Dear Dental Council,

I am writing in regard to the 'Consultation on the age limit for restorative activities in the oral health therapy scope of practise'

I disagree with the proposal to remove the 18 year age limit for restorative activities from the OHT scope of practise.

I am incredibly worried about patient safety and fragmentation of patient care for the following reasons.

-Dentists have 4 years of clinical practise on patients at Otago Dental School, how can this expertise be replicated in a shorter time frame with a post-graduate 'upskill' course or OHT degree?

-Informed consent. Patients may not understand the difference in training between a fully trained dentist and an OHT. Will this be fully explained to the patient if there is a financial interest of the owner of the practise for the patient to be treated by the OHT?

-Informed consent. How can an OHT provide patients with enough information so that fully informed decisions can be made on possible treatment options if the OHT has a limited scope of practise.

-How is the Dental Council going to monitor the OHT's and make sure that they are practising within their scope of practise? The public will have no way of assessing this.

-Unscrupulous practise owners will use OHT to make money, this will appeal to the corporate model of maximum profit at the expense of patient care.This is happening already with unnecessary three monthly hygiene recalls.

-Evidence is increasing yearly on the correlation between oral disease and systemic diseases. OHT's have less training than dentists in pathology, both oral and systemic. Oral pathologies and patients medical histories and medications can change during a course of dental treatment. Ignorance is bliss, mistakes will happen.

-What are the implications of a much lower academic entry for OHT, when it comes to quick clear decision making and problem solving when treatment plans change.

-Even with careful planning and interpretation of special tests, treatment requirements and patient expectations can change. What looks like a small filling can turn into a large one. This poses 2 problems. If OHT aren't able to do crown work (for instance) in their scope of practise, how can they be able to recognise when one is needed? If a tooth requires an unplanned root canal therapy, will the patient be paying twice for what a dentist could have recognised immediately, or worse referred to a specialists for a larger fee when a dentist could have completed the work. Patients will have multiple operators and be seen as a series of procedures and not as a total person.

-Dentists often provide complex and simple procedures at the same appointment for 3 possible reasons. Reduce cost, reduce visits and to avoid multiple administrations of local anaesthetic. This will not happen if simple procedures are passed off to an OHT.

- This proposal will not make dentistry cheaper for patients. The cost of materials, equipment and compliance will be the same. And furthermore the OHT employer will want to make money from the OHT as well. This has happened with hygienists.

-Children’s oral health status in NZ is poor. SDT recalls are inconsistent. Quick and cheap materials are being used (fuji9 and 2 in [redacted]) This proposal will create further problems in the SDT service when SDT's are enticed to OHT practise for potentially greater income than in the public sector. Children's oral health will suffer further.

Finally, the Dental Council proposal states that the change to OHT scope of practise will “make access to primary oral healthcare easier for a broader group of patients” How will this be achieved by a workforce that, has less clinical and medical training than dentists, the same compliance and material costs and will most likely be employed by a practise owner for a profit?

Yours sincerely,

Sarah Whitehead.
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