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25 May 2016

Dear Marie,

Submission for:
Follow-up consultation on a proposed Oral Health Therapy Scope of Practice

Firstly thank you for providing a response to my original submission on this proposal. It was indeed timely.
I was concerned at the short time frame allowed for the initial submissions to be made, when the consultation has come back for review so long after the initial proposal.

The issue regarding the proposed oral health therapy scope of practice should be allowed to lie on the table to be further assessed, as was decided over six years ago.

It concerns me that the institutions with the most to gain financially from running the oral health therapist's courses have had so much time to amend their approach to get to a point where the courses are now deemed acceptable.

The basic problem still remains that at the present time, at the Otago University Dental School there is a shortage of suitable patients to practise dental processes on, as there is an amazing pressure on patient numbers. There are barely enough resources of patients to allow even dental students to be taught the basics except under computer simulators, but the dental therapist/hygienist operatives were even more affected.

The dental drill is a dangerous instrument in the hands of the inept. The reality is that dental treatments are invasive and destructive.

I am also concerned that there seemed to be a lack of significance attached to the response from NZDA, an organisation that represents 2400 practitioners, a significant document, carrying far more weight than this feeble missive. There were 86 submissions but the NZDA submission should have been given its due weight, and its suggestions taken seriously.

P1. Based on the balance of information provided by the oral health programmes, it is proposed that restorative activities on patients 18 years and over under prescription of a dentist, be removed from the proposed oral health therapy scope of practice.

Q1: Do you agree with the proposed changes to the oral health therapy scope of practice? If not, please explain.

I agree with this proposed change. I think that all Oral Health Therapists in whatever part of the work force they are in should work under the prescription of a dentist.

I was under the impression that adolescents under the age of 18 could only be treated by a contracting dentist to avail themselves of the government funding for this process.

Does the introduction of this requirement mean that the oral health therapists do not have to work under the authority of a Dental Benefit Contractor?

The contractors and their relationship with the Principal Dental Advisors are essentially the gate keepers, ensuring that the standard of service given children up to the age of eighteen is monitored. Without this the treatment programmes will become more inadequate.

P2. A consultative professional relationship between the oral health therapist and one or more dentists or dental specialists is required for the practice of oral health therapy, to provide a clearly identifiable and reliable means for the oral health therapist to seek professional advice, when needed; no written agreement is required.

P3. A guidance document for the establishment and maintenance of the consultative professional relationship be published by the Council. The guidance document would identify some suggested areas for consideration and discussion between the parties involved.

Q2: Do you agree with the proposed consultative professional relationship between an oral health therapist and one, or more, dentists/dental specialists, without the need for a signed agreement? If not, please explain.

I do not agree with this proposal. The contractor has to sign a document allowing children to be treated by him/her. It is therefore entirely reasonable that oral health therapists, or dentists for that matter, working under the contractor's authority, should have a signed agreement in order to work on those children.

This means that there is protection for the treatment of children, and further that their activities can be audited by a dental officer and the Department of Health.

I am one of the few submitters who, as a past Principal Dental Officer for Pacific Health, have had firsthand experience of the responsibility of carrying the manifest that allowed dental therapists to operate.

There was no restriction of having to operate on the same site as the signatory, but there was a chain of responsibility that ensured that certain legal obligations had to be met.

With the legal change in function of the Principal Dental Officer in 2001, at which time the dental therapist became autonomous, this responsibility was lost.

The hospital boards have since been allowed to abdicate their responsibilities to ensure that all children under the age of 18 have free dental treatment.

- For instance, mobile clinics no longer have access for the handicapped patient.
- For instance, many sections of disadvantaged communities remain untreated, as the responsibility to ensure that treatment needs are met, no longer exists.

To support this view I enclose a recent article from the "Whakatane Beacon" in which the problems that have resulted from the laissez faire approach have been exposed. The number of dental therapists has been reduced, and so many school clinics closed, that children can no longer get treatment.

The problem is so symptomatic of the corrupted model of treatment of preschool children that the district health board representative does not really see the real extent of the problem.

Someone, somewhere, in a world of corporate dentistry, cost cutting, and changing personnel, needs to be responsible for treatment of the patient in their care. The oral health therapists do not have the expertise because they have not been able to acquire it during training, so the patients can never really have an informed consent process.

Consider this example: The Dental School has a slogan, "The seal is the deal" in treating incipient tooth decay, and uses this as the basis for the Hall technique of providing stainless steel crowns on decayed teeth.

But in the Eastern Bay of Plenty the workforce has been reduced so much that the incipient decay becomes an abscessed tooth as children often wait 14 months to two years for treatment.

Once the abscessed deciduous teeth are extracted, the permanent teeth are allowed to drift unimpeded with the parents unaware of the likely costs of the resulting orthodontic treatment.

Nowhere in the planning module of the oral health therapists is there any mention of the provision of space maintainers, (and I enclose a picture of one) to prevent future orthodontic problems.

The orthodontic problems quickly become periodontal problems. Hypoplastic gingival tissue prevails in the crowded anterior section with the most effective treatment being the provision of a gingivectomy to reshape the gingival tissue. But there is no training in the oral health therapists' programme for this - hence the need for a signed relationship with a dentist who can oversee the work.

It is sad that in New Zealand too few dentists get to see the teeth of children. And with the oral health therapists gradually allowed to practise unchecked, the problem will probably get worse.

Q3: Do you agree that the following orthodontic activities from the oral health therapy scope of practice be moved from direct clinical supervision to being performed within the consultative professional relationship?

a. **Tracing cephalometric radiographs;**
b. **Fabricating retainers and undertaking simple laboratory procedures of an orthodontic nature.**

Obviously this was a glaring anomaly in the system. It should probably be that these activities are the only ones that do not require direct supervision, and that all other activities should be supervised, or at least performed under a signed agreement.

Q4: Do you agree with the proposal to end-date the two oral health programmes as prescribed qualifications for the orthodontic auxiliary scope of practice? Consequently, oral health graduates that register as an oral health therapist will be removed from the

orthodontic auxiliary scope of practice – if registered in the orthodontic auxiliary scope of practice. If you do not agree with the proposal, please explain.

No comment

Q5: Do you agree with the proposed competency standards for oral health therapists? If not, please explain.

In the section Restorative Intervention under: "Alleviate tooth discomfort and/or pain by restorative intervention, or deciduous tooth extraction, as appropriate"
The implication in this section is that deciduous tooth extraction is the only option. This is not the case.

Restorative intervention:

- Determine the need for restorative intervention
- Consider current clinical practice guidelines and scientific evidence in decision-making
- Select the appropriate restorative procedure and dental materials
- Restore the integrity and function of teeth
- Alleviate tooth discomfort and/or pain by restorative intervention or deciduous tooth extraction , as appropriate

I have an example that has come to the clinic today:

The child was going back to the dental therapist to have an 85 extracted.
There are two problems here:

The first problem is that the child should have been seen earlier and the incipient decay diagnosed.
The second is that no referral was sent to a dentist to see whether the tooth could have a root filling placed to manage the tooth, so that the drifting on the lower molar could be prevented. This process may save the patient thousands of dollars of orthodontic treatment as well – just a minor issue really.

This is the same ghastly experience that most children in the Eastern Bay suffer.
An extraction of a lower deciduous second molar is not usually that easy so the child has a long lasting memory that the dental clinic is not a nice place, compared to the more gentle, ambient approach of having the tooth drained and dressed, and eventually filled and a stainless steel crown placed.

In conclusion, I strongly support the NZDA submission. The written relationship in essence is the cornerstone of a shared sense of responsibility for children's teeth, both morally and legally. I can only echo the sentiments of the NZDA submission.

I feel the oral health therapy scope of practice is unnecessary.

The graduates certainly need a written document assigning the responsibility for their treatments to a registered dentist. The current problems in the dental therapist workforce are unlikely to be addressed by the addition of a new scope of practice.

The proposed Oral Health Therapy Scope of Practice should be assessed in five years as was previously decided, as no significant changes to the content of courses has occurred.

Yours faithfully,

John Twaddle

PS I have an interesting addition to this response.

Today I have heard of a young patient who was hospitalized at Christchurch Hospital with a severe dental infection, needing three deciduous teeth extracted just weeks after being given an all clear by a dental therapist. Without any written chain of responsibility this is symptomatic of what will happen if there is no signed agreement between the oral health therapists and a supervising dentist.

It is already causing problems with patients treated by dental therapists.

Dentist pulls 30 teeth from four children

THE dental health of Eastern Bay children is behind a proposal for a new outreach clinic for under-fives in Kawerau.

Bay of Plenty District Health Board principal dental officer Rudi Johnson said she regularly dealt with the sad consequences of youngsters not being taught to look after their teeth properly.

"I recently removed 30 teeth from four children during a four-hour general anaesthetic session at Whakatane Hospital.

"I removed 12 teeth from one child who was under three."

Ms Johnson, a Tauranga-based dentist, travels to Whakatane Hospital once a week and performs dental procedures, mainly on children and adults who cannot be seen at a community dentist.

She said between Whakatane and Tauranga hospitals, she and other health board dentists saw about 400 children a year.

Although there was no change in the number of children needing work every year, the procedures she needed to do were becoming more extensive.

"A lot of teeth are pulled," she said.

There were many reasons why children needed their teeth extracted and Ms Johnson said it could be poor hygiene or not being seen by a dentist for a while, or at all.

She said she had seen children from all over the Eastern Bay and she could see a difference in the teeth of children from areas with fluoridated water.

Dental work was still required for children from fluoridated Whakatane and Ohope, but it was less extensive compared with children in outlying, unfluoridated areas.

Ms Johnson said improving children's dental health in the Eastern Bay was an important topic.

The proposed outreach clinic was about increasing access to services for the community. Although based in Kawerau, patients from surrounding areas would be invited to attend.

A community meeting about the proposed clinics, run by the health board, would take place on Wednesday, May 18, at the Conference Building in Kawerau, from 10am until 11.30am.

"The purpose of the meeting is to talk to the community face-to-face and hear what their needs are, to get their ideas and opinions. So we hope to see as many people there as possible," Ms Johnson said.

FOR KIDS: Dentist Rudi Johnson is keen to establish an outreach dental clinic in Kawerau for under-five-year-olds. Photo supplied

Dental meeting identifies community needs

Haylee King
Kawerau reporter

ACCESS to additional health facilities for children was the collective goal for 20 people who attended a community meeting about a proposed dental outreach clinic in Kawerau for under-fives on May 18.

The meeting enabled dental health professionals to talk to the community and hear what their needs were.

Bay of Plenty District Health Board principal dental officer Rudi Johnson said improving children's dental health in the Eastern Bay was an important topic and the proposed outreach clinic was about increasing access to services for the community.

The group participated in a brainstorm discussion about dental care and health services for pre-schoolers and identified main concerns.

Transport was a major issue as some families did not have access to a vehicle to attend out-of-town appointments.

Or, if they did, they would receive parking fines because they were unregistered and unwarranted.

Lack of education and service knowledge was another factor, which indicated a need for more promotion in the community.

Building community trust was a goal the group wanted to pursue because different services approaching a family could be daunting.

The group decided a collective approach was needed and working together was a solution to the concerns raised.

Tuwharetoa ki Kawerau health services manager Jayne Beeching said the meeting went well.

She said the discussion was the beginning of more access to health facilities, which a collective would work to achieve.

HEALTH: Rudi Johnson and Jewels Toko share at a Kawerau meeting how they believe children's dental health can be improved. Photo Haylee King D3687-14