

Executive Officer
National Board of Australia
AHPRA
GPO Box 9958
Melbourne 3001

19th July 2013

Dear Sir/Madam

I understand that the scope of practice for dental auxiliaries is under review, and I write to express my concerns regarding details contained in the draft scope of practice registration standard and guidelines document dated 8th May 2013.

It is proposed to increase the scope of practice for hygienists, therapists, and oral health therapists. It is concerning that this increased scope is proposed concurrently with a decrease in the levels of their supervision. Supervision is essential not only to assess the complexity of treatment, but to also provide emergency management should an unforeseen event occur. Only the dentist or dental specialist has these skills.

For example, it is foreseeable that a pulp exposure may occur when a therapist is removing caries from an adult tooth, despite initial assessments indicating that the caries was relatively shallow. The therapist does not have the skill to manage this complication, necessitating referral back to the dentist and delaying management. Delay in management of this adverse event may result in salivary contamination of the pulpal tissues, increased chances that a well-executed direct pulp cap will not stabilise the tooth, increased chances that a tooth will require root canal treatment, and increased pain, discomfort, additional treatment and additional costs for a patient.

It is proposed that therapists will be able to provide fillings that are up to four surfaces in size, with no cuspal coverage, for adult patients. The size of the required restoration is to be estimated from radiographs prior to the patient being booked for the procedure. What will happen if a cusp is actually undermined and requires consolidation? The therapist will not have sufficient training and knowledge to be able to identify at-risk teeth in at-risk patients and thus many structurally compromised cusps may not be consolidated in a timely manner. This will increase the incidence of teeth fracture, subsequently requiring crowns or even extraction, and will increase the cost and burden of treatment for patients (or third parties) in the medium to long term.

Allowing therapists to manage "simple" restorations in deciduous dentitions and young adult dentitions is unlikely to increase the future treatment burden for patients. However, it is predictably foreseeable that extending the scope of practice to allow therapists to manage apparently simple restorations in more mature dentitions will increase the future treatment burden for patients (or a third party). It is these mature dentitions that present with more risk factors such as increased width of cavity preparations, parafunctional habits (both primary and secondary to altered medical conditions and medication regimens) and guidance involving posterior teeth

(as canine guidance has become group function). Increased scope places public dental health at risk.

Changes to the proposed scope of practice for dental prosthetists is also concerning.

Extension of the scope of practice to include implant retained overdentures undermines prosthetically-driven treatment planning. It is noted that patients are to be specifically referred to prosthetists by a dentist or specialist for this treatment modality, but it raises the question of who is planning the treatment? Diagnosis and planning is challenging in implant related cases, especially for the overdenture. It also raises the question of who is maintaining the treatment? Assessment and modification of occlusal forces improves treatment outcomes, and it is unlikely that the dental prosthetist will be sufficiently trained to achieve such understanding. So, who becomes responsible for such maintenance regimens? This is specifically concerning for patients with lower socio-economic status, who may seek possible reduced cost implant therapies through dental prosthetists. How would these patients respond when they realise the implant overdenture issue appointment is but the beginning of an extended maintenance regimen with a more specialised, and higher cost, practitioner?

Mandibular overdentures are often placed in our most frail patients, those with significant ridge resorptions, friable tissues and those who are medically compromised, commonly with polypharmacy. The two implant retained overdenture is not the standard of care for patients with mandibular edentulism, and care must be taken to ascertain why a patient is an unsuccessful denture wearer. Challenges with comfort and function often relate to non-prosthetic aetiology including parafunctional habits, reduced ability of compromised friable tissues to support denture loads, and reduced anatomical regions to provide support, to name a few. Implant retained overdentures, by definition, help retain a denture. They do not support the occlusal load; they do not address problems with support and secondary medical conditions. Additionally, implant placement options are often not ideal, and compromises must be made regarding prosthetic performance versus bone location. Although the treatment is to be overseen by a dentist or specialist, it is likely that important planning decisions will occur after the initial referral has been made to the dental prosthetist via the structured professional relationship. The choice of supporting components is also quite complex. One, two, three or four implants? Bars, balls or clips? Currently, with good patient selection, implant retained mandibular overdentures provide good outcomes with good cost:benefit for many patients, but increasing the scope of practice for prosthetists to provide such treatments, even under the direction of a dentist, is likely to result in overtreatment and inappropriate treatment, undermining patient care.

Maxillary overdentures have very high complication rates. Implant failure rates are reported to be over 10 times higher than for mandibular implant retained overdentures, and biological and mechanical complications are also equally high. This treatment modality should not be performed by any operator who has not undertaken additional university-based specialist training programmes.

Occlusal splint therapy is also an area of concern. 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, few conditions warrant the provision of an occlusal splint. However, when such a splint is required, care must be taken to ensure its design is optimal. It is known that occlusal splints with an inappropriate design contribute to changed occlusal conditions, such as anterior open bites and overeruption of posterior teeth. It is foreseeable that the incidence of such conditions would increase with a change in the scope of practice.

Additionally, such patients have complex bio-psycho-social conditions, and management must involve a wide variety of strategies, which often no longer includes occlusal splints. It is also foreseeable that overtreatment will ensue. Occlusal splints may become the first line of treatment, an easy solution when a patient with orofacial pain presents at a general dental practice, providing such a patient with a referral for a "budget" appliance. This would be inappropriate, and may well be more than detrimental.

Occlusal splints may also be indicated for protection of the dentition from destructive parafunctional loads. Such splints are designed as a sacrificial lamb, to be destroyed in-lieu of the dentition. However, this treatment also needs to be considered as part of an overall plan. An occlusal splint will only protect teeth from destructive loads when it is being worn, and that is generally for a third of the day (at night). Heavy loads will also occur during the day, and without an overall plan which may include alterations to the occlusal plane, changes to freedom in centric, reduction of cuspal angles, consolidation of at risk teeth, monitoring of weakened teeth, the patients condition will deteriorate. Rehabilitation would then incur much higher fees for those patients than would have been necessary if the appropriate monitoring, review and modification had been instigated at the beginning of treatment. Such ongoing review could be provided by the initial referring dentist or specialist, but we again run the risk of patients not being completely informed of the consequences of treatments and the importance of follow up. Patients may be lulled into a false sense of security, having been provided with a "set of crutches", and choose not to return to their dentist for additional management.

Immediate dentures are also an area of concern. The journey of the patient through this treatment regimen is confusing. Is it proposed that a patient would see the dentist for diagnosis, receive a referral to the prosthetist for records for an immediate denture, return to the dentist for the extraction, then return to the prosthetist for denture issue, then return to the dentist to review the healing socket? This is not "lean practice". Often patients requiring tooth removal and immediate dentures are medically compromised. Multiple treatments in multiple locations are not in their best interest. Any movement following oral surgery (for example, to relocate from the dental surgery to the prosthetist office) results in increased bleeding and swelling. Such swelling, causes pain, interferes with the seating of a denture, and it results in denture overadjustment and the additional costs of denture relining to amend such overadjustment.

Additionally, immediate dentures have multiple uses. They can be designed to condition and sculpt tissue prior to a definitive denture (or implant), improving the emergence profile from the gingiva and improving the appearance for patients. Will patients gain the benefit of tissue sculpting under the care of a prosthetist? The

dentures are also excellent haemostatic aids. Following extraction, bleeding is reduced by pressure, and thus delaying a denture issue compromises the formation of blood clots and may increase the incidence of post-operative complications.

Sleep apnoea devices are also an area of concern. I have seen multiple devices made by prosthetists, without sanction, which have resulted in block mobility of the patient's entire dentition. Such devices are associated with the onset of a number of problems such as temporomandibular conditions, increased decay susceptibility, and irreversible changes to the location of the dentition as teeth change position and growth continues. Such devices also have low efficacy. In the right circumstances, they can reduce the sleep apnoea condition by one level, for example, from moderate to mild. However, a mild sleep apnoeic patient still has sleep apnoea and care must be taken to ensure additional help is provided as part of an overall care plan for this patient. Provision of "budget" sleep apnoea devices runs the risk that patients will not have the opportunity to be informed about the adverse outcomes and limitations that can occur, and give them a false sense of security that their condition has now been cured.

The extension of the scope of practice to allow hygienists, therapists, oral health therapists and prosthetists to "work" with cone beam tomography is unclear. Is it envisaged that these operators can take the radiographs, request the radiographs or interpret the radiographs, or are they allowed to perform all of the above actions? It is unclear why these team members would have the need to request such a radiograph. These radiographs provide cross-sectional views and are often employed to review bony contours prior to implant placement planning, symptomatic endodontically treated teeth, unusual hard tissues identified on plain film and temporomandibular joint anatomy. The scope of practice is not increasing the duties of these team members in diagnosis of endodontically treated teeth, diagnosis of temporomandibular conditions, or investigation of possible pathology. Arguments have also been presented above regarding the involvement of prosthetists in implant therapies. There is no need to increase the scope of practice to include these modalities, and inclusion is likely to result only in overservicing and increased radiation exposure. It is unlikely to improve patient care.

Overall, the proposed changes increased the risk of overtreatment, poor follow up, increased future treatment costs and patient harm. It also increases the risk of patients making uninformed decisions, and finding that they then cannot afford to maintain the new treatments that have been provided.

I am of the opinion that the suggested changes to the existing Scope of Practice will jeopardise the current high standard of dental care that Australians enjoy. I would ask that the Dental Board of Australia reject these changes.

Yours Sincerely,

Danielle Layton

*Prosthodontist
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