



10 June 2013

Dear sir/madam,

I wish to make a submission with respect to the consultation paper titled "Draft Scope of practice registration standard and guidelines[1].pdf."

In answer to your particular questions raised on page 10 of the document, I offer the following:

- 1) I do not believe that the revision will provide greater clarity and or certainty for dental practitioners registered with the DBA to work within their scope of practice. I believe that the proposal requires more prescriptive terminology. The relatively recent yet generalised adoption of the term "dental practitioner" by the DBA to refer to a range of operators with quite separate skillsets and training levels provokes confusion. The common usage of the term "dental practitioner" has been in Australian terminology, synonymous with the protected term "dentist". The public has long understood this term to refer to dentists, not auxiliary practitioners nor independent prosthetists. To enable any of these groups to refer to themselves as "dental practitioners" will no doubt increase confusion and definitely mislead the public as to the particular skill sets held by a registered natural person. There are a number of terms introduced that have no common meaning and are so tenuously defined that a realistic interpretation would only be provided subsequent to a legal challenge in the application of the administrative law. I believe that plain language is not being used in the submission.

Indeed, the public has an entitlement that all advertising and promotional materials that specifically referenced scope of practice information when a person registered with the Dental Board of Australia published or caused to be published, information regarding their practice details. The definition of dentistry is incomplete: there is a complete absence of reference to dental implants – which forms a significant part of treatments provided by dentists.

The definition of dentistry should be tiered: the public would automatically associate the Board's definition with the protected term "dentist". There should be a definition of "Oral Health Practice". This could be a subset of the dentistry definition that is appropriate for a division but should not co-exist with the definition applied to dentistry. It would not be fair and reasonable to expect a member of the public to distinguish between the protected term "dentist" and the unprotected term "dental practitioner".

I believe that this is an unnecessary and unwelcome complication to the draft registration standards and may well be unintended. If the objective is to provide a more efficient and less confusing service to the public, the present draft is in need of significant revision.

In as much as the document's intended alterations would lead to public confusion, it would also lead to far less clarity in the interpretation of terminology contained within the document. The document should read so that the reasonable registrant would understand the terminology and hence their obligations whereas the present draft only creates further uncertainty and confusion.

- 2) I do not agree that the introduction of the guidelines adds to clarity. The interpretation of the existing guidelines with respect to the clinical practice of dentists and the supervision of other persons registered with the DBA has never resulted in clear definitions that a reasonable person could interpret with certainty. It is my understanding that the requirements of compliance with "supervision" would only be determined via a complaint directed to a responsible authority. While this suits certain stakeholders, it does not serve the public interest. I believe it adds further to the confusion of both practitioners and the public and does so in a manner in which a reasonable person would easily misinterpret the obligations of different registration categories and also in which a registered person could challenge the validity of some of the key terms. Given that the HWA has an intention to remove requirements for supervision in the longer term for non-dentist registrants, it should have a clear definition available so that all stakeholders can rightly gauge the

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correct limitations relevant to each registration group.

- 3) Additional elements that should be included in the guidelines to support the standard should be related to serving the public interest, rather than a subset of stakeholders. I believe that the DBA has an obligation, both in its own right and as a body answerable to AHPRA to set more conclusive terms in relation to practitioner obligations in training and experience related to performance of more complicated clinical procedures. At present, I believe that the DBA does not fulfil its responsibilities in this regard, particularly with respect to a virtual hands off approach to the question of CPD. I believe that the present lack of clarity in relation to the quality of CPD undertaken does nothing to clarify the obligations of registered persons, nor delivers any protection whatsoever to the public in terms of quality of care. The DBA should undertake a review of these aspects in order that the public's interest is protected. Other jurisdictions have a much more proactive approach to maintaining clinical and professional standards while also protecting the public interest. While I appreciate that the Board has had an overwhelming challenge to implement a national strategy, I believe that the present situation is untenable in the longer term and the proposed alterations fall far short of the direction necessary to achieve the suggested outcomes of the WHA and the statutory requirements of the DBA and its agreement with AHPRA. The Board should have a system of approval of CPD programs to avoid a rotting of the system. The administrative cost of this would be negligible. I believe that the Board should recognise this as a basic obligation of the registering authority and if it does not possess the necessary expertise to implement the procedures, it should delegate this to a body that has the necessary experience and expertise. There are a number of reputable, independent bodies that could provide the necessary expertise.
- 4) I do not agree with the list of skills listed to extend the scope of practice. I do not understand why registered persons other than dentists or specialist dentists should be allowed to independently order cone beam computed tomography. This seems to be a contradictory element given that the over riding issue is public interest. Cone beams offer a specific diagnostic service, and really I do not believe that the other registration categories could knowledgeably determine the need for a cone beam radiograph, nor interpret the information as required. There is a circular definition in the extension of scope for dental prosthetists in particular. They are classified as independent practitioners. In addition, they are required to act only on written referral from a dentist or dental specialist in provision of: inter alia, immediate dentures, appliances for sleep apnoea and snoring. However this is subjective directive, and while the scope table suggests that they are able to deliver such devices there is a separate definition requiring them to be responsible to a team leader in a structured professional relationship. These two definitions are inconsistent. The definition of a structured professional relationship is flawed: particularly as the definition starts with "means", it should not be ambiguous, but the wording is indeed ambiguous. The definition is circular and hence "meaningless".
- 5) I believe that the proposal satisfies some key stakeholders that are registered with the DBA and appears to favour those groups exclusively. There is a reduction in protection of the public where the chain of responsibility is broken. Extending the scope of practice is all very well from the business point of view of those persons registered in a capacity other than as dentists, but there is absolutely no benefit to the public whatsoever. While such a benefit is mooted and requested by the HWA, it is clear that the implementation as outlined offers nothing. Indeed, there is a danger inherent in the approach of a "dental team" in that the onus for the responsibility for decision making lies within a "team" and accountability ultimately ends with the team leader (a dentist or dental specialist). What is not made clear, is that the members of any such team are only required to have a loosely defined "professional relationship" to escape what should be their own responsibilities. It may be that the dentist or dental specialist has unwittingly constructed an unintended "structured professional relationship" and thereby is unknowingly accountable for treatments for patients with whom they have no direct relationship. This is untenable.

Other matters:

- 1) The DBA has indicated in a footnote that it has not specified an approval process for courses or course providers for CPD. I believe this is a fundamental abrogation of the duty of the DBA to the registered persons, AHPRA and ultimately to the public. The DBA should have a procedural responsibility to ensure that its own regulations provide a benefit to the public. Otherwise, the impost on the industry in terms of time and expense becomes a totally meaningless exercise and mere paper shuffling with no tangible outcomes.
- 2) Due to the previous comments, I would therefore consider that the Board's findings with respect to its internal assessment against AHPRA's procedures for registration standards and COAG principles for best practice regulation is fundamentally flawed.

- a. I would dispute the finding at section 3 in referring to the COAG principles. The board has outlined some horrendous principles that are absolutely against the public interest, and there is nothing that minimises cost to the community. The proposal does not strike the balance it purports to at page 22. The public interest has not been served. Rather than clarify, the proposal is destined to add layers of confusion and lead ultimately to a very much greater risk of adverse outcomes for the public.
  - b. There is certainly no restriction of competition, in fact it is quite the opposite. However, the fundamental concept behind protection of the public interest has been lost in offering a poorly thought out addition to the scope of practice. While some of the scope elements have precedents internationally and can therefore be supported with some substance, others are more typical of an ambit award claim. Those range of skills outlined in the table related to extending scope fall into the range of skills developed by an above average dentist or dental specialist, and the public interest is not served by ignoring the training required to perform these invasive tasks.
- 3) If a dentist or dental specialist is responsible for the planning, issuance and management of a range of services such as sleep apnoea/ anti snoring devices, immediate dentures and immediate additions to dentures, what is the point or competitive advantage in extending the scope of prosthetists to provide these devices. It is a superfluous scope extension and simply increases the public risk to no benefit. In circumstances where a written referral is required, at what point in time does the responsibility move at any time to the prosthetist? As prosthetists are independent practitioners, it is quite probable that the paper trail is not followed, and in these range of devices, effective communication with health management/maintenance teams include practitioners from other specialised health fields. I would argue that prosthetists do not have the necessary skill sets to enable that efficiency. Accordingly it places the public at huge risk. That an argument may be made that such practices already occur should not imply that it is in the public interest. Indeed, it is most certainly not so.
  - 4) Under the description of the dental profession provided by the board in the Scope of practice document, the Board places the onus of scope judgement on the registered person. Those who are not aware of their limitations are likely to provide treatment for which they are not trained or competent. As competency would appear to be self adduced, those who are incompetent may still practice if they believe that they have satisfactory competency. It is a circular argument which is not satisfied in any part of the document.
  - 5) There remains a distinct lack of clarity over what constitutes a structured professional relationship.

Yours sincerely

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