Australian Dental Association (WA Branch) Inc

12th May 2018

Dr J. Lockwood
Chairman
Dental Board of Australia
GPO Box 9958
Melbourne Vic 3001

Dear Dr Lockwood,

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

Thank you for affording the Australian Dental Association WA Branch Inc (ADAWA) the opportunity to provide comment to this Dental Board of Australia's (DBA) consultation process.

ADAWA members have expressed considerable concern regarding two key aspects of the DBA's public consultation document:
Removal of the requirements of "independent practitioner" (page 6/7) and
Remove the requirement of a Structured professional relationship (page7).

ADAWA contends that in the best interests of quality dental practise and the provision of dental care in Australia, that rather than remove the requirements of "independent practitioner" and the requirement of a structured professional relationship, that careful consideration be given to modifying these requirements to an already existing system that works, rather than removal. ADAWA asserts; **option one- maintain the status quo** with a subsequent additional period of consultation as the most appropriate decision at this time to ensure the retention of the true team approach to contemporary Australian dental care.

In response to some numbered points contained within the DBA public consultation document:

45. Most documentation relating to the role of dental hygienists, dental therapists and oral health therapists (allied dental practitioners: ADPs) refer in some way to their role as practicing in a professional and ethical manner as part of the *dental team.* Several examples of where this expectation is mentioned include the DBA public consultation document, the Australian Dental & Oral Health Therapy Association (ADOHTA) media release, dated 7th April 2018 and here in WA, the Curtin University 2018 Course Handbook in terms of their oral health therapy course outcome. This all suggests the dental team is the optimum approach to providing quality dental health outcomes.

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Disappointingly the DBA and groups such as ADOHTA have made no attempt to define a "team-based setting" in the context of an ADP practicing "independently."

The identity and education of the various members of the dental team are not understood by the public. The vocational education of a dental hygienist at Gillies Plains TAFE is vastly different from that of a graduate from the La Trobe University adult dental therapy or Curtin University oral health therapy courses. Differentiating the scope across the various categories of ADP's adds significant complexity in assessing the boundaries of an independent ADP outside the dental team.

ADAWA understands the original concept of introducing the ADP to the dental team was to compliment and improve comprehensive dental care, surely not to eventually see them removed them from the dental team and potentially replace dentists. Some might consider the notion; "you don't know what you don't know" simplistic however it is most relevant to this discussion. Basic concepts such as recognition verses diagnosis, particularly with complex cases clearly differentiate the ADP from a dentist. An independent ADP's inability to undertake a thorough medical history taking, carry out complex diagnosis and provide alternate comprehensive treatment plans to patients would prove a disservice to their patients and potentially expose the ADP to negligence.

46. It would be most-surprising if stakeholder feed-back from WA concurred with the view that there is significant confusion and subjective interpretation of the "independent practitioner." WA Dental Health Services, particularly in rural and remote regions of WA could not function without the flexibility of their dental therapists practicing with some degree of independence. Similarly, ADAWA speaks regularly with members and their employed ADPs who seek advice on practicing without a dentist "on-site." The restriction in flexibility of e-health models is untrue.

47. The use of DBA statistical analysis of notification data to suggest ADPs are proportionately less risk to the public is somewhat mischievous. Anecdotal information would suggest complaints against ADPs employed in private dental practice are effectively managed by the practice. ADPs practicing outside the "comfort" of a dental practice team will not receive that level of protection. There should be awareness that DBA notifications and claims against the ADPs indemnity insurance policies may well increase. The DBA should very guarded in using this aspect in their justification of option 2.

50. The Board says, it "has strengthened its expectations for working through the team approach for dental practitioners." Taken into context with the introduction of independence and a removal of structure within the professional relationship, the DBA is making incongruous statements. If a team approach is what is expected from this consultation process, then surely there must be structure and responsibility within a collaborative dental practice.

63. The DBA make no effort to clarify the subjective comment, "while facilitating access to services in accordance with the public interest." Comments by ADOHTA infer the DBA's implication to mean ADPs will provide a solution to Australia's access to dental care problems, such as social and geographic disadvantage. Obviously an introduction of this model of care would be based more on the provision of care by the lowest paid provider rather than a comprehensive care model.

The deregulation of removable denture treatments was introduced in WA nearly forty years ago. The desired outcome in registering dental prosthetists was more affordable denture care, particularly for those most in need. That outcome has not been achieved and no perceivable benefit to the public from the introduction of a mid-level dental practitioner.

There are many positive reports of the benefits of independent dental therapy practice in both the United States and United Kingdom. It is inappropriate to compare the provision of public dental care in Australia with the US Medicaid and UK National Health systems. The US studies, most notably those from the Pew Charitable Trust and the W K Kellogg Foundation are somewhat misleading. They draw from observational studies and unable to draw casual conclusions. The findings are associations focussed on utilisation rather than unmet dental needs and prevention. Unfortunately, randomised clinical trials are obviously difficult and expensive. The most studied US models of dental therapist care, principally Alaska and Minnesota both have some level of supervisory care safety net.

Remove the reference to programs to extend scope & the development of a new reflective tool for scope of practice.

Sadly, many dental practitioners in Australia are in the unenviable position of not having understood their scope of practice until they received a notification from the Australian Health Practitioner Regulation Agency or their professional indemnity insurer. The proposals to remove the reference to programs to extend scope and the development of a somewhat subjective simpler reflective tool are not the panacea.

In the absence of comprehensive quality studies of comparable reflective tools in healthcare and analysis of the impact of continuing education on the provision of dental care, ADAWA believes discussions on both these proposals should be deferred until a decision on independent practice and the structured professional relationship has been resolved. The complex issues addressed in the DBA consultation should not be considered in unison.

ADAWA are most disappointed we were not consulted prior to the release of this public consultation document. ADAWA represents 94 per cent of all registered dentists in WA. With the exception of the Dental Health Services WA dental therapists, ADAWA members employ nearly all other registered ADPs in WA. In addition, the Branch collaborates with the University of WA in providing a comprehensive CPD program to dental practitioners in WA and under a scheme of arrangement, takes an indemnity insurance product to the majority of dentists in WA. ADAWA could have provided a unique perspective to the DBA prior to the drafting of this public consultation document.

ADAWA trust the DBA will give both this submission and those from ADAWA members the due consideration they deserve.

Yours faithfully,

Dr David F. Hallett
ADAWA CEO