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Alpha Omega Dental Fraternity
Australian Society of Lingual Orthodontists

Monday 10 June 2013

Deliver to:-
dentalboardconsultation@ahpra.gov.au

Dear Consultation Committee at AHPRA,

Submission to the Review of
Scope of Practice Registration Standard

I am a registered orthodontist engaged in specialist private practice since 1989.

I commenced as a dentist in 1980 at DHSV and in 1984 I qualified as a children's dentist at the University of Melbourne after which I worked as a pedodontist at Royal Dental Hospital of Melbourne for two years. In 1988 I qualified in orthodontic training at Eastman Dental Hospital, Institute of Dental Surgery, University of London and became a registered specialist in orthodontics in Victoria three years later.

I have held professional association positions in Australia, such as ADA suburban group Chairman, and Vic State President of the Australian Society of Orthodontists.

I have employed dental therapists, dental hygienists and more lately, oral health therapists in my orthodontic practice for two decades.

I have provided "in-course" placements to students of the University of Melbourne, Bachelor of Oral Health Therapy (or courses in Dental Hygiene) in my practice for 10 consecutive years as well as having taught orthodontic photography at the BOH course for the same number of years.

TOPIC 1. – Registration Standard s –
a). Scope of Practice &
b). CPD (not allowed to improve Scope of Practice)

The present Scope of Practice Registration Standard applies equally to *dentists*, dental therapists, hygienists & oral health therapists. They must
"only perform those dental procedures: 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 present Continuing Professional Development Registration Standard applies equally to *dentists, dental therapists, hygienists and oral health therapists and it
"is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives".

However, the Board *disallows* CPD to be approved for improving Scope of Practice. This restricts the scope of practice for all practitioners, (whether dentists, or therapists or hygienists) to what was once learnt long ago, in courses of study approved by the Dental Board(s) or ADC. Because in practice, there are no courses approved by the Board, this is an unreasonable restriction which holds back practitioners' scopes of practice, to those of the past.

Practically the only *approved* courses are the original University training (although in the case of therapists, there are two other approved bridging courses dating back already six & seven years from today, and OHT3ACP which has highly limited access to relevant practitioners). In the past period and until now – for whatever reasons - there have been no Board Approved Scope-Widening Courses available to dentists and very few and limited ones for the other practitioners. The result is that the *Registration Standard relating to Scope of Practice conflicts with the intention of Registration Standard relating to CPD.*

Over a career of decades, (but much sooner than that), it is quite clear that all the approved original trainings will have become highly outdated, and will thereby fall below expected standards of practice.

While the CPD Standard of Registration mandates acquisition of knowledge (and most of the profession is following these good requirements), the AHPRA Scope of Practice Standard of

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Registration at the same time *prohibits* the use of that acquired knowledge in practice, at the expense of the benefit and the safety of the public. This is an illogical impasse, not only for dentists, but also for oral health therapists, dental hygienists and dental therapists.

In the real world of dentistry, CPD is the main way most dentists are improving their Scope of Practice and their expertise over long times. This is not meaning that they are honing an existing expertise they "learnt at school", but they are acquiring totally new expertise and putting it into practice. It is un-realistic to think that a very old dental training can be "expanded" or "stretched" with CPD to keep up with really new technologies without a real change in the scope of practice. CPD is the new training. The best example is the use of dental implants. Even the most experienced, most expert and most recognised specialist practitioners in the country did not learn implants "at school". It was all from CPD.

But this avenue for improvement through CPD is officially denied for usage by the current CPD Standard of Registration, applying to all dental practitioners. Looking ahead, it seems that the same hiatus of requirement for CPD together with restriction of usage will be embodied in the new standard. This is referred to in the current Draft of Scope of Practice Standard of Registration, intended to apply to hygienists, dental therapists, oral health therapists and dentists for the next five years.

Going by current Standards of Registration for CPD and Scope of Practice, the Board must go ahead to prosecute almost all registered dental practitioners who practice in ways learned through their CPD activities, where methods of practicing were not acquired in approved original, board approved courses of learning. There are myriad examples in ubiquitous use, apart from placement of Dental Implants. Just look at Cerec Restorations, the use of high-tech custom made therapeutic agents like Invisalign, Incognito, CBCT Radiography and dental scanning of the mouth or jaws for making therapeutic parts for jaw surgery. The list involves a huge swathe of restorative, periodontic, prosthetic and orthodontic techniques, now including 3D printing of thing made from scans, that have deep health implications and effects. Please ask yourselves when and where was the use of these practicing scopes taught in any University dental trainings, or any other courses approved by the ADC or any Dental Board? How has the Dental Board acted in relation to these ubiquitous and extensive putative offences? What evidence is there that public safety has been put at risk by these un-monitored activities? There is very little evidence of widespread malfeasance, which means we have a very good system, but I don't believe the way it is working is accurately embodied in the AHPRA standards.

Changes in dental practice are driven by advancing technology. Technology changes are adopted when they are recognised to bring improvements to standards of care, public safety or if they improve public access through productivity. However, universities (being the only significant sources of Board approved training courses) lack the resources that are required to acquire or teach most new technologies. The above situation means that for public safety ***there is a strong need to recognise a diverse range of Continuing Professional Development for all dental professionals and to allow them to legitimately include these learnings in their Scope of Practice.***

I am not advocating independence of therapists or fundamentally changing their scope of practice. Dentists must remain the clinical leaders. I am not advocating re-validation of training.

Therapists need to remain limited in their scopes, because they have not acquired an educational base that will enable them to become independent, wide scope practitioners. They have been trained for and need to work within a wider team with very close referral and consultation, if not supervision. My argument does not support therapists' becoming independent in their practices.

Proper Accreditation of CPD is needed

There is risk to public safety when CPD can widen scope of practice. The risk lies in the promotion of unsound practices by profit-driven and fringe educators.

This risk is probably the reason why CPD has been prevented from being recognised to increase scope of practice. Proper accreditation control of CPD approval is needed to minimise this risk.

TOPIC 2. - Scope of Practice Registration Standard

The Nature of the Relationship between the Dentist / Dental Specialist ("dentist") and the "Oral Health Therapist", "Dental Therapist", "Dental Hygienist" ("therapist")

The Oral Health Therapist, Dental Hygienist or Dental Therapist is a registered Dental Practitioner of limited training in comparison to a general dentist or dental specialist, but who is able to operate within a scope of practice that is limited in comparison to a dentist, and is a subset of a dentist's

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scope, in an appropriate and defined relationship with a dentist general or specialist. This relationship is not strictly a relationship of supervision, direction and control.

The nature of the relationship between the dentist & therapist for the Scope of Practice Registration Standard should be described as a:-
"Referral and consultative relationship within a team framework of care delivery, where the dentist or specialist dentist is the lead member of the dental care team".

Experience is gained during a mentoring / consultative / referral relationship with a more senior and more experienced and more educated dental practitioners, knowledge is gained and in a way that is similar to further education over a practitioner's career of life-long learning. Experience is gained through a practitioner's own practice. Scope of Practice is enhanced through both of these means the Scope of Practice Registration Standard needs to recognise this for all types of dental practitioners.

TOPIC 3. - Orthodontics

Mention of Orthodontics is omitted from the Draft Scope of Practice registration Standard in the section titled Education and Training requirements For the Treatment of Patients of all Ages.

Oral Health Therapists are trained in all of basic techniques performed in the delivery of orthodontic services and this fact needs acknowledgement.

The use the manpower of Dental therapists, Oral Health Therapists and Dental Hygienists, increases the availability of orthodontic services at point of service. It may possibly lead to reduction of cost of delivery of orthodontic services in Australia. Half of the families in Australia use orthodontic services and many of these services involve the hands of oral health therapists, dental therapists or dental hygienists, working within orthodontic teams.

Orthodontics needs to be specifically included in all the sections where other specialties of dentistry are included and mentioned in the Drafts relating to Scope of Practice Registration Standard.

I expect this information and viewpoint will be useful to the committee and I hope that they can agree with it to the point that it may be embodied in the adopted Standards.

Yours Sincerely,

Geoffrey Wexler.
Dr Geoffrey Wexler, Specialist Orthodontist
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