From: [redacted]
To: dentalboardconsultation
Subject: DBA Scopoe of Practice
Date: Wednesday, 19 June 2013 4:45:41 PM

Dear Sir/Madam
I am an Adelaide periodontist and I am writing in response to the proposed changes to scope of practice in dentistry. I agree wholeheartedly with the submission from the Australian and New Zealand Society of Periodontists, but also wish to state the following:

RE: DBA Draft *Scope of practice registration standard* and guidelines

The responses below are my own views and answered as per the requested feedback questions.

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

No. By definition as professionals we have an obligation to put the interests of the public ahead of our own self-interest. We are not aiming for balance between public protection and regulation. We are looking to balance our available workforce against the burden of oral disease.

The National Oral Health Plan 2004-2013 (NOHP 2004-2013) outlines the at risk areas of our population as cited by the HWA report. Children and adolescents are listed as an area of priority. If we do not deal with dental problems in our young population we will never be able to meet the oral health demand as the population grows older. Dental therapist were introduced to address this problem head on.

Removing/Redistributing the dental therapist workforce away from an area of need (children) would be a neglect of duty by the Dental Board of Australia, by not ensuring an equitable distribution of services to the population.

The Service Charter which sets the values which guide AHPRA (DBA) specify that "We act in the interest of **public health** and safety". Children are the present and future 'public health'. Childhood dental disease is ballooning problem, this change is not in their best interests.

"We act in the interest of public health and **safety**" - DBA.
Even though a dental therapist can perform the technical skill of drilling and filling on children, they are not equipped with the necessary diagnostic skills to diagnose and treat **adults of all ages**. If you can't provide the diagnosis, you shouldn't provide the treatment. The diagnostic skills necessary require an entire dental degree as per the current standard.

The concept that only simple fillings could be performed is also not evidenced based.

The proposed guidelines state 'that cusps can't be replaced', fails to recognise that often when treating adults a simple occlusal filling can turn into a multiple cusp replacing restoration. This will potentially put therapists in a position where they either can't complete planned treatment or have to break the registration guidelines and replace cusps. The proposed guidelines are not practical, not evidence based and will put therapists in an impossible position unless they work with a supervising dentist. Taking away supervision requirements and removing the age restriction, cannot be considered to be a safe move by the DBA.

A dental therapist working without supervision, on adults, with limited training, *who doesn't know what they don't know* – is inevitably going to miss or make a poor diagnosis of the problem, then not treatment plan appropriately and may then go on to perform an irreversible change to the adult dentition of that patient. This is a public safety issue. The proposed changes to the scope of practice will put the public at risk.

The proposed changes are not in the interests of public health and safety. The HWA report which is driving these changes is based on a list of issues (p36) compiled from *'storytelling data'* collection. These issues are well known, no new data emerged. The National Oral Health Plan 2004-2013 has covered all of these issues with greater clarity and purpose and with less self-serving intent than the HWA report. We do need to meet these challenges, but we don't need to lower the standard of dental training required to safely treat the public.

The more obvious solution is to increase the number of dental graduates, which has already happened and is supported by DBA's own workforce data. Indeed the number of dentists practicing exceeds the required number forecast by the NOHP 2004-2013.

We are not aiming for balance between public protection and regulation. We are looking to balance our available workforce against the burden of oral disease. The proposed changes do not provide balance to either the public or the profession.

Lastly, The definition of dentistry for a dentist is overly restrictive. A Dental degree provides a core skill set, which allows further evaluation and integration of additional skills. There is no need for an all-inclusive definition of what constitutes dentistry to exist, to then be applied to a dentist. However lower skill level providers (dental auxiliary staff) who offer a restricted scope of practice, should have all of the elements of their scope of practice defined.

Auxiliary degrees do not provide the necessary foundation to allow the addition of a single skill set. Correct diagnosis of adult patients requires a variety of skill sets, which require 5-7 years to acquire through a dental degree. Without this complete skill set accurate diagnosis is not possible.

The current and proposed guidelines essentially dictate that all 'dental practitioners' should be self-regulating in the 'dentistry' they practice. However, only those with the highest level of training should have the capacity to self regulate. Those with limited

skill sets need to have those skill sets well defined, to match the community need and overall ensure public safety is maintained. The only formal education and training, which would allow an extension of the scope of practice for therapists is a Dental Degree.

In summary, the Dental Board of Australia should reject the proposed changes.

Sincerely,

Dr Siobhan Gannon
Periodontist