Page 2: Your demographics

Q1 Your details

Name	**Poppy Horne**
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

Firstly, I have concerns from a patient safety perspective. Even as a young dentist having completed a 5-year BDS degree, I felt ill-equipped to identify and differentiate the lesions which would require more complex restorative treatment. Fortunately, these skills developed with time and great mentorship, but these cases continue to surprise us; while removing a small restoration, a cusp might fracture subgingivally, the caries might encroach on the pulp chamber, or a fracture might be identified within a tooth planned for a direct restoration, which might be better managed with an indirect restoration or a crown. In other words, in 'simple restorative dentistry' those cases that might appear straightforward upon clinical or radiographic diagnosis can quickly become complex as we begin to treat them. I struggle to understand how an OHT with adult scope could be expected to make these difficult diagnostic decisions and obtain informed consent when the clinical management of such scenarios is not included in their scope. Dentistry is a difficult profession which demands that the clinician assimilates its multiple disciplines at all times; it is therefore impossible to separate 'simple restorative dentistry'. Treatment planning is one of the most difficult and important aspects of dentistry and can have serious consequences for patients if not done well initially.

There are few details available regarding the additional training that will be offered to OHTs with adult scope but this is also a cause for concern. From a purely anecdotal perspective, I am aware that many OHTs are currently reluctant to use local anaesthesia. Many patients are referred to our practice having undergone complex subgingival root debridement by their hygienist without local anaesthesia. Understandably, these patients have been discouraged by the painful treatment they have experienced. Perhaps the reluctance of OHTs to use local anaesthesia is related to a lack of training or experience providing during their current training programme? Adding adult scope would therefore demand considerable additional training in order to ensure proficiency in the management of the more complex procedures and medical conditions commonly encountered in patients over 18 years of age. It is unclear how this additional training will be provided and the duration over which it will take place.

Next, the OHT adult scope has been proposed as a possible solution to reduce costs and improve access to dental care in New Zealand. There is little evidence to suggest that this is the case. The high costs of running a dental practice would not differ if the restorative treatment was provided by an OHT with adult scope, as opposed to a dentist. It is expensive to provide dental treatment to a high standard, and it is unreasonable to expect that it these costs could be reduced simply by changing the provider. In addition, this proposal has the potential to confuse the public. There is already a great degree of confusion about the difference between therapists, dentists, hygienists and specialists, and adding adult scope into the mix could heighten this. I suspect that this may also lead to patients having to pay for two consultation visits if they present to an OHT first to be informed that their needs require a dentist, which will cause frustration and a loss of trust.

Finally, I have serious concerns about the provision of dental care to children in New Zealand, if this proposal was to be accepted. Our childhood caries statistics are shameful and it seems ludicrous to be extending the scope of OHTs to treat adults when there is already so much need in the under-18 population. It is logical that OHTs with adult scope may prefer to work in private practice where the remuneration may be higher than in the DHB. I do not believe that this proposal will significantly improve access to lower-cost dental care for adults, and in doing so it may actually decrease access to care for children who are already facing long waitlists and a stretched system.

Page 6: Details about OHT scope, qualifications and competencies

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?

No

Page 7: Specific comments on the proposal

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

Respondent skipped this question

Page 8: Anything else

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

Page 10: Last thoughts

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