Consultation on a proposed revised *Scope of practice registration standard* and *Guidelines for scope of practice*

Submission to Dental Board of Australia - Dr Terence K. Pitsikas AM

Dear Dr Lockwood,

I welcome the opportunity to make a submission regarding revised scope of practice registration and guidelines for scope of practice.

I am a general practice dentist in a group practice with 3 partners, 2 Associate dentists, 1 employee dentist, 3 dental hygienists, 2 dental therapists and 1 oral health therapist.

I have worked for dental health services and was dentist in charge of 2 mobile dental clinics serving very remote areas of rural WA, have had a private remote location practice and now currently in an inner city region general dental practice. I have in the past owned my own dental laboratory employing 2 technicians one of whom was registered as a prosthetist . I have been past ADAWA President on 2 separate occasions, have been on ADAWA council for over 20 yrs, have been an ADA Inc federal councillor for nearly 20 yrs and currently serve on the ADA In Executive committee. I have served and continue to serve as an ADA external representative on several committees in the past and present including DVA, ACQSHC, HWA and NOHPMG and have served on several ADA committees so I feel that I have the ability to make some comments based upon my experience and evidence.

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

i. I believe the 2013 review was a retrograde step to what was on offer in 2010 and what is proposed under option 2 is even worse. My understanding was that the primary role of the DBA was the safety of the public. This has gone by the wayside and self interest groups and public service provision of dental service seems to have driven the DBA direction in the past and current review.

ii. The introduction of the Structured Professional Relationship [SPR] was the most significant outcome that has proven very successful within the profession and been widely acclaimed by all who participate in it. I have attached the SPR used within our practices as an example -Attachment 1.

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

The current system has some issues, none of which are resolved by the proposed Option 2.

i. The bundling of all registered dental providers and dental practitioners has proven to be an issue to both the public and the profession. You do not see nurse practitioners or mid-wives bundled as medical practitioners. The DBA has created confusion within the profession and created issues that ought simply not be there due to the ill founded decision to bundle them all together. There is no protection of title and quite simply the public do not have a clue if it is a dentist, dental hygienist [DH], dental therapist [DT], oral health therapist [OHT] or prosthetist that provides the care. Those already with independent practice ie prosthetist have with deliberate intent misguided the public and have used "'Dr" and even "Professor" as a nominal in some cases that I am aware.

ii. The DBA and the ADC have been delinquent in their role of protecting the public. The roles and attributes and competencies for each registrant category read almost identically, The competencies for DT and OHT are exactly the same yet are 2 different registrants with 2 different qualifications. The public and the profession have no idea as to what procedures they are registered to provide. The DBA and ADC have deliberately for reasons best known to themselves not listed the specific duties of care. The UK,USA, Canada and all countries that have Auxiliary Dental Providers [ADP] all list the specific duties of care.

iii. The public have no idea if ADPs can treat adults and what services they can provide to them. The DBA has allowed expanded duties of care for some to be under 18, under 25, over 25, adults. The whole concept of ADPs was for the treatment for school aged children . With no evidence of benefit both in terms of cost or standards the DBA has changed registration standards and competencies. . Neither the public or the profession understand why?

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

Not at all. In fact the very opposite.

i. The SPR was the most useful result of the 2013 review. It helped clarify the relationships between the various levels of registration . This is now being removed - why?

ii. The benefit of the SPR was that the ADPs could practice autonomously in private practice - this will be destroyed with Option 2.

iii. The obscure defining of competency and services permitted for each level of registration have not been addressed - why?

iv. The public safety is being put at risk- why?

v. The proposed reflective tool is pathetic and endangers the safety of the public.

vi. The role of CPD seems to have taken the place of bonafide qualifications. This was something the DBA was completely against. This is going to create problems with competencies.

vii. The DBA makes reference to cost savings with expanded scope. I am not aware of any cost benefit analysis done in Australia or overseas that supports such a comment. The analysis I have seen done overseas was that they did not offer the cost benefit suggested and in many cases were more expensive than previously. The only ADPs in Australia

viii. The DBA has made comment on workforce issues and improved access to dental services. The HWA reports do not support such a statement. Based on what evidence is the DBA making this conclusion. The HWA emphatically stated -

- Workforce projections conducted by HWA indicate extra capacity exists within the oral health workforce
- seven alterntaive workforce planning projection scenarios were developed, examining changes in demand, immigration, the number of graduates, productivity and an existing workforce oversupply and undersupply. All scenarios presented the same result => that across the projection period the supply of the oral health workforce is projected to exceed demand

ix. The DBA will be aware that the HWA projection period was from 2013-2025. ie if the DBA stays with 3 yr reviews this report is applicable to the next 2 reviews and should have been considered in 2013

x. The DBA also makes comment about increased access in remote and very remote. I have practiced in these areas in WA and the only ADP with independent practice other than dentists are prosthetists. I am not aware of any prosthetist in WA that practices in a remote area that does not

already have a dentist. This has been the experience in the USA as well. ie the independent registration did not resolve remote access to dental care issues. In the states in the USA where this did result in practice in remote areas this was stipulated as the condition of the independent practice ie they could only practice in specified remote areas. The DBA has not provided any evidence to support the claim.

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

   i. Clearly list the dental services permitted in the competency of each registrant. As an employer of ADPs I should not have the ignominy of asking what their competencies are. They should be listed as part of their registration. This would also be helpful for the public it assess whether an appropriate provider has provided their care.

   ii. revert back to titles of registered providers ie remove dental practitioner reference to ADPs

   iii. keep current CPD guidelines

   iv. restrict DH,DT and OHT to treating school aged children as was the original intent

   v. respect the HWA report with respect to oversupply for all dental registrants

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

5 yrs is more appropriate. Time is better spent on more productive roles

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

The DBA makes comment on there being significantly less complaints against ADPs compared to dentists. Given that the ADPs are in a SPR and before that under the supervision of the dentists it would be expected that there would be very few complaints. This is bonafide evidence that the SPR works and protects the public. The premiums for indemnity insurance for ADPs is commensurately low because of this. This can only increase as the risk profile grows if independent practice grows

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

   It is pathetic and places the safety of the public at risk. It seems the DBA wants to abrogate itself of one of its major roles- why?

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

   Ability to assess the veracity of the assessment.

Attachment 1

Structured Professional Relationship

Allied Dental Practitioner

Full Name:

Position:

AHPRA Registration Number:

Contact Number(s):

Professional Indemnity Insurance details for ADP named above:

Category:

Amount: $20,000,000

Restrictions on practice (if any): NIL

Loading on policy (if any): NIL

Clinical Team Leader Dentist/Dental Specialist

Full Name:

AHPRA Registration Number:

Contact Number(s):

Additional Dentist/Dental Specialist 1

Full Name:

Practice Name:

Practice Address:

AHPRA Registration Number:

Contact Number(s):

Additional Dentist/Dental Specialist 1

Full Name:

Practice Name:

Practice Address:

AHPRA Registration Number:

Contact Number(s):

Full Name

Practice Name:

Practice Address:

AHPRA Registration Number:

Contact Number(s):

Scope and Operation

Duration

This framework will:

- commence on 11 November 2017 and finish on 11 November 2018

The Setting(s) in which the ADP services may be performed

Practice Name:

Practice Address:

Practice Name:

Practice Address:

Areas of Practice for ADP

Under this framework …….... .agrees to work within the following scope of practice:

[Please indicate which services you would like to provide]

- Oral health education
- Oral health examination
- Instruction in monitoring and recording of plaque control routines and recording of periodontal disease indicies
- Prophylaxis
- Pre and post-operative instruction
- Polishing of restorations
- Fluoride therapy, application of remineralising solutions and desensitising agents
- Debridement to remove supragingival and subgingival deposits from teeth
- Irrigation of the mouth
- Application of non-invasive fissure sealants
- Taking of alginate impressions other than for the fabrication of prosthetic appliances
- Taking of dental radiographs
- Administration of local anaesthesia by infiltration and mandibular nerve block
- Direct coronal restoration of primary teeth in children
- Simple extraction primary teeth in children.

A referral is triggered from the ADP to the Dentist/Dental Specialist if the treatment of the patient:

1. Is outside your education and training
2. Is not within your level of competency

3. Requires the guidance and advice of the dentist.

At the discretion of the dentist/dental specialist, a patient may be delegated by the Dentist/Dental Specialist to the ADP if treatment:

1. Is within the scope for which the ADP can properly exercise autonomous decision making
2. Requires services for which the ADP is adequately trained and competent, and
3. Does not require the involvement of the dentist.

Acknowledgement

On ……/……/…… I ……. acknowledge that I have read and understood this framework document.

I will use my best endeavours to work within the structured professional relationship described in this document.

x

(Signature of ADP)

x

(Signature of Dentist)