[redacted]

Page 2: Your demographics

Q1 Your details

Name	**David Rumble**
Company/organisation	[redacted]
City/town	[redacted]
Email	[redacted]

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

Inadequate training and position in the profession to complete the work proposed.

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?	**Yes**

Page 7: Specific comments on the proposal

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

I am writing in concern to the extension of scope for Oral Health Therapists without age restriction. My concern is mostly around the high needs of low income New Zealanders. I agree with and support the submission by the New Zealand Dental Association by Dr David Crum. I do not support age of treatment changes, isolated from a structured supervisory relationship with a dentist. I disagree with the current formulation for changes by the Dental Council; as I do not believe the adult scope portion of work provides adequate protection for the vulnerable group of the population that this change is proposing to help. My experience includes 12 years as South Island Approving Dental Officer , 12 years as South Island Regional Dental Officer, specifically reviewing and focussed on the provision of care in under 18 year olds and low income groups. It involved a wide and varied community need through- out the whole of the south island. I also have owned two private dental practices over a period of 18 years, I am currently a senior lead dentist in Lumino The Dentists Group. I have since graduation been providing restorative dental care for the group that the proposed changes covers. This includes high needs low socioeconomic patients. I qualified and able to fulfil the roll of specialist dental support, in the Auditing of the dental environment. I feel I have a very experienced and deep grasp on what arrives at dental clinics, this includes treatment in the lower socioeconomic groups and the impact of poor assessments and practicing standards for this group in our community. There is already poorly administered community dental service's in district health boards I had been involved with, and this service will only be impacted upon with the proposed changes. The Longitudinal study out of Otago University, has clearly shown the target groups are 0-5 years of age not 18 and above, in resolving the community dental disease issues. The lack of clear understanding of these unequivocal results completely baffles me. The Dental Council when tasked with protecting the people of New Zealand should start with the interests of the most vulnerable and not the interests of a few self-serving pseudo-professionals. The proposed treatment group due to the reality of their financial situations will be caught twice by the proposals. The assessment of minor filling need will not solve the major more complex presentation of the community group needing care at the present time in New Zealand. We need to have paid attention to serious investment in education and resources already available to us, up wards of $10 million in the last 10 years in Canterbury DHB alone, in public health education to change this, while providing better leadership in the community dental departments. We need to acknowledge that despite free dental care for under 18's, there is still an appallingly low completion and uptake of the OHSA contract services by adolescents. I am a fully qualified dentist with a BDS, it took 5 years and have been maligned for my whole practicing career for being greedy. This proposal acts as if it is a sharp modern tool , but in fact it will divide the profession and is a blunt tool at best, and will dumb down the profession to the general public. Medical assessments, dental need diagnosis and operator skills are the foundation of good restorative dentistry, if we wish for this for all of our adult patients, then obtain a BDS or equivalent. This will prove to the public you are able to apply the science of dentistry safely. The answer to whether to save teeth and what is appropriate in those situations needs full consent prior to treatment, and in order to give that consent, the operator doing consent must have a full understanding of each procedure. The public will be more exposed due to the proposed changes at the most basic level medically, diagnostically and restoratively. The flies in the face of the role of the DCNZ. The implications for treating medically compromised people who you do not identify as medically compromised can be serious. This is unacceptable when it can been seen as a real event if this proposal goes through. I strongly believe it takes a very solid scientific and medical background in a 5 year minimum dental degree to provide that base of knowledge to ethically provide treatment planning advice to patients. I believe that Oral Health Therapists and Hygienists have a huge amount to offer the public, and the dental community, but not separate from the dental team. Both Dentists and Oral Health Therapists have a set of skills that have been developed to be used in team environments. The proposal is one of divisiveness, the accusation of "defending our turf from greed" has blighted the real issue which is skills and outcomes for the betterment of the public. The real points for the argument are the dangers of incompetent treatment or diagnosis. The role of Dental Council should be to safeguard better health outcomes to the public.

Page 8: Anything else

Q8 Do you have any further comments on the proposal? **Yes**

Page 10: Last thoughts

Q9 Please provide us your feedback

DCNZ role has been moved away from what it is intrinsically meant to provide to the public. The move has created a destabilizing effect and a concurrent dumbing down of the skilled professionaly qualified group, the dentist. The accidental side effect is the distrust of the public generated but a lack of clear support for the qualification of BDS by the DCNZ.