## Page 2: Your demographics

**Q1** Your details

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|---|---|
| Name | **Jeremy Bywater** |
| Company/organisation | |
| City/town | |
| Email | |

**Q2** Your submission is in the capacity as

**dentist or dental specialist**

## Page 3: The proposal

**Q3** Do you agree or disagree with the proposal to remove the 18-year age limit for restorative activities from the OHT scope of practice including: accredited, gazetted programmes allowing oral health therapists to perform restorative treatment on patients 18 years and older an exclusion, such as "Restorative treatment on patients 18 years and older", being placed on oral health therapists' scopes of practice until they complete an accredited adult restorative programme which will allow them to apply to have the exclusion removed (noting that the activities registered oral health therapists can currently perform within their scope of practice remain unchanged).

**Strongly disagree**

## Page 4: Your support

**Q4** Please describe why you support the proposal

**Respondent skipped this question**

## Page 5: Your concerns

**Q5** Please describe your specific concern/s with the proposal

The council has made comparisons with the dental therapist annex for adult scope which states: “[adult restorative treatment] is provided in a team situation under direct clinical supervision2 or the clinical guidance3 of a practising dentist/s or dental specialist/s. Disease prevention and oral health promotion and maintenance are core activities.”
This current proposal lacks a similar clause and lacks any specifics with regards to clinical setting or level of clinical autonomy that the OHT’s would have. These specifics are what will ultimately determine whether any changes pose a risk to the public through delivery of inappropriate or substandard care; failure to adequately inform patients of their disease process and treatment options and therefore to obtain informed consent; and inappropriate allocation of state funded resources.
If your proposal is that an accredited, gazetted course, other than a BDS, is sufficient to enable an OHT or therapist to provide adult restorative treatment autonomously then I would strongly disagree. Adult restorative needs and treatment are far more complex than for children or teenagers due to the more complex aetiology of the situations needing restoration, and of the concomitant factors present that may affect their condition and treatment. For example, TMJ disorders, erosion and wear, and loss of occlusal vertical dimension may all result in treatment requiring adjustment of an existing occlusal scheme in order to provide a simple filling. A thorough understanding of all these factors and how they influence “simple” restorative treatment only come from the training and experience acquired in the subjects of fixed and removable prosthodontics and endodontics as studied in a BDS, and the ongoing CPD in these subjects required of a dentist. That is to say that a knowledge of how to set up an occlusal scheme on fixed crowns or full dentures will allow a clinician to do a better or more appropriate filling. Similarly, I don’t see how you can effectively discuss treatment options with a patient without the knowledge of which cracks in back teeth, commonly seen in adult patients, may worsen and lead to root canal infection or tooth loss. This knowledge comes from providing treatment with ceramic or gold onlays, and from providing root canal treatment, and again from the hours of ongoing CPD in these subjects as would normally be undertaken by a dentist.
A “simple filling” in a fifty year old patient is in most cases very different to that of a sixteen year old and this fact needs to be recognised. It is clear from a cursory glance through the submission from OHTs on this subject that this has not been explained to them. It is also important to be aware that other pathologies of the dento-facial complex may be uncovered as part of a routine dental exam, and that “diagnosing caries” is only a very small part of what constitutes a complete and comprehensive exam. For example, the training needed to screen for malignant or pre-malignant disorders of the soft tissues is much more extensive for adults than for children, and other conditions such as reflux and sleep disordered breathing might also be missed if a dentist is not performing the examination. There is risk that the general public would be confused about the difference in what they are receiving and the training and experience of the clinician providing their diagnosis and treatment, and again this affects their ability to give informed consent.
There is also risk that in diluting the focus of that treatment that the OHT’s are providing will result in poorer provision of treatment to all groups, as more of the procedures that they undertake would be undertaken less often.
Also, I believe that although it is outside of the dental council’s assignment to consider allocation of resources which is a political responsibility, I do not believe that the council can omit any sense of social responsibility. The decision made by the council here has the potential to divert resources and work force away from an already under resourced and inadequate system for the provision of dental care to children, which contributes to the thousands of under five-year olds being admitted to hospital each year due to tooth decay.
This decision has the potential to greatly increase the suffering of children New Zealand, particularly those which are impoverished. Suffering which will almost certainly continue into later life where the same problems of poor dental health will repeat. I do not believe that the changes proposed will reduce the cost of basic restorative care as the bottom line overhead costs in providing this treatment make up the majority of the costs to patients, and the reduced inefficiency in an OHT providing this treatment will result in final costs being about the same, even if the hourly rate might be minimally less. Indeed, this seems to be the case with treatment offered by OHTs overseas. There is also the question of the increased funding by the government of the tertiary institutions providing these programs, versus the opportunity cost of not directly funding treatment of at need adults by a workforce that is ready now.
I can foresee that there will be some situations, particularly in rural New Zealand, where it would be of benefit for an OHT working as part of a team to provide adult restorative treatment only on direct referral from a dentist or dental specialist who has undertaken the examination, diagnosis, and explanation and consent of treatment, and then ultimately takes responsibility for the provision of the treatment by the OHT. Not dissimilar to how an OHT currently works as an orthodontic auxiliary. If the council where to propose changes to the OHT scope with a more clear and comprehensive rewording reflecting this type of team relationship, as opposed to simply dropping the exclusions, then I would be more inclined to agree with a proposed change.

## Page 6: Details about OHT scope, qualifications and competencies

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| **Q6** Do you have any specific feedback on the proposed amendments to the OHT scope of practice, prescribed qualifications or competencies as set out in appendices 1 & 2? | **Yes** |

## Page 7: Specific comments on the proposal

**Q7** Please provide us specific comments related to the OHT scope, qualifications and competencies.

Yes – my specific feedback has been largely covered in my last paragraph. However I would also add with respect to the following scope items: “-Obtaining informed consent” – I believe that in many cases it is not possible for a patient to give consent to simple restorative treatment without having alternative more complex options explained to them by someone who is able to provide those alternatives. This is a breach of the health and disabilities code. “-extracting primary teeth”- primary teeth are frequently retained into adulthood, and potentially those with a complex medical history or drug regime. The extraction of any tooth on such a patient could pose threat of prolonged bleeding or medication-related osteonecrosis of the jaw. There is also the sequela of a lost tooth when there is no permanent successor that needs to be explained to the patient along with treatment options that would involve orthodontics, or fixed or removeable prosthodontic treatment. There is a lack of an inclusion in the scope or competency standards relating to the diagnosis of endodontic disease and infection, or of non-carious tooth surface loss other than erosion. Unless this diagnosis has already been made or excluded by a dentist or dental specialist then resulting treatment could be inappropriate and even dangerous, for example filling a hole in a tooth with underlying endodontic infection could lead to a spreading of that infection and pus through the tissues and could be life threatening. I believe that the competency standards presented reflect the OHTs’ current scope, but for reasons already mentioned not the proposed scope. With regards to the prescribed qualifications this is highly theoretical as these New Zealand qualifications have not yet seen the light of day, and there has not been the chance to assess whether the training is adequate for the proposed changes, or whether graduates are competent in an extended scope. This would been to be assessed under a close working relationship with a dentist or specialist as I have previously mentioned. Likewise, I would not automatically expect those having completed the Australian program to have the necessary competencies. The Adult scope course offered to OHTs by the University of Sydney is only 39.5 hours which I do not believe would to give the necessary skills for an OHT to provide adult restorative treatment autonomously.

## Page 8: Anything else

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| **Q8** Do you have any further comments on the proposal? | **No** |

## Page 10: Last thoughts

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| **Q9** Please provide us your feedback | **Respondent skipped this question** |