September 2011. Nash DA. Journal of Public Health Dentistry 70 (2010) 259–261 © 2010 American Association of Public Health Dentistry 259



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Example 2:

Anterior teeth often have 4 surface restorations that can become very difficult.



**Diagram 1**



**Diagram 2**

Both restorations are deemed '4 surface' and may or may not have required pins for retention. Permitting this to occur at the hands of an ADP, outside the ADA's proposed 'structured professional relationship', is plainly unsafe and not in the interests of the patient. The decision whether to use pins for added retention in most cases cannot be made before the restoration form has been cut. To allow an ADP to cut such a restoration and then find it cannot be completed is inherently unfair on the patient and is not the expected standard of care patients should receive. The Board will be encouraging such practices in the expanded scope of practice being proposed.

Example 3:

Whilst diagrams 3 & 4 are of 5 surface restorations they could have started as a "simple" restoration. The same principle applies for 4 surface restorations. The complexity of the restoration in diagram 4 compared to the one in diagram 3 is significant yet both of the above would be deemed 5 surface restorations.

Diagram 5 shows that pin retention is required to successfully restore the tooth. The decision as to whether to use pins is rarely made before the cavity form has been cut. To not complete the restoration is inherently unfair to the patient and a significant waste of time. This raises significant productivity and cost issues.



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**Diagram 3**



**Diagram 4**



**Diagram 5**

***“development of knowledge in management of patients with fixed or removable oral prostheses”***

There is no definition of “management”. The expectation for an ADP to have “knowledge in management” from a full denture to a partial denture to removable implant supported prosthesis to a fixed-implant prosthesis is unrealistic. The potential for mishap is substantial. Early recognition of the required treatment modality, as in all aspects of dental care, is vital if problems from inappropriate treatment planning are to be avoided. ADPs do not have the requisite skills to provide these services.

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**Diagram 6**



**Diagram 7**



**Diagram 8**

The examples above in diagrams 6, 7 & 8 are of one form of removable implant retained prosthesis. Long term prognosis is critical and dependent upon the correct initial diagnosis and treatment planning, the correct alignment and surgical placement of the implant fixture and then ensuring the correct maintenance and care for long-term enduring outcomes. To expect ADPs to be doing this is unrealistic and unsafe.



**Diagram 9**



**Diagram 10**

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Diagram 11



Diagram 12

The above illustrations (9-12) provide a small sample of different attachments used for removable implant retained prostheses. Early recognition of failure or wear of components is critical and can be extremely costly to repair if not recognised early.

With the all too common "tourist dentistry" that is occurring, myriad components are being used, and to expect ADPs to be managing these cases is unrealistic.



Diagram 13



Diagram 14

When fitted the prostheses in diagrams 6 and 14 look identical. The type of implant, the number of implants, the position of the implants, the method of fixation of the abutments to the implant[s] and the superstructure used all vary. The success of these cases is not just the "overdenture", and to assume that ADPs will have the same expertise as dentists is naive.

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Diagram 15



Diagram 16

Diagrams 15 & 16 illustrate a prosthesis that is more difficult to remove but this prosthesis is removable. It is not designed for the patient to remove. When the access holes are filled with the same colour material as the base, this prosthesis looks remarkably similar to those in diagrams 6 & 14. As with all implant prostheses treatment planning, care and maintenance are critical for longevity.

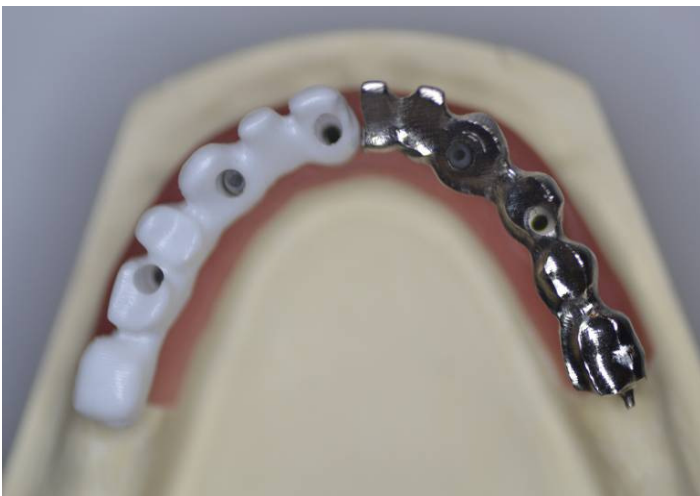


Diagram 17

Diagram 17 shows another 2 different frames of very different materials - one obviously a metal alloy and the other all ceramic. These are also deemed removable but not intended for the patient to remove. The finished prostheses on these frames will look similar to those in diagrams 6, 14 & 16 yet are fundamentally different and require very different management.

All of the above prostheses, if not managed expertly, can lead to premature failure with significant biological as well as financial cost to the patient. To allow an ADP to be involved in the fitting of the final prostheses overlooks the consequences of failure, not to mention the important issue of responsibility for the failure. The professional indemnity issues are very significant and cannot be overlooked.

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### ***“development of knowledge in the identification and the preventive management of root caries”***

If the intent is to allow ADPs to restore such carious lesions then this is well beyond the expected scope of practice for ADPs as they represent very challenging restorations with very frequent endodontic and periodontal consequences.

### ***“management of medically compromised patients”***

The safety of the public must be paramount in the Board’s deliberations in this area. To expect some simple add-on course for ADPs to enable them to cope with medically compromised patients in an unsupervised practice environment places ADPs in an untenable position, and this situation is unsafe for patients. The potential liability ramifications are considerable.

### ***“recognition and identification of oral pathological conditions in the clinical situation”***

Given the Board itself recognises Oral Pathology and Oral Medicine as specialist disciplines, to place this upon ADPs with the limited undergraduate exposure to this area is placing substantial burden for an add-on course. The training programmes of ADPs do not cover the depth of knowledge in the clinical sciences, and in particular oral pathology, to allow them to adequately recognise, diagnose, identify and manage complex oral pathological conditions. The expectation that ADPs will gain competency in the recognition of oral pathological conditions by a simple add-on course is unrealistic.

The concerns for patient welfare and "missed" diagnosis will be significant and is likely to have liability ramifications.

### ***“recognition of polypharmacy in the adult population”***

The safety of the public must be paramount in the Board’s deliberations in this area. Understanding the interactions of various drugs, the complexity of diseases being treated by medication and the impact both the diseases and medication have on the jaw and teeth is fundamental to be able to provide appropriate treatment and care for the adult patient.

During their university training, dentist students cover the supporting biomedical sciences in physiology, pharmacology, biochemistry and clinical therapeutics to ensure that they can both prescribe and identify the dental implications of medications, potential interactions between medicines the patient is taking and any drugs that the dentist may use or prescribe.

ADPs do not have the biomedical science background of the dentist to effectively recognise and understand the significance of polypharmacy.

## **Extension of scope of practice**

The ADA approves of this discussion and the defining of skills and competencies for ADPs. The fact that the Board is consulting on this matter in this manner supports the ADA’s contention that the scope of practice of ADPs should be defined as a list of skills or competencies.

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Range of skills covered in programs to extend scope	
Extension of scope	Division of dental practitioner
Local anaesthesia/analgesia	Dental hygienist <i>The ADA supports this extension</i>
Periodontal diagnosis and instrumentation skills	Dental therapist <i>The ADA supports this extension but only if dental therapists upgrade their skills in this domain through a one-year dental hygiene programme. Training is already available to acquire these skills in courses such as those available at TAFE, SA.</i>
External Tooth whitening	Dental hygienist, dental therapist, oral health therapist.  <i>The ADA does not support this proposed extension of practice and advocates that only dentists should use tooth whitening (bleaching) agents incorporating hydrogen peroxide at concentrations exceeding 3% or carbamide peroxide exceeding 9%.</i>  <i>Hydrogen peroxide is the active bleaching agent in professionally applied dental bleaching products. The effective concentration of hydrogen peroxide varies greatly from concentrations as low as 3% for whitening toothpastes to 35% in some office-based bleaching products. WorkSafe Australia’s current guidelines designate hydrogen peroxide at concentrations above 5% as a hazardous substance.</i>
Limited orthodontic treatments	Dental hygienist, dental therapist, oral health therapist  <i>The ADA does not support the expansion of duties beyond those listed previously. There is no existing evidence to support the need for, or safety of, extension of scope beyond those duties.</i>
Direct simple restorations for adults	Dental therapist and oral health therapist  <i>The ADA does not support this extension of practice.</i>  <i>The ADA advocates that the scope remain restricted to pre and school aged children. There are no rigorous longitudinal studies to confirm evidence of long-term efficacy or evidence for the need for this extension of scope.</i>
Stainless steel crowns	Dental therapist, oral health therapist.  <i>The ADA only supports this extension of practice to pre and school age children on the prescription of a dentist.</i>

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Range of skills covered in programs to extend scope	
Extension of scope	Division of dental practitioner
Implant retained overdentures	<p>Dental prosthetist.</p> <p><i>The ADA does not support this expansion.</i></p> <p><i>Long term prognosis is critical and dependent upon initially the correct diagnosis and treatment planning and then ensuring the correct maintenance and care for long term enduring outcomes. See previous comments regarding diagrams 6 -17.</i></p>
Partial dentures	<p>Dental prosthetist.</p> <p><i>The ADA only supports the construction and fitting of partial dentures by prosthetists in healthy dentitions where the prosthetist has undergone specific training and has demonstrated competency in their construction and fitting.</i></p> <p><i>Further extension would need to encompass education in full examination and management skills, which are beyond the parameters of an add-on course.</i></p>
Occlusal splints	<p>Dental prosthetist</p> <p><i>The ADA does not support this expansion of scope.</i></p> <p><i>Evidence based dentistry supports the current concepts that occlusal splints are not appropriate treatment solutions for many conditions. When used as part of a diagnosed temporomandibular condition, care must be taken to ensure its design is optimal as inappropriate design will contribute to changed occlusal conditions.</i></p> <p><i>Additionally, such patients have complex bio-psycho-social conditions, and management must involve a wide variety of strategies. Recognition of the complications often requires specialist <b>prosthodontist</b> intervention.</i></p>
Immediate dentures and immediate additions to existing dentures	<p>Dental prosthetist</p> <p><i>The ADA does not support this expansion of scope.</i></p> <p><i>Dental prosthetists are not trained to provide full examinations, diagnose and manage teeth which may require extractions. ADA policy advocates that dental prosthetists may construct immediate dentures and make immediate additions to existing dentures. The denture must be fitted by the dentist performing the extraction for haemorrhage control, patient convenience and best outcome.</i></p>



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**Range of skills covered in programs to extend scope**

Extension of scope	Division of dental practitioner
<p>Intra-oral appliances to manage sleep apnoea and snoring</p>	<p>Dental prosthetists</p> <p><i>The ADA does not support this extension</i></p> <p><i>Sleep apnoea devices can have significant morbidity issues. Strict adherence to advice and prescription from respiratory physicians is necessary. ADA policy is that dental prosthetists can construct sleep apnoea devices on the prescription of a dentist or dentist specialist but not fit them.</i></p>
<p>Conscious Sedation</p> <p>*Note: this requires a specific endorsement from the Dental Board of Australia</p>	<p>Dentist and specialist dentists</p> <p><i>The ADA does not support the inclusion of this extension in this format as it is currently covered by the registration standard on conscious sedation endorsement process already established.</i></p> <p><i>The ADA has been a strong supporter of the endorsement requirement.</i></p>
<p>Cone Beam Computed Tomography</p>	<p>All</p> <p><i>The ADA does not support the expansion of scope for allied dental practitioners.</i></p>
<p>Radiography</p>	<p>All</p> <p><i>The ADA does not believe that there is any need to change current arrangements.</i></p>



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**CONCLUSION**

Patient centred and continuity of care are the founding principles of dental practice.

It has been widely claimed that preventive dental services is where the future demand will be for ADPs. The proposal by HWA for expanded scope of practice into areas of more complex restorative treatment and exodontia does not meet this demand. There is therefore no justification to expand the scope of practice of ADPs into these areas of practice.

Current undergraduate programmes leading to registration as a dentist provide students with these skills and knowledge on graduation. Furthermore, a dentist is not restricted by the complexity of the disease process or the extent of treatment required. This allows for multiple treatments to be provided in a single visit.

Even with the more recent introduction of a Bachelor of Oral Health programme, which produces a graduate able to practise as a dental hygienist, dental therapist or oral health therapist, such programmes produce a graduate with only a subset of knowledge and skills. This programme of study has now condensed two courses, which were previously two years in length, each into one 3-year course.

The depth of knowledge that can be imparted in such a short time period cannot compare to five-year undergraduate or four-year post graduate programmes. While ADPs have been shown to deliver effective safe and quality services to patients, there are limits to the depth of knowledge and technical skills they achieve during their education and training. The regulatory environment prior to the introduction of national registration recognised the limitations of these practitioners and required them to work under the supervision of a dentist. Most dental practitioners still believe these supervision arrangements are appropriate.

Dental therapists, dental hygienists and oral health therapists are not a homogenous group. As indicated earlier, the majority of ADPs were educated and trained within the VET sector. Previous state and territory dental legislation recognised the limitations of their education and training and required them to work under supervision. To make a broad sweeping decision that they can work without supervision does not take into consideration the disparity in competence, skills and training and ignores the role of the Board in the safety of the public.

There is a need to separate the competencies of dental hygienists, dental therapists and oral health therapists. There is not and should not be a 'simple fix for all' as there will be some ADPs who will remain in a single division of the register. The Dental Board should set the 'minimum' acceptable standards.

The original request from the Ministerial Council to assess whether or not there had been any unintended and negative impacts on the scope of practice of ADPs has been completely overlooked. There is no evidence of unintended or negative impacts identified in the Consultation paper as a result of the existing Standard. Furthermore, claims by ADPs that there is uncertainty about their scope of practice provides further evidence of the need for a list of duties to be specified.

Therefore the ADA advocates Option 1.

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