NEW ZEALAND DENTAL ASSOCIATION

10th May 2016

Follow-up Consultation on a proposed oral health therapy scope of practice

The New Zealand Dental Association (the Association) thanks the Dental Council for the opportunity to comment on the Council's proposed introduction of an Oral Health Therapy Scope of Practice, has read and discussed the material that the Council distributed and the letter (M Warner, dated 11 April) regarding our earlier submission.

We note the Council is now seeking a response to specified questions and we present the following comment on behalf of our membership of over 2400 dental and specialist practitioners.

Proposals & Questions

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.

RESPONSE:
As previously submitted, the Association disagrees that there is a need for, or significant advantage in having an additional scope of practice (Oral Health Therapy) at this time and we have previously outlined our reasons for that view.

It is clear that the Dental Council has determined that there will be an Oral Health Therapy Scope of Practice.

The Association AGREES that restorative activities on patients 18 years and over under prescription of a dentist, should be removed from the previously proposed oral health therapy scope of practice i.e. that the provision of restorative care provided by oral health therapists be restricted to patients under 18 years of age.

Whilst the consultation is not seeking comment on periodontal care for patients over the age of 18, the Association also believes patients over the age of 18 receiving periodontal care, should receive that care as part of an overall treatment plan devised by a dentist or dental specialist.

It is the Association's view that:

1. Oral health therapists have a scope of practice defined by the level of education and training that they have undertaken. It remains our view that they cannot "provide oral health assessment, diagnosis, management, treatment and preventive care for patients of all ages" as their education and training does not prepare them to do so.

2. Care, in the patient's best interests, should be provided within an overall oral health care plan.
   - <u>All</u> patients 18 years and over (and many of a younger age) should have both their <u>periodontal and restorative</u> care provided as part of an overall care plan.
   - These should be planned in tandem and not in isolation.
   - When considering the requirements of informed consent, it is clear that a discussion of an adult's overall care plan needs to follow full diagnosis and full presentation of all the treatment and preventive options.
   - Delivery of comprehensive oral care to patients 18 years and over should follow full informed consent process, based on diagnosis and treatment planning, and explanation of all options by the practitioner who has the training to carry out such tasks i.e. the dentist.
   - It is our understanding that the current Oral Health Programme at Otago and the Health Science Programme at AUT do not include restorative clinical experience on adults.

3. Essentially the Association continues to request the Dental Council gives appropriate recognition to the following:

   - Overall treatment plans best serve patient's needs: Patients are best served by having an overall treatment plan that encompasses preventive, restorative and periodontal needs.
   - Generally there is a progression towards the need for more substantive diagnostic processes, treatment requirements and modalities / procedures, when providing care for adult patients, although many younger patients require such processes for both dental and medical reasons.
   - Informed Consent relies on broad and specific practitioner knowledge: Patients are best served when that treatment plan is delivered following discussion that meets informed consent requirements and an understanding of all the treatment options provides more assurance that all relevant treatment options are adequately explained. For adult patients in particular this informed consent process requires the dentist's level of understanding of treatment options.
   - Isolated determination or provision of parts of the treatment plan do not benefit patients: Isolated practice of a subset of dentistry (Oral Health Therapy) is not in the best interests of patients as the provision of appropriate care stems from full diagnosis and informed discussions with patients. There should be a lead clinician in this scenario and in New Zealand we have been well served by the graduates of dentistry (BDS) providing that leadership / 'gate keeper' role.
   - Depth and breadth of understanding are required to provide informed consent: The dentist has academic, clinical, and diagnostic training of considerably more depth and breadth than an oral health therapist, dental hygienist or dental therapist. Informed consent involving fair, balanced and appropriate detail requires this more

substantial knowledge if adult patients are to be fairly assisted into selecting appropriate care. This, in the interests of patients, should not be limited to just isolated, restorative care. Therefore there is a sensible need to have the overall treatment planning provided, and consent for adult patients' treatment obtained, by dentists. It remains the Association's view that periodontal care as provided by dental hygienists or oral health therapists should be part of a dentist led overall treatment plan.

- Medical emergencies and treatment complications: Graduates of the Oral Health Programme have a less detailed knowledge of medicine and management of medical emergencies than dental graduates, and an inability to handle treatment complications that can arise that are out of their scope of practice. In providing both restorative and periodontal care throughout the age-span these health professionals would provide more treatment to adults with:
  - More complex health needs including multiple medications and an increased likelihood of having a medical emergency.
  - More likelihood of treatment complications occurring

  This may be especially true for low-income and elderly population. In such circumstances (medical emergency or treatment complication) immediate assistance and care is important in improving outcome.

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.

RESPONSE:

1. The Association strongly DISAGREES with the proposal to remove the need for a signed working relationship agreement.

2. The Association AGREES with the elements listed in the Guidance document (it is a very helpful document) but continues to believe it is sensible to retain the mandatory requirement to record (in writing) such agreed actions between dentists and oral health therapists.

3. The proposed scope of practice states, '*practitioners within a consultative professional relationship are jointly responsible and accountable for the standard of decisions and care delivered to patients based on the professional advice sought and given'.* It remains the Association's strong view that dentists (our members) being, as the Council describes, '*…practitioners within a consultative professional relationship [who] are <u>jointly responsible</u>*

<u>and accountable</u>' would be very unwise to not have a written formal agreement describing that professional relationship. Removing these written agreements does nothing to enhance public safety and in our view increases the risk of poorly coordinated patient care and confusion as to who is responsible for what in the 'consultative' working relationship.

4. In the main, the varying degrees of clinical guidance and supervision which currently support the dental hygiene and the dental therapy scopes of practice, are cognisant of, and related to the patient's age and, as a consequence, their treatment needs, which flow from the context of planning and providing overall dental health care for each patient. Written working relationship agreements assist this and are a valuable tool for the protection the public. Removing the clinical guidance and supervision elements and simultaneously also removing written agreements is, in our view, not in the interests of the practitioners or the public.

5. Currently dental therapists and dentists have a consultative working relationship, which is documented in an agreement between the parties. Dental therapists can practise independently for the care of children and adolescents up to the age of 18 years within the scope of practice described for dental therapy. Such an arrangement exists because of the nature of the scope of practice (limited subset of dentistry) and the degree and type of intervention many of those in these age groups (children and adolescents) require as compared to those required for adult patients. The 'restorative treatment up to the age of 18' requirement remains and so should the written professional relationship agreements. Written agreements between a dentist and a 'oral health therapist' provide an appropriate level of assistance to ensure <u>coordinated and appropriate</u> care is delivered when one of those providers 'oral health therapist' has a scope of practice which is a subset of the other (dentists).

IN SUMMARY:
Written agreements help to ensure responsibility for, and coordination of, preventive and clinical care provided. When care is provided by several clinicians in a manner which overlaps, the risks associated with the occurrence of possible gaps in care and misunderstandings of responsibilities, are lessened through clarity of agreement. Written agreements assist in this and in the Association's view very definitely should be retained as a requirement.
At the very least a written professional relationship agreement should contain the elements listed in the Discussion Guidance document (page 22). Having a written record / agreement regarding many of the points listed in the discussion document is very important should a dispute / complaint regarding patient care later occur.

e.g. written confirmation of the;

- willingness of the dentist to provide advice or assistance
- need for the oral health therapist to inform the dentist of the particulars of their scope of practice, and their individual level of knowledge ….
- dentist having a current APC…
- agreed understanding of the shared responsibilities…
- agreed preferred form of communication for consultation
- agreed understanding of 'timely advice' etc. etc.

Attempting to remember or confirm a verbal discussion that is perceived or not perceived by the parties to have occurred, at some point in time many months or years later, seems prone to difficulties. Difficulties that are unhelpful to the practitioners and patients concerned.

P4. That the proposal to not require direct clinical supervision and clinical guidance for the proposed oral health therapy scope of practice remain unchanged, subject to the requirement for a consultative professional relationship.

RESPONSE:
The Association continues to disagree with the proposal.

1. The majority of activities undertaken within the current dental hygiene scope of practice are under 'clinical guidance', some are appropriately under 'direct clinical supervision'.

2. It is the Association's view that such arrangements appropriately ensure overall treatment planning benefits and increase patient safety. As such when these activities are listed within the Oral Health Therapists Scope of Practice they should be performed under the existing 'clinical guidance' and 'direct clinical supervision' provisions.

P5. To leave the proposed supervision for the administration of local anaesthetic unchanged, that is, performed within a consultative professional relationship.

P6. The orthodontic activities remain under direct clinical supervision of the dentist/dental specialist, except for the following activities to be moved from the list of activities requiring 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.

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.

RESPONSE: The Association AGREES that these two specified activities are removed from direct clinical supervision but that all other activities remain under direct clinical supervision. Such direct supervision is required by a practitioner with the knowledge and training to fully understand the evidenced based objectives and mechanics of treatment.

P7. All oral health practitioners have the same requirement to remain competent in their registered scope(s) of practice, and the creation of an oral health therapy scope of practice would not prevent or limit these practitioners to maintain competence across all scope activities. The potential risk of a practitioner not maintaining competence across the full scope of practice was not significantly higher than other oral health practitioners.

P8. An oral health graduate registered in the oral health therapy scope of practice does not need to additionally register in the orthodontic auxiliary scope of practice. The two oral health programmes would be end-dated as prescribed qualifications for the orthodontic auxiliary scope of practice, similar to the dental hygiene and dental therapy scopes of practice. Oral health graduates that register as an oral health therapist will be removed from the orthodontic auxiliary scope of practice, if registered as an orthodontic auxiliary.

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.

RESPONSE: The Association AGREES

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

RESPONSE: generally AGREE, but because the Association strongly believes written agreements are still necessary

1. Items listed in Attachment 2 – '*Guidance for the consultative professional relationship between an oral health therapist and dentist/ dental specialist*' (pg. 22) should be clearly titled within the document. The title could be '*Items requiring discussion, and written agreement*' and
2. There should be an addition within listed Competencies as follows:

   Refer and collaborate with the appropriate health professionals,
3. With a 'measure' that states:

   has a written professional relationship agreement with a dentist(s) which adequately records the discussions and agreements reached with respect to '*Items requiring discussion, and written agreement* 'as per the Dental Council's document '*Guidance for the consultative professional relationship between an oral health therapist and dentist/ dental specialist*'.

P9. All oral health graduates with a University of Otago Bachelor of Oral Health, obtained since 2009; or an Auckland University of Technology Bachelor of Health Science in oral health, obtained since 2008, are eligible for registration in the oral health therapy scope of practice subject to meeting the recency of practice and/or fitness for registration requirements - as it relates to the individual practitioner's scenario. This is further explained in the scenarios listed on the next page.

P10. All eligible oral health graduates, currently registered in both the dental hygiene and dental therapy scopes of practice and holding a valid practising certificate in both scopes of practice, will automatically be registered in the oral health therapy scope of practice and issued with a corresponding APC.

P11. The registration transition process would start after the Council's final decision has been made and the oral health therapy scope of practice has been gazetted.

P12. No time limit will apply for eligible practitioners to register in the oral health therapy scope of practice, if not automatically transferred.

Q6: Do you agree with the proposed registration transition for oral health graduates? If not, please explain.

RESPONSE:

1. The Association does not agree with automatic registration as outlined above.

2. The first oral health graduates graduated eight years ago (2008). The Association previously expressed our concerns that Dental Council has registered 437 oral health graduates of which 389 are registered (and have an APC) in both the dental hygiene and the dental therapy scopes of practice. It is our clear impression that the majority of these graduates are only practising in one (not both) scopes i.e. they are employed as a dental hygienist or a dental therapist - not both.

3. Recency of practice: This leads us to believe that there may well be extensive recency of practice issues making 'automatic' transitioning a very difficult and an inappropriate process. It is our view that there are 2008, 2009, 2010 and 2011 graduates who have not practiced one of the two scopes for three years or more and who have inappropriately been issued APC's in both scopes. These practitioners should not be automatically transitioned into the joint scope should a scope 'oral health therapy' eventuate. It is apparent that the Dental Council has sought a declaration from practitioners that they are practising both scopes, but it is equally clear that many are in employment situations that will have excluded them practising both scopes (i.e. employed singularly as a dental hygienist or as a dental therapist). It seems inconceivable that a practitioner employed only as a dental hygienist since 2008, 2009 etc. can, in 2015 have retained recency in dental therapy.

4. Workforce Data: What is of concern is the Dental Council has not analysed the workforce data on an individual practitioner level (ref: letter M Warner to the Association dated 12 December 2014) so cannot provide figures regarding the levels of the workforce practising just dental therapy or just dental hygiene, and therefore has no cross check to establish what appears to be a significant recency of practice issue.

IN SUMMARY:

The Association is of the very strong view that the dentist has academic, clinical, and diagnostic training of considerably more depth and breadth than an oral health graduate and therefore:

- The current oral health graduate is not clinically experienced in providing restorative care (even within their scope of practice) to adult patients. We strongly AGREE that restorative activities on patients 18 years and over under prescription of a dentist, be removed from the previously proposed oral health therapy scope of practice.
- The Association believes patients 18 years and older should also have their periodontal care planned in conjunction with the restorative care and as such continues to believe that treatment planning for adult patients is best provided by a dentist. That planning of periodontal care in isolation from the restorative plan does not serve the best interests of patients.

- The written working relationship agreements are essential and beneficial to all concerned, particularly patients in shared care. The Association DISAGREES with the proposed removal of written agreements, supports the guidance document and believes the guidance document should assist in defining written agreements
- The Association has suggested an addition to the Competencies and measures to assist embed signed agreements that support better coordination of care to patients when that care is shared between oral health therapists ('subset' scope of practice) and dentists ('full' scope of practice).
- The Association is supportive / not supportive of the proposed changes regarding Orthodontic Auxiliaries.
- The Association has requests the Council look more closely at the proposed ' 'automatic' registration of '2008 onward' oral health graduates into the oral health therapist scope of practice. This suggestion may well save Council 'embarrassment' at a later date as the Association continues to believe significant recency of practice issues exist. Is the Council certain a significant percentage of these graduates have been practicing the two elements of their previously individual scopes?
- The Association prefers the retention of the existing two scopes of practice and two associated professional titles, and sincerely believes the addition of a third does nothing to further or better protect the public.

Kind regards

David Crum
Chief Executive Officer
New Zealand Dental Association