

Brisbane City Periodontics & Implants

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Dental Board of Australia
Australian Health Practitioner Regulation Agency
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Feedback from Stakeholder Consultations on a proposed revised *Scope of practice registration standard and Guidelines for scope of practice*

As a dentist of some 30 years, it has indeed been intriguing to watch the development of Dental Auxiliaries in the Australian context. Starting out with School Dental Therapists working exclusively on children within the public system and, in the Queensland context, seeing the introduction of hygienists into the dental workforce and then the development of BOH degrees and OHTs. For the most part, all of these developments have been broadly welcomed by Dentists and the various Auxiliaries, in both the public and private sectors.

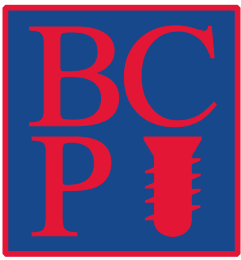
Much has changed in the intervening 30 years in terms of clinical developments, and yet some fundamental public health issues remain. Issues of access to care due to geographical and financial impediments are principle among them. Essentially these have not been adequately dealt with across that entire period. The burden of disease remains largely unchanged and at least in many sectors remains unmet with little hope of improvement.

The COAG process and the formation of a national Board under the AHPRA umbrella has potentially provided a framework for reducing duplication and to bring about a uniform framework to streamline the delivery of dental services, at least from a regulatory point of view.

The revised registration standard and associated guidelines effective from 30 June 2014 especially as it relates to the requirement of a *structured professional relationship* came about largely on the advice proffered by the Health Workforce Australia (HWA) report of August 2012. One of its recommendations was an adjustment of “the standard to reflect team-based practice with autonomous decision-making and without supervision requirements for review within five years, with a view to remove the bar on independent practice.” The HWA was subsequently abolished in August of 2014.

The Board’s proposed changes would appear to be not based on any additional evidence, reports etc. but rather merely blindly following through with a suggestion from a single report which is now six years old and by the time any changes are implemented will be seven years old. A report from a small part of a defunct agency that was not subject to peer review and did not meet with anything like universal support at the time of release. The agency tasked with writing the report had little to no experience in the dental field, but rather came from a medical and paramedical perspective principally based on the medical public delivery model via Medicare and state health departments and the private interactions with public funding via Medicare. This can be plainly seen in their other reports and grants which were generally praised for innovative thinking. The Dental setting at the time, with the vast majority of services provided through a private practice model was far removed from anything else the agency ever investigated. It is perhaps not surprising, given this background, that the well-meaning recommendations have to date essentially done nothing to improve patient geographical or financial access to appropriate care.





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To continue down this flawed path does not strike me as a sound basis for deciding on the future direction of health care. The changing professional landscape, the Commonwealth Dental Health Program (CDHP) *experiment*, the corporatization of many dental practices, the “oversupply” of dentists and the reduction in the number of BOH degree programs have all occurred during the intervening years since the report was written. These changes have been some of the most significant during my time in practice. It seems fool hardy, in the extreme, to pretend that the dental environment in Australia today can be equated to that of 2011.

There has been almost no study of the efficacy of the 2014 changes and the work that has been done has been confined to the public sector setting (mainly as part of Dental Health Services Victoria) ie. one of the smallest sectors of the wider dental profession and certainly not representative of the clinical settings where the vast majority of dental services are provided, namely private practice.

Hopcraft *et al* (2015) showed that after additional training to extend the scope of practice of OHTs to the provision of care to over 26 year olds, even in a supervised setting, increased confidence developed but both OHTs and supervising dentists identified that further education was required in “oral medicine, pathology, medically compromised patients, medications, prosthodontics, and referrals.” Thus, the additional education and training can be seen to have created a (overly?) confident practitioner with inadequate knowledge of potential life-threatening conditions with poor knowledge of to whom and how to refer to.

It can be concluded that in common matters that relate directly to public safety the lack of a structured professional relationship will likely lead to highly compromised, if not dangerous, provision of care.

The often cited Alaskan experience of OHTs (DHATs) (Williard and Feuteux, 2011) working without direct supervision, is akin to the current situation in Australia. Key findings from this paper include

- 1) Dentists can provide effective supervision for DHATs whether they are in the operatory next door or many miles away.
- 2) Care is perceived as a team effort with both DHATs and dentists sharing responsibility for improving the population’s oral health.
- 3) Quality assurance is integral to the DHAT model and
- 4) Problems encountered during delivery of care by a DHAT are well handled by the existing system of referral.

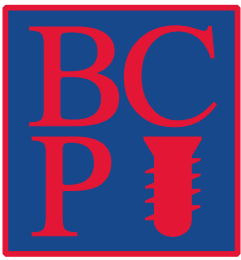
Much of the success of this program can be attributed to the **structured professional relationships** between the OHTs and their dentists. Specifically, “the group practice model itself functions as a powerful quality assurance mechanism”, “DHATs know their scope of practice and err on the side of caution. As a result, clinical problems,... are true rarities, and when they arise, systems are in place to transport patients to a dental provider with a broader scope of practice.”

This data strongly suggests that a *structured professional relationship* is key to OHTs providing a high level of care.

This equates with my own observations that OHTs are distinctly comfortable with the knowledge that they have a structured professional relationship and some even prefer to still have quite close supervision, depending on the complexity of the case.

A recent meta-analysis of the international literature of attitudes towards independent practice for dental hygienists (Reinders *et al* 2017) found only three suitable papers of the attitudes of hygienists themselves, and concluded that 59% of respondents had a positive attitude towards independent practice BUT significantly, the 95% confidence intervals ranged from 0.48 to 0.71.





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In short, the attitude amongst hygienists towards independent practice for themselves cannot be said to be convincingly positive or negative. And the single Australian study (Hopcraft *et al* 2008) was even less convincing with a positive proportion of 52% but a 95% CI ranging from 0.40 to 0.64, ie even less of a definitive answer.

Similarly, Oregon allows some Hygienists to practice without direct supervision. When asked to identify barriers to independent practice they cited “challenges with insurance reimbursement, lack of knowledge/acceptance, equipment cost/maintenance, difficulty obtaining a collaborative agreement/cooperating facility, advertising and inability to make a living wage.” (Coplen and Bell 2015). In Maine, hygienists that already have independent practice identified “deficits in exposure to public health, business skills necessary for independent practice, communication training and understanding of situations which require referral for treatment beyond the IPDH scope of practice.” (Vannah *et al*, 2014)

It appears that independent OHT practices face many of the common business issues facing all dental practices. Alarmingly, again a deficiency in understanding situations that require referral seems to highlight that issues of access may be similar to any dental practice, but issues of safety may be at a lower level than would exist with a *structured professional relationship*.

The board is charged with forming the opinion that removal of a “structured professional relationship” will be of benefit to the public and I would say most importantly in improving geographical and financial access to quality care. It is far from clear on what basis they are forming this opinion. Where is the evidence that the board has considered? Where is the evidence of improved oral health outcomes for those with limited access to care? Where is the evidence that outcomes are achieved with the same level of safety? A majority of the states of the USA now allow independent practice, yet there does not appear to be a single published peer reviewed paper showing improved outcomes for patients.

One assumes that a review has been made of the current situation and short fallings have been identified which the Board feels can be addressed by the removal of the structured professional relationship. If this is the case, it should be widely publicised, the short fallings can be used to benchmark the proposed changes when reviewed again in another five years.

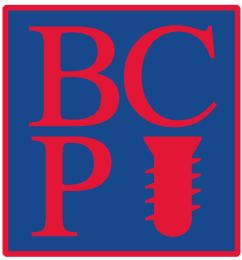
To justify the change, (any change) the Board must set specific criteria that it feels will be improved and can thus be objectively measured at a later review. The lack of a such benchmarking since the 2014 changes, should be viewed as a failing, that if carried out appropriately would have provided a sound basis for examining future changes. The past mistakes should not be repeated.

The Board’s primary responsibility is to protect the public. Does it have a sufficient evidence base to conclude that removal of a *structured professional relationship* will protect the public to the same level that exists today? I feel the objective answer is no.

Yours faithfully

Dr Rod Marshall
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