New Zealand
Dental Assoc.

NZDA House,195 Main Highway
Ellerslie, Auckland 1051
PO Box 28084
Remuera, Auckland 1541
New Zealand
tel. +64 9 579 8001
fax. +64 9 580 0010

Consultations
Dental Council of New Zealand
PO Box 10-448
Wellington 6143

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Sent via email only

NZDA Submission re: Consultation on proposed updates to professional competencies and changes to related scopes of practice.

Thank you for providing us with the opportunity to comment and to ask questions regarding the above matters.

1. Do you agree/disagree with the proposed draft:

a. Dentist competencies

The Association generally disagrees with the list and approach to the clinical competencies. See answer to Q2

The Association has some questions (very few) regarding the cultural competencies and the competencies as listed for several of the other oral health professions (items listed 22-26 of this submission)

2. Do you agree/disagree to remove the detailed scope of practice activities from the gazetted scopes of practice, and to replace these with gazetted professional competencies? The changes to the scopes of practice are detailed in appendices 10 –17. Please detail your position.

The Association response is mainly confined to comments relating to the 'Dentist' competencies.

1. The Association disagrees that the proposed replacement of the existing scope of practice definition, with a list of minimum prescribed competencies, will provide a better way to regulate our profession. We believe the existing definition to be more encompassing of the realities of dental practice and scope.

2. The Association believes that the existing definition of scope of practice, in conjunction with the requirement of ongoing professional development (recertification requirements) remains the better way to regulate our profession. That, and continuing professional development is what we support. We include that previous scope of practice definition for convenience (appendix 1).

3. The Association believes there is an inherent problem in the proposed attempt to list prescribed, minimum competencies when accompanied with the Council's declared position that practitioners may elect to not retain those prescribed minimum competencies by way of referring patients to others who have.

Our reasons are as follows:

4. The existing definition includes defining the scope as: *'the practice of dentistry as the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures within the scope of the practitioner's approved education, training and competence* '.
   It also defines dentistry as: '*performing procedures on the orofacial complex, teeth and the hard and soft tissues surrounding and supporting teeth'*

   To us, this indicates in this particular aspect (there are a number of aspects listed in the existing definition – see Appendix1) that dentists are competent if they can adequately perform procedures on the orofacial complex, teeth and the hard and soft tissues surrounding and supporting the teeth. It encompasses competencies across a range of clinical skill levels and experience and absorbs skills learnt through continuing professional development…and most importantly relates the clinical delivery to their actual competencies – not just the level at which they exited dental school. It moves from minimum standard to the reality of care delivery to patients

5. In our view, this provides a more sensible, encompassing position than trying to prescribe every minimum competency (and keep such a prescribed list up to date).

6. Whilst the consultation document states:
   The review was undertaken to ensure the professional competencies and related scopes of practice remain up to date, fit for purpose, reflect contemporary practice and enable oral health practitioners to meet the oralhealth needs of Aotearoa New Zealand'.

7. We do not believe that the proposed competency list will achieve that. It does not adequately describe contemporary practice, nor would it allow dentists to meet the oral health needs of patients.

8. We believe it is very difficult to attempt to list every minimum competency in a prescriptive way. Any prescribed list would soon be out of date.

9. The proposed competency list will require the undergraduate BDS course to remain relatively static, however, we believe that this will need to be regularly updated.

10. Is it implied that when the list does need up-dating (e.g. the addition of needed cultural competencies) the re-gazetting of the prescribed list is the most simple process?

11. Council is also stating that:
    *'This means **all** detailed information about the knowledge, skills, attitudes, and behaviours an oral health practitioner **must** have to practise safely, competently, and professionally in **their** scope of practice are defined in the professional competencies, rather than being included in the scope of practice'.* We believe that this sentence implies that dentists are generally practicing at the minimum level of their scope when in fact most are likely practicing well above the minimum standard.

12. The Association therefore contends that within Council's proposal, insufficient weight has been given to the reality, that competency in practice is in excess of what a practitioner could provide at 'entry' level. The defining of 'minimum' of well below what the scope actually is, seems a backward step.

13. What Council is proposing, in prescribing detailed minimum competencies being equal in law to the scope of practice, leads to a prescribed scope that discards what patients actually require daily, as competent care, within dental practice.

14. To illustrate a few aspects of this – the list of competencies you are proposing has excluded areas of general practice dentistry that are commonly regarded within scope.

15. More importantly these were previously adequately included within the existing and encompassing definition but are missing in what you are proposing.
    e.g.
    - Surgical root canal treatments
    - Bodily tooth movement
    - Arch expansion
    - Fixed orthodontics
    - Extraction of unerupted teeth (e.g. 3rd molars)
    - Implant placement
    - Biopsies

The issue of effectively excluding minimum prescribed competencies from the scope.

16. The consultation document states this proposal is to:
    - *update the professional competencies that prescribe the knowledge, skills,attitudes, and behaviours an oral health practitioner must have to practise safely, competently, and professionally in their scope of practice*
    - *gazette the updated professional competencies which means they willhave the same legal standing as the scopes of practice*
    - *Oral health practitioners in Aotearoa New Zealand can only practise in the scope(s) of practice in which they æregistered. To register in that scope of practice they are expected to meet the related professional competencies.*

17. It appears Council is stating professional competencies prescribe what a practitioner must have to practise within their registered scope, that the competencies will have same legal standing as the scope and, to register in a scope of practice, a practitioner will need to be able to meet the related minimum prescribed competencies.

18 In the Association's view, it is contradictory to state that despite there being a list of minimum competencies required, that:
Some practitioners may choose to limit their individual practice to certain clinical areas in their scope of practice. This may be where practitioners were educated in these areas but did not maintain competence and currency, or areas of new development since graduation where competence was not attained through further learning and experience.
Patient care in those areas where competence has not been maintained, must be referred to another suitable practitioner

19 Which is it? – now that Council has prescribed a minimum set of competencies, to be registered (i.e claim the registered title of 'dentist'), The Council is also stating such a dentist can exclude minimum competencies and refer those tasks out to others who by the prescribed minimum competencies, are actually 'dentists'.

20 For example, would, someone who does not meet the minimum cultural competencies be able to refer patients requiring that prescribed competency to another practitioner who meets the minimum prescribed competency?

21 We perceive there is a difficulty in attempting to list minimum prescribed competencies and then stating one can elect to not retain those competencies by way of referring patients to others.

3. Any further feedback not provided in an earlier response?

Cultural Competency

22. The Association's supports the addition of the cultural competency aspects of the proposal, not because it is consistent with central government's wider health policy, but because it is simply the right thing for our profession and practitioners within it, to be doing. The Association does seek some points of clarification.

23. Questions have been raised with us regarding the following sentence (pg5)

    It is the person and/or their community, whānau or hapū receiving the care who determine what culturally safe care means for them.

    Perhaps some further explanation as to how this would work, why the patient, rather than the Council is setting the standard and how this competency might be assessed and actually how a practitioner would overcome issues relating to cultural safety where the patient (being treated) has a different view to whānau or hapū.

24. Clarification of the dentist competency Pg 11 item 5.7
    The dentist will be able to apply scientific and clinical knowledge relating to:
    5.7 The core principles of infection prevention and control, including standard precautions, reprocessing of reusable items, performance testing and validation. This includes consideration of Te Ao Māori and Tikanga Māori.

    At this point we do not understand how reprocessing of reusable items, performance testing and validation of autoclaves relates to consideration of Te Ao Māori and Tikanga Māori.
    Could further explanation be given please?

Dental technician competencies

25. We have been asked for clarification regarding the following item please.

    It has been suggested to us that there appears to be a significant change in the Scope of Practice for implant overdentures and the way it is incorporated into the scope for clinical dental technicians.
    6.24 now includes removal and attachment of impression copings abutments etc.
    Is this a change in scope and an addition of clinical tasks? Previously, this clinical activity was quite contentious and specifically excluded as it was considered invasive under the old scope.
    Or have we misinterpreted something?

Comparison for dentists, oral health therapists, hygienists and therapists

26. We have been asked for clarification regarding the following item please.
    Page 5: Preventive care dental therapists apparently do not promote periodontal health compared with the other oral health practitioners. There are dental therapists with an adult scope who might remove hard deposits etc from teeth and implants.

Request

Given the importance of the proposed ideas, the Association requests from the Council general comment regarding our submission and would also very much appreciate a response to the questions contained in points 10,19,20,24 and 25 of this submission.

Appendix 1

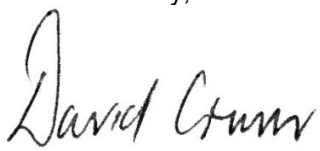
Detailed Scope of Practice for General Dental Practice

The Dental Council of New Zealand defines the practice of dentistry as the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures within the scope of the practitioner's approved education, training and competence.

This involves:
• diagnosis of orofacial conditions and the provision of appropriate information to patients of diagnosis, treatment or management options and their consequences
• removing tooth tissue and/or placing materials for the purpose of either the temporary or permanent restoration or replacement of tooth structure or the rehabilitation of the dentition
• performing procedures on the orofacial complex, teeth, and the hard and soft tissues surrounding or supporting the teeth

• extracting teeth
• administration of local analgesia and/or sedative drugs in connection with procedures on the teeth, jaws and the soft tissues surrounding or supporting the teeth
• prescribing medicines appropriate to the scope of practice, the sale or supply of which is restricted by law to prescription by designated health practitioners
• prescribing special tests in the course of dental treatment
• using ionising radiation, for diagnostic purposes, in the course of the practice of dentistry
• performing procedures on any person preparatory to, or for the purpose of, the construction, fitting, adjustment, repair, or renewal of artificial dentures or restorative or corrective dental appliances.

Yours sincerely,



David Crum ONZM
Chief Executive
New Zealand Dental Association