DENTAL COUNCIL OF NEW ZEALAND
Te Kaunihera Tiaki Niho o Aotearoa

DCNZ NEWS

Governance changes: Council and Boards downsize

As part of an ongoing review of its structure Council is pleased to announce changes that it believes will contribute to the achievement of a sustainable and cost-effective governance model.

At the commencement of the HPCAA era a 14-member Council was appointed by the Minister of Health which acknowledged: representation of all the oral health professions; the need for a lay or consumer presence and roughly proportional representation. Therefore, the first Council was comprised of five dentists, one educationalist (who was also a dentist), one hygienist, two dental technicians, two therapists and three lay persons.

The primary role of Council is to promote and protect the public interest by ensuring that oral health practitioners are safe and competent to practise. To enable that it also needs good governance and management and to provide strategic vision. In order to attend to matters specific to each profession, 8-9 persons committees of Council called workforce boards were established. This model enabled the four professions to develop compliance frameworks and systems for their practitioners to a Council-wide standard.

During the last two years Council has adapted its infrastructure to accommodate a much higher than anticipated workload under HPCAA. This has necessitated the recruitment of additional staff, relocation to larger premises and so on.

The recent governance changes are:

Reducing the size of Council

Council noted that good governance practice required a reduction in its size and therefore recommended to the Minister a reduction in numbers from 14 appointed members to 11. The Minister supported this initiative and as part of the recent reappointment process in March 2007 reappointed Dr Erin Collins, Dr Mary Livingston (dentists) and Professor Robert Love (educationalist and dental specialist) and Mr John Robertson (layperson) and appointed Ms Helen Colebrook (layperson). Full details of Council can be found on the website – www.dcnz.org.nz – and recognition of departing members on page 7 of this newsletter.

The new composition maintains the proportionality of representation of the four practitioner groups and, in the case of dentists, sustains representation across the profession. At the February Council meeting Dr Mary Livingston was re-elected chair and Professor Robert Love was elected deputy chair.

Reducing the size of workforce boards

To complement the downsizing of Council, workforce boards were also reduced in size to six persons with the requirement that a layperson and an educationalist complement the practitioner group.

This rationalisation across the organisation has resulted in a 25% reduction in appointed members and will contribute to savings in meeting costs.

Increasing delegations to the Registrar

Other initiatives that form part of the current "round" include increasing the delegations to the Registrar with respect to consideration of registration applications and annual practising certificates. The aim is to capitalise on "institutional" knowledge and expertise without compromising public safety.

The Health Committee

With the workforce board focus now on practitioner and professional matters the pan-professional health committee has been disbanded. Dr Ed Kiddle, chair of the Health Committee and medical practitioner specialising in addictive behaviours has been approached to advise the individual workforce boards on practitioner related health matters.

Council is committed to effective management of its fiduciary responsibilities.

continued on page 2

May 2007

inside this issue

Level 5, 138 The Terrace
PO Box 10-448
Wellington 6143
New Zealand
telephone: 64-4-499 4820
facsimile: 64-4-499 1668
email: inquiries@dcnz.org.nz
www.dcnz.org.nz

The existing model of Council and Workforce Boards has served its purpose well and permitted consolidation under HPCAA, the development of standards for each profession and the retention of identity. The achievements of Council, Workforce Boards and the professional associations working together have been significant, all the more so given that the health practitioner sector as a whole has been working with new legislation and the oral health professions in a unique regulatory configuration.

The Ministry of Health is currently drawing up terms of reference for a review of HPCAA. This will take place some time after September 2007 and will provide an opportunity for stakeholders to comment on the legislation. The experience across the health sector generally has been that it has generated a huge workload and has imposed significant costs which have been borne mostly by practitioners. Some authorities such as the Nursing Council have doubled their APC fees in order to develop their infrastructure and capability to handle the demands of HPCAA.

Council faces the challenge of ensuring that it meets its statutory public protection obligations with funding from a comparatively small and yet extremely diverse practitioner population of around 3,200. It will continue to review its structure and performance in order to meet its obligations under the act in the most cost-effective manner possible.

DCNZ Decision to Reopen the Oral Surgery Specialist Scope of Practice

In light of recent decisions in Australia the Dental Council has decided to reopen the oral surgery scope of practice but will not implement this decision (through publication in the *Gazette*) until finalisation of the contents of the scope of practice and decisions on the training requirements.

The Council consulted with major stakeholders before making this decision and took into account the following considerations:

- the availability of registration as a specialist oral surgeon in the New South Wales and Western Australian dental jurisdictions
- Trans Tasman Mutual Recognition (TTMR) implications – jurisdictions that do not have an oral surgery category are likely to have to register Mutual Recognition and TTMR oral surgery specialist applicants as oral and maxillofacial surgeon (OMS) specialists
- DCNZ's belief that registering oral surgery applicants in the scope of OMS lacks transparency and is potentially detrimental to public safety
- ANZAOMS strong preference for one combined oral and maxillofacial surgery specialty and use of the HPCAA provisions to register those who do not fully meet the registration requirements in a limited scope of OMS practice
- DCNZ's policy that to be registered applicants must demonstrate competence in the full scope of practice
- the decision by the Australian Dental Board Presidents at their October 2006 meeting to urge Australian dental schools to establish oral surgery training programmes
- the continued (anecdotal) concerns in New Zealand and Australia that the OMS training pathway is inhibiting access to surgical dental services.

Major stakeholders have been formally advised of Council's decision and asked to comment further:

- on the detailed scope of oral surgery practice
- on the sufficiency of the current Master of Dental Surgery in Oral Surgery to equip applicants for registration in the oral surgery scope of practice (given that the University of Otago has signalled that it will ask that its programme be accredited).

Dentists Disciplinary Tribunal

Suresh Kanji Patel

Following a hearing on the 14 February 2007 at which he pleaded guilty to charges relating to his treatment of three named patients, the Dentists Disciplinary Tribunal (Dental Act 1988) ordered that the name of Suresh Kanji Patel be removed from the Dental Register commencing 1 July 2007.

The Tribunal found that Dr Patel was guilty of professional misconduct and ordered that in addition to striking off he be censured and pay to the Council 20% of the costs of and incidental to the hearing.

In accordance with the Tribunal decision Dr Patel may apply to have his name restored to the register after a period of two years from 1 July 2007.

The Tribunal noted that Dr Patel had appeared previously.

The full decision of the Tribunal may be viewed at http://www.dcnz.org.nz/dcStandardsDDT on the DCNZ website.

Informed consent

Recently the Health and Disability Commissioner referred a complaint to the Dental Council of New Zealand regarding possible over-treatment. It was referred on the basis of concerns about the competency of the practitioner.

The issue involved a patient who sought a dental health check prior to departing for overseas for a period of four years. The dentist carried out an examination including radiographs. The patient was told that eight fillings were required at an approximate cost of $1600. The patient felt that this was rather extreme considering that there had been a regular recall examination only one year prior to this appointment and no treatment had been recommended. After speaking to friends, neighbours and colleagues it became apparent that she was not alone in being surprised at the amount of work that was being prescribed by this practitioner.

The patient decided to make an appointment with another dental practitioner to obtain a second opinion. After a full examination and further radiographs the second dentist explained to the patient what he was looking for and said to the patient that there was no need for any work at all to be done on the teeth although a couple of areas would need to be monitored.

After talking around it became apparent to the patient that at least four others had experienced a similar situation and had chosen to move to another practice.

So which practitioner was right? Maybe both were!

Dentists will have various opinions on when to undertake treatment. For example one practitioner may consider marginal breakdown and leakage or porosity of a restoration as a reason for its replacement while another practitioner may be prepared to monitor the situation for a period of time. Early caries may be treated by one practitioner by remineralisation and preventive measures while another may decide that a restoration is required.

Because the patient departed for overseas it is not possible to reach a definitive decision in this particular case but the case demonstrates a couple of important issues:

- Practices are often developed on the basis of word of mouth referrals. When questions arise or concerns expressed word will often get around to many other patients of that same practice.
- Treatment decisions should be evidence based.
- In these situations **informed consent** is essential. It is a requirement under the DCNZ Code of Practice on informed consent and this case demonstrates why.

Informed consent requires practitioners to fully inform patients on oral health status, treatment options and recommendations. Allowing the patient to be part of the process of diagnosis by direct vision, clinical photographs and having radiographs projected and explained to them could well have prevented this complaint to the HDC.

The interface between dentistry, dental technology and clinical dental technology

Guidance for dentists, dental technicians and clinical dental technicians

All dentists, dental technicians and clinical dental technicians need to be familiar with the provisions of the Code of Practice on "The Practice of Dental Technology and Clinical Dental Technology and the Working Relationship within the Practice of Dentistry".

This describes the scopes of dental technology and clinical dental technology practice and sets out practitioners' responsibilities when sourcing or providing technology services.

Copies of the Code are available from the Dental Council Secretariat on request or can be downloaded at www.dcnz.org.nz/dcStandardsCodes.

The main requirements of the code are summarised below.

Dental technicians:

- do not work directly with the public with the exception of non-clinical tasks such as shade taking or simple denture repairs
- provide services only on the prescription of another health practitioner authorised to fit the appliance or prosthesis (usually a dentist or clinical dental technician)
- undertake simple repairs of dentures, not involving impressions or relines, without a prescription. In such cases dental technicians refer the patient to a suitable clinician and include a record of this referral in the patient's record.

continued on page 4

Clinical dental technicians:

- deal directly with the public in making, repairing and
  - fitting removable complete dentures when there are no natural teeth remaining and there is no diseased or unhealed tissue
  - fitting partial dentures after an oral health certificate has been obtained from a dentist
- deal directly with the public in taking impressions and undertaking other non invasive procedures involved in making, repairing and supplying
  - removable complete and partial immediate dentures, removable complete and partial root/tooth overdentures and anti-snoring devices but only on the prescription of a dentist (or medical practitioner) who is responsible for final fitting and the patient's clinical care outcomes
  - extra-oral maxillofacial prostheses, but only on the prescription of a dentist or medical practitioner who is responsible for the patient's clinical care outcomes and subject to suitable training in this area. Impressions may not be taken of defects that are in direct communication with the naso- or the orophayngeal airway
  - removable complete and partial root/tooth overdentures on oral implants but only on the prescription of a dentist who is responsible for final fitting and the patient's clinical care outcomes and subject to the clinical dental technician being registered in the additional oral implant overdenture scope of practice
- ensure by clinical examination and/or oral health certificate that the patient's mouth is fit for the purpose and free of disease, disorder or abnormality before taking any impression or fitting any denture or appliance
- do not adjust, modify or treat the natural dentition, bone, soft tissue or dental restorations (apart from the use of tissue conditioners and soft lining materials)
- ensure that patients are informed of all treatment options available.

Dentists

- should source dental technology work from registered dental technicians (or overseas dental laboratories with accredited ISO management systems)
- only provide oral health certificates for patients seeking partial dentures from clinical dental technicians when there is no diseased or unhealed hard or soft tissue, or any other contraindication to treatment
- ensure that prescriptions are written, signed and dated and include clear instructions
- ensure that prescriptions for clinical dental technicians to undertake clinical procedures include details of the patient's medical history as necessary for the provision of treatment
- do not request technicians to remove temporary crowns unless under their direct observation, direction and monitoring
- do not request technicians to try-in crowns or bridge work or make adjustments to crowns or bridges on the patient
- accept responsibility for the final fitting of immediate dentures, overdentures (including those on oral implants) and anti-snoring devices and do not request or expect clinical dental technicians to undertake this activity
- accept responsibility for the case management/clinical care outcomes of patients who require immediate dentures, overdentures (including those on oral implants), extra-oral maxillofacial prostheses and anti-snoring devices
- ensure that clinical dental technicians providing clinical procedures associated with implant overdentures are registered in (or seeking registration before 30 June 2007) in the additional scope of implant overdentures
- ensure that dental technicians providing clinical procedures associated with extra-oral maxillofacial prostheses are registered to do so
- ensure that patients are aware of all treatment options available
- provide timely advice to the technicians undertaking the work
- keep accurate records of advice given, prescriptions provided and oral health certificates issued.

APC Renewal Update

The Dental Council wishes to acknowledge the oral health practitioners who met the due date of 23 March 2007 in relation to renewal of Annual Practising Certificates this year. Thank you for your timely response.

The Registration Team has been very busy with over 4,000 practitioner applications being processed and issued. The Register has been updated as has the information on the DCNZ website regarding APC status.

If you have not completed your APC renewal process you are reminded that:

- You must hold a valid APC to practice.
- Additionally, if you are a dentist and do not hold a valid APC:
  - your patients may not be covered by their health insurers or ACC – if you do not hold a current APC at the time of the treatment ACC is likely to decline to fund the treatment
  - you may not be covered by your dental indemnity insurer
  - pharmacies may not fill prescriptions for your patients.

Medical Emergency Training and Compliance

The DCNZ Code of Practice for Medical Emergencies in Dental Practice for Dental Therapists, Dental Hygienists, Dental Technicians and Clinical Dental Technicians (December 2006), states that "*oral heath professionals must be adequately prepared and equipped to deal with common life threatening conditions*".

It also states that Dental Therapists, Dental Hygienists, and Clinical Dental Technicians must have completed training to a level equivalent to the NZRC Modular Certificate of Resuscitation and Emergency Care (CORE) Level 3. The code also states that Level 1 is suitable for Dental Technicians as they have little direct contact with public and little or no access to emergency equipment or drugs.

The issue of appropriate medical training has been raised by a number of concerned parties, especially in light of the recent APC renewal round and compliance declarations. The DCNZ has been advised that the CORE Level 3 certificate is not modular. It takes four days to complete and is very comprehensive, containing a lot of material unnecessary for Dental Therapists, Dental Hygienists, and Clinical Dental Technicians. In light of this DCNZ has specified that the training courses need to cover airway management, adult and paediatric collapse and emergency situations as set out in the code. Oral health practitioners can best meet this requirement by undertaking the NZRC Modular Certificate of Resuscitation and Emergency Care (CORE) Level 4 courses or equivalent.
The training provider should hold New Zealand Resuscitation Council (NZRC) certification to provide the training (at the appropriate level). The code of practice will be amended accordingly.

The following organisations can provide the training required:

- Red Cross (Southern and Canterbury Divisions)
- Paramed
- Resuscitation Matters
- MediTrain
- Triple One Care
- Emcare

Other training providers who have been accredited by NZDA are also acceptable.

The DCNZ has sought expert advice as to whether the St John training is set at a level which is equivalent to the NZRC Modular Certificate of Resuscitation and Emergency Care (CORE) Level 4. Based on the advice given, Council approved St John to provide training until 31 March 2007. Courses that were arranged prior to 31 March 2007, but not yet delivered, will still be acceptable.

The DCNZ recognises that immediate compliance to this training requirement will not be possible for all oral health practitioners. Our advice to practitioners is that:

- if they do not hold a current certificate in emergency care they must take immediate steps to enrol in a course
- if they hold a current certificate at a lower level, they need to upgrade to the required level by 31 March 2008.

Clarification of requirements on the use of x-rays by unlicensed persons

The Council continues to receive enquiries about who can take radiographs and what kind of training is required for those who undertake radiography under the supervision or instruction of a National Radiation Laboratory (NRL) license holder.

With a view to resolving this matter DCNZ and NRL representatives have met and NRL has now drawn up the following set of rules based on a distinction between:

- *instruction* which relates to a situation where the user works remotely from the licensed dentist and satisfies certain requirements, which include having received suitable training
- *supervision* which relates to the situation where the dentist is physically present

NRL Rules applying to unlicensed users working under the supervision and instruction of a licensed dentist

- A registered dentist cannot work under the supervision or instruction of another dentist and must hold his or her own licence.
- Instruction relates to the situation where the user works remotely from the licensed dentist. In order to satisfy the requirements for instruction the user must:

  - be working under a written system of work including rules setting out the circumstances in which x-rays can or cannot be taken; and
  - comply with the provisions of the Radiation Protection Regulations 1982 and any conditions to which the instructing dentist's licence is subject; and
  - understand the radiation hazards of his or her work and the precautions to be taken in relation thereto; and
  - have received suitable training. In the case of therapists and hygienists this involves the training required for registration in one of the additional scopes of practice (1) Radiography in Dental Therapy Practice, (2) Diagnostic Radiography in Dental Therapy Practice, (3) Intra Oral Radiography in Dental Hygiene, Dental Auxillary and Orthodontic Auxillary Practice or (4) Extra Oral Radiography in Dental Hygiene, Dental Auxillary and Orthodontic Auxillary Practice. However there are also circumstances where a student in the final stages of training can take x-rays under instruction because s/he has received sufficient training to enable the safe taking of x-rays without the immediate oversight of a supervising licensee.
- Supervision relates to the situation where a licensed dentist is physically present. In order to meet the requirements for supervision the licensee must:
  - be physically present; and
  - be able to intervene if required; and
  - issue specific directives and the unlicensed user must be carrying out those specific directives.

The overriding consideration is the safe use of the radiation. If the supervisee is inexperienced then the physical presence and ability to intervene require direct visual contact and oversight. However with more experienced supervisees, who can recognise abnormalities when they occur, these terms require that the licensee is within hearing range and sufficiently close that s/he can take remedial action within a very short period of time (i.e. this may not require that the supervising licensee is present in the same room with direct visual contact).

This explanation of the term 'supervision' applies only to that used in the Radiation Protection Act and not to that used in any other legislation with which practitioners may be required to comply.

In either case (i.e. supervision or instruction) the unlicensed user must know the identity of the licensee s/he is working under, and the licensee remains responsible for the overall safety of the procedure.

These rules are applied to actual circumstances as follows:

- Registered dentists - must have their own licence
- Therapists and hygienists - can operate under instruction if they are registered in an additional scope of practice relating to the taking of x-rays. Otherwise they can only operate under the supervision of a licensed dentist.
- Oral health students - initially students must act under supervision. However later in their training they can operate under instruction assuming sufficient training has been received. Note that there is nothing to stop a person operating under supervision one day, instruction the next and then back to supervision the next.
- Dental assistants - it is most unlikely that dental assistants will ever have enough training to be able to operate under instruction and therefore they can only operate under supervision.

New Chair of Health Practitioners Disciplinary Tribunal

Mr Bruce Corkill was recently appointed as Chair of the Health Practitioners Disciplinary Tribunal (HPDT). He replaces the inaugural Chair, Dr David Collins.

Mr Corkill frequently acted as Legal Assessor and Counsel for the Medical Practitioners Disciplinary Tribunal, the Dentists Disciplinary Tribunal, the Nursing Council of New Zealand, and more recently also acted in both capacities for the Health Practitioners Disciplinary Tribunal.

He has frequently appeared for the Accident Compensation Corporation with regard to appeals for cover and entitlements, in the High Court and Court of Appeal; and has been an independent advisor to the Medical Misadventure Unit of the Corporation. He has been involved in a number of significant common law actions for personal injury.

He acted for the New Zealand Medical law Reform Group, which was a significant single issue group formed to seek reform of the law relating to medical manslaughter – a reform which was achieved in 1997.

He is a Past President of the Wellington Medico-Legal Society and a current member of the Quality and Safety Committee of the Australia and New Zealand College of Anaesthetists.

Council to take action to prevent tooth whitening/bleaching by unregistered persons

The Dental Council is seriously concerned about the provision of tooth whitening/bleaching services by unregistered people because of the risk to the public posed by infection control issues, the potential for gingival and mucosal tissue damage, and the risk of pulp inflammation or necrosis if the caustic oxidising agents used breach the surface of a tooth.

At present, however, the Ministry of Health does not consider that bleaching procedures should be restricted to registered practitioners, despite the Council submitting a detailed evidence based submission arguing that they should be.

The Council's jurisdiction only extends to registered oral health practitioners.

Council has however:

- written to all local authorities alerting them to the dangers of tooth bleaching being carried out by unregistered persons and raising concerns about sterilisation and cross infection control issues
- issued a policy statement on bleaching by other than registered practitioners, which states amongst other things that " At the very least an unregistered person should not provide whitening services without an oral health certificate from a registered dentist or dental specialist".

In the face of the Ministry's refusal to include bleaching procedures on the list of activities which are restricted to registered practitioners Council has explored other avenues to protect the public in this area.

We are currently preparing a submission, with the support of NZDA, to the Environmental Risk Management Authority (ERMA) with a view to restricting tooth whitening products containing more than 0.1% of hydrogen peroxide to registered oral health practitioners who are permitted by their scope of practice to undertake tooth bleaching procedures. It should be noted that ERMA has identified in their product standards that concentrations of hydrogen peroxide greater than this in dental or cosmetic products are a risk to the public.

Changes at the Dental Council

The Dental Council recently said farewell to four of its members. Dr Mary Livingston, Chair, acknowledged their commitment to the Dental Council, their years of service, both to DCNZ and the oral health professions, and their contribution to the forming and consolidating period of the Dental Council. She thanked them and wished them well.

Trish Simpson was an inaugural member of the new Council and Dental Therapist Board and was first appointed in December 2003. Trish has demonstrated her commitment to registration of Dental Therapists and their CPD by her active contribution to the development of policies around the HPCAA.

Victoria Hinson has been a lay member on the Dental Council twice – first in 1999/2000 and then since 2003 – and has also served as the Deputy Chair for the Council. Victoria has been a committed and tireless contributor. Her expertise and ability to assist other Council and Workforce Board members to come to terms with the legal implications and interpretation of the HPCAA have been invaluable. Victoria has served on a number of Council Committees and Workforce Boards, always ensuring that the lay member's perspective is presented and keeping Council focused on its purpose of administering the HPCAA.

Brent Stanley has been a member of the Dental Council for 14 years. He was Chair from 2002 to 2005, a critical time for the Dental Council as it worked through the development and implementation of the HPCAA. Under Brent's leadership the Council made significant steps in unifying the diverse oral health groups into one effective body. His ability to think strategically and to assess the implications of the proposed Act for dentistry provided valuable input into the development of the HPCAA. Brent has been involved in dental politics both locally and internationally since 1978. Although he is leaving DCNZ he will continue to be involved in dental politics via the FDI (World Dental Federation).

Keith Pine played a pivotal role in promoting and gaining acceptance for the dental technology profession to be regulated under the combined Dental Council. He has served on the Dental Technicians Board since its formation in 2003 and was Chair until 2006. Keith had previously chaired the former Dental Technicians Board from 2000 to 2003.

Helen Colebrook was welcomed to the Dental Council in March 2007 as the new lay person appointed by the Minister of Health. Helen has a legal background and has recently worked as an investigator with the Office of the Health and Disability Commissioner. In addition to her responsibilities with the Dental Council, Helen is currently a legal representative for the Central Region Ethics Committee.

The Cost of Dental Services

Informed Consent does not just apply to treatment recommendations and choices. An important consideration is the cost of treatment. The Dental Council of New Zealand is fielding numerous inquiries and telephone calls about dentists' charges.

Informed consent includes discussing fees, along with options available, before treatment is undertaken.

It is especially important for the first visit. There is a wide variation in the cost of an initial consultation:

- Some practitioners may offer a greatly reduced fee to attract new patients.
- Some dentists will allow a short initial consultation with a deferral of a more detailed assessment.
- Some will allow a longer consultation time and may utilise special tests such as radiographs, study models, laser diagnosis and clinical photography.
- Not all practitioners will see patients eligible for adolescent or special dental benefits or WINZ support.

Patients attending for their first visit or returning to a practice after an extended period of time may not have an appreciation of the current fees in the practice. For example:

- fees may have increased
- there may be more treatment required
- there may have been advances in materials and techniques used.

The important issue is for patients to have a realistic expectation of the fee before the initial visit takes place. Practices should develop a protocol to help reception staff discuss fees on the telephone at the time an appointment is made. At the initial appointment it is important to confirm that the patient has an appreciation of the costs involved before proceeding.

Patients discuss fees amongst themselves but may not have an accurate understanding of the variations in cost for what can seem like similar treatment experiences. For example the cost of a filling will vary widely because of:

- size and number of surfaces involved
- material and technique used
- extent of decay and proximity to the pulp.

Patients need enough information to be satisfied that they understand the nature of the treatment proposed and the estimated fee. During treatment there may be a variation in the treatment plan so it is important to update the consent process to reflect any changes proposed.

Council Decisions on Dental Auxiliary Scope of Practice

The scope of dental auxiliary practice was established under HPCAA to allow those Section 11 workers with no formal hygiene qualifications to continue to practise.

The scope is a limited version of the dental hygiene scope and expires on 18 September 2009. Dental auxiliaries (DAs) wishing to continue practising past that date were previously advised that they needed to upgrade to the Dental Hygiene scope of practice by sitting and passing the New Zealand Dental Hygiene Registration Examinations.

There are 44 practising and 8 non-practising DAs on the dental register. All but 5 hold formal dental qualifications.

At its meeting on 26 February 2007 the Council re-examined its position and agreed to:

- remove the 2009 time limit on the dental auxiliary scope
- look to register all practising dental auxiliaries in an ongoing limited dental hygiene scope of practice with conditions (including onsite supervision, the requirement for the dentist to undertake a periodontal examination of the patient and the public display of the APC certificate).

This means that those who have been practising as a dental auxiliary will be able to continue to practise past 2009 and will not be required to sit and pass the registration examinations unless they wish to have the conditions on their scope removed. The other route to gaining an unlimited dental hygiene scope will be for the individuals concerned to complete a Bachelor of Oral Health.

Council took into account the following factors in making its decision:

- the limited interest in the proposed 18 month University of Otago distance learning course to prepare candidates for the registration examination process
- its desire for consistency in managing those groups who were previously practising under the Dental Act exemption provisions
- the significant personal and financial hardships which would result from maintaining the time limit on the scope (as documented in a number of communications from individual dental auxiliaries)
- its view that the risks to public safety are minimal provided the individuals concerned practise within their scope of practice and adhere to recertification requirements
- its view that registration of dental auxiliaries in a limited ongoing dental hygiene scope of practice is more transparent for the public given the conditions on their practice will be recorded on their public dental register entry and on their registration and practising certificates.