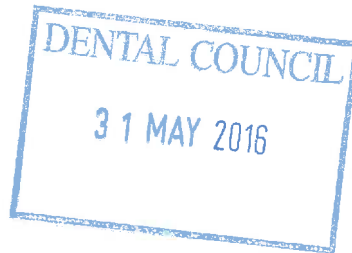


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Marie Warner  
Chief Executive Officer  
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Wellington 6143



24<sup>th</sup> May 2016

**Emailed and posted**

Dear Marie,

Submission for:

**Follow-up consultation on a proposed Oral Health Therapy Scope of Practice**

Below are our comments on the consultation questions, on behalf of the New Zealand Society of Periodontology:

**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.**

We **agree** with the removal of restorative activities on patients 18 years and over under prescription of a dentist, as originally proposed in the Oral Health Therapy Scope of Practice Consultation document.

- If there is limited training provided for treatment of adult patients, then the scope of practice should not allow for restorative treatment for all ages. **This was the most inappropriate part of the proposal.**
- The fact that the diagnosis and treatment of adult patients needs to be prescribed by a dentist indicates that the graduate will not be able to operate in an autonomous environment with respect to restorative care for adult patients.
- If an Oral Health graduate wishes to provide restorative care, diagnosis of caries/periodontal disease, treatment planning and overall care for patients of all ages, then graduates should enrol for a degree in Bachelor of Dental Surgery.
- We were concerned that with the limited ability to manage more difficult restorative care (i.e. crowns) and teeth with endodontic complications, inadequate treatment will be provided. This may also provide time concerns, as the appropriate treatment will not be able to be completed if a pulpal exposure occurs during removal of caries. Patients will then have to wait to see a dentist, which could lead to the risk of an acute infection and pain.
- Patients over the age of 18 years old (particularly the elderly) are more likely to have medical complications (i.e. poly-pharmacy) that can affect the treatment and without adequate medical knowledge and training this will serve as a risk to the general community.

Many dental professionals realise the benefit of working closely with colleagues within a group relationship so if medical emergencies develop, there is support from an adequately trained professional. Cases can also be discussed with a multidisciplinary approach and if there was not the requirement to work with clinical supervision or alone, problems may arise.

**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.**

We **disagree** with the proposal to remove the written agreement for Code of Practice-Working relationship between Dental Hygienists/Dental Therapists and Dentists.

The agreement facilitates a team approach, however it is important that the dentist maintains general oversight of the clinical care outcomes of the patient. This ensures safety for the general public with achievement of the best clinical result for the patient. Without an agreement, the graduates may overlook the need to discuss and provide care as a team approach.

There may be confusion with the newly proposed Consultative Professional Relationship for responsibility and accountability if there is no formal written agreement.

**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.**

**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.**

We **agree** that the orthodontic activities be moved from direct clinical supervision to being performed within the consultative professional relationship (but with a signed document still required).

An Orthodontist would still determine the subsequent orthodontic treatment plan, as a result of cephalometric radiograph analysis.

It seemed bizarre that within the newly proposed scope for an Oral Health graduate, they would still require clinical supervision for orthodontic auxiliary procedures, when it was proposed previously to remove supervision for much more technically demanding procedures that have a higher risk of more serious complications (i.e. restorations on adult patients compared with tracing cephalometric radiographs etc.).

**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.**

We **agree** with the proposal to end-date the two oral health programmes as prescribed qualifications for the orthodontic auxiliary scope of practice.

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

We **disagree** with the proposed competency standards and performance measures for oral health therapists.

Oral health therapy graduates will not be able to give effective information for a patient to give “informed consent” if they have not had adequate training in all areas of dental care.

**Selected points from the listed competency standards-**

Maintain competence section: allows review of ones own professional practice and competence with no adequate assessment by other dental professionals and this has the potential for graduates to perform treatment beyond their scope of practice with no observation. We have known of this to occur with hygienists who have not continued competency in dental therapy; taking x-rays to check for caries and deterring patients from having further dental examinations with dentists, that they consider are unnecessary. There has then been subsequent under-diagnosis of caries and periodontal disease for long periods of time.

We **disagree** with Dental hygienists diagnosing periodontal disease in patients of all ages for the reasons stated above.

We **disagree** with the change of provisional diagnosis of dental caries and periodontal disease to diagnosis of periodontal disease.

Graduates of the Bachelor of Oral Health Therapy are not adept at diagnosis of all gingival and periodontal diseases (there are many); as certain diseases such as lichen planus require biopsy. Graduates would have the ability to recognise abnormal conditions only, however without adequate training would be unable to provide an accurate diagnosis. This could lead to either mis-diagnosis and inappropriate treatment or late diagnosis and progression of disease with serious consequences. These cases would then require referral to a dentist or dental specialist after severe bone loss may have occurred.

**A dentist or dental specialist must provide the diagnosis.**

Appropriate treatment planning would then be directed by the dentist or dental specialist with dental hygienists as part of an overall team for care of the patient and stabilisation of disease.

We also **disagree** with determination of a recall regime by an Oral Health Graduate. We have known hygienists to recall the patient too frequently and not change this appropriately if the patient does not have active disease. On the other hand we have known hygienists to not detect periodontal changes and worsening of disease.

Recall frequency needs to be tailored to a patient, which will have variation; as all Specialist Periodontists realise periodontal disease is episodic in nature.

**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.**

We **disagree** with the proposed registration transition for oral health graduates.

We **did not agree** that there should be a new oral health therapy scope of practice and that the degree titles should remain unchanged.

The requirements for assessment of competency are ambiguous, if an Oral Health graduate has not maintained dual scopes of practice and wishes to transition to the Oral Health therapy scope of practice.

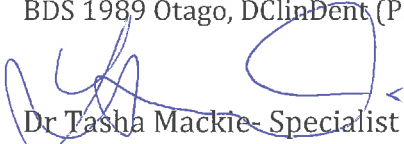
Many oral health graduates only practice in one scope; either dental hygiene or therapy. To have automatic registration would mean those who are not competent and have not practised in that area for many years would be able to do so.

The two scopes of dental hygiene and dental therapy appear to function well; building a team approach between dentists (with higher training and competency) and hygienists/dental therapists to give overall improved outcomes for patients.

Kind regards



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BDS 1989 Otago, DClindent (Periodontic) 2011 Otago



Dr Tasha Mackie- Specialist Periodontist, Treasurer New Zealand Society of Periodontology  
BDS, Doctor of Clinical Dentistry(Perio), FRACDS(Perio)

## Oral Health Scope of Practice Submission

Dear Colleague

We are writing on behalf of the NZ Society of Periodontology with regards to the draft proposals as supplied for changes in the Oral Health Scope of Practice. We are concerned that the inclusion of "Diagnosis of periodontal disease" is beyond the training and capability of dental hygienists.

Periodontal disease describes a suite of conditions affecting the periodontium (Armitage 1999). These conditions typically present with inflamed or swollen marginal gingival tissues and may be associated with loss of bone or support for the dentition. Accurate diagnosis depends on knowledge of the pathogenesis and symptoms of the disease. A biopsy is frequently needed to confirm the diagnosis.

Gingivitis is a near universal inflammatory condition of the gingiva. It is caused by plaque and resolves quickly, 3 -10 days, in the absence of plaque (Loe 1966). Chronic periodontitis, plaque induced inflammatory destruction of the supporting dental structures, significantly affects up to 80% of the population. There is a broad spectrum of susceptibility, with approximately 5% of the population affected so severely that advanced intervention strategies are mandated. Bone loss at affected sites is irreversible and early prevention and intervention the best option. Severe bone loss is frequently unrelated to absolute plaque levels. Early diagnosis and ongoing management is critical.

Oral health therapy, with respect to periodontal disease, is focussed on removal of plaque and plaque retentive features around teeth. Therapists routinely consult with patients who have marginal gingival inflammation and varying degrees of bone loss around the teeth. Most patients with gingival inflammation also have plaque adjacent to the inflamed tissue. This plaque may be acting as a primary inflammatory agent "gingivitis" or as a consequence of the inflammation eg lichen planus, pemphigoid, which can make cleaning very uncomfortable. Accurate diagnosis of the underlying condition, if any, is necessary for correct management. For example, consequences for unmanaged pemphigoid can include corneal scarring and blindness. Bone loss around teeth may be a symptom of current plaque related disease, a history of plaque related disease or a non-plaque related disease, eg cysts, tumours, resorption and endodontic infection.

Our members regularly see patients on referral for non-resolving periodontal disease(s). It is not uncommon for these patients to have been treated for some time in efforts to improve their plaque control, when this is a symptom of underlying disease rather than a cause. Earlier referral would benefit the patient in terms of comfort and cost. High risk /very susceptible patients are frequently referred after significant bone loss has occurred. Localised periodontal bone loss is not uncommon and frequently presents with an associated, superficial plaque but is also frequently not primarily caused by plaque. Again, mis-diagnosis of

localised disease frustrates patients and can lead to unnecessary tooth loss, cost or delayed diagnosis of serious disease.

Oral Health Therapists are very well trained to recognise healthy soft tissue and routinely provide excellent oral health advice. Interestingly, their scope of practice acknowledges that they are able to detect plaque induced hard tissue disease, caries, but only up until the age of 18 years! This arbitrary restriction is imposed despite no actual difference in the disease entity.

In contrast, accurately diagnosing periodontal disease(s) is fundamentally beyond their scope of training, other than to recognise abnormality and seek advice from a suitably qualified professional i.e. a dentist /dental specialist. This approach restricts Oral Health Therapists to their area of training. Patients benefit by requiring therapists to refer when plaque removal does not resolve the presenting condition(s) or when the presenting condition is inconsistent with the plaque levels detected. Current training in the Oral Health programme is insufficient to inform therapists as to the differences between gingivitis, chronic periodontitis and other periodontal diseases.

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