Who do you turn to when you need help?

Dr Steven Liew

One Friday evening last month I received a call from a colleague around 9.30pm while I was driving through Carlton. She had left her car in the ADAVB carpark after a CPD event, then gone to dinner. As the building was locked for the weekend, her house keys and car were inaccessible until Monday morning. At this point, it started raining heavily.

I considered who I could call for support, then soon realised there really wasn't anyone else I could guarantee would look after her this late on a Friday. Therefore, I turned my car around and drove to South Yarra to help.

The parallel to our professional lives should seem obvious. In a world of increasing corporatisation of healthcare and third parties meddling with the vital dental services we provide, acts of collegiality and unity amongst our profession are more important than ever before. If we consider who we can call for help as a dental professional, who would take our issues to the highest level of government and inspire action - it's pretty simple: our Australian Dental Association. Perhaps the most personal example of how the ADAVB supports members is our Benevolent Fund, which not only supports members in times of need, but also the family of members when tragedy strikes. Many dentists across the State donate to this to aid their colleagues and you can too – see page 33.

Member engagement

Unfortunately at times our altruism and tireless work do not seem obvious to some members. It is frustrating to volunteers on ADA Councils across Australia that we can be seen as 'inactive'. Things couldn't be further than the truth. To me, it indicates a misunderstanding and lack of communication via the correct formats. Your representatives on the ADAVB Council recognised this at our recent annual Council Development Day. There we focused on engagement and key messaging to media and members, with literally questions as ridiculous as, 'So obviously you're all lion hunters and mega rich, what do you have to say about that?' being thrown at us to respond to in front of the entire Council. This hones our ability to stay true to our mission and focus on positive actions in the face of sensationalism.

Media engagement

While we're speaking about media engagement, we should acknowledge the difficulties we face as a not-for-profit organisation that wants to advocate for the health of the public. We can't call a TV station and ask for a segment on flossing. Instead, we must leverage any issue facing dentistry and comment in a way that brings us back to our core advocacy messages. We have recently been focusing on exactly that - and the resulting activity has been incredible. On the back of recent issues and coinciding with Dental Health Week, you will have seen me and councillor Matt Hopcraft appearing on Channel 7 Sunrise and News, 9 News, and 10 News about sugar dangers, public dental funding, and sports dental trauma. Additionally, I was enthusiastically interviewed by Fairfax Media for a feature length article on basic dental health and systemic links which appeared in the Health and Wellbeing section of The Age and The Sydney Morning Herald last month.

Focus on collegiality and allied health disciplines

It's obvious after all this that through united participation in our association, we can improve our professional lives and the dental health of the public far quicker. It's time to cease activities like non-constructive commentary in social media forums and instead focus on collegiality amongst the profession and allied health disciplines.

Not alone

Finally, I'll finish the story I started above. By the time I arrived in South Yarra to help open the carpark, another colleague had already just come to her aid. As I turned my car around and did another lap of Chapel Street like my teenage years, I left satisfied that she, and our members, are most definitely not alone in this world.

ADAVB IN ACTION

The Branch shares the frustration expressed by our community clinic-employed members that EBA negotiations with their employers continue to falter. We encourage all affected dentists to participate in these negotiations, and work towards an equitable conclusion with their employers. Although ADAVB is not legally permitted to act directly in EBA negotiations, we fund the professional industrial relations advice service to nominated employees, which is provided by BroadReach Employee Relations. ADAVB was pleased to be advised that the EBA negotiations for public dentists working in hospitals have already reached a successful conclusion.

The Branch expressed concern about the State Government's proposed two additional public holidays – the Friday before the AFL Grand Final (now declared a public holiday via

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Non-dental services in dental practices

Mr Garry Pearson

Health Ministers agreed last April to progress the National Code of Conduct for Health Care Workers, and the Victorian Department of Health and Human Services is currently working on the legislative changes required to implement this code.

The ADAVB welcomes clarification provided in the National Code of Conduct FAQ Sheet 2015, which states:

"The National Code, once enacted in a state or territory, applies to any person who provides a health service and is not subject to regulation under the National Registration and Accreditation Scheme (NRAS). In some circumstances it also applies to health practitioners registered under NRAS, to the extent that they provide services that are unrelated to or outside the typical scope of practice of their registration." (Emphasis added)

The Branch was recently invited to offer comments on a consultation paper canvassing a number of key issues requiring attention in the Victorian legislation. Some of our key points are:

Key Issue 1 – Scope of the Act

Recognising the broader scope of services offered in some 'health' practices, we find the definition of 'health service' considered by the COAG Health Ministers offers better coverage of all possible services which may require resolution of complaints.

We suggest that the Australian Health Practitioner Regulation Agency and the 14 national registration boards may need to be invited to review their Codes of Conduct to cross-reference the National Code.

Where the registered health practitioner is providing services outside the scope of any registered discipline, they too should be subject to the National Code of Conduct. Examples of issues which may arise where a non-dental service is provided in a dental practice include:

- A dental practitioner seamlessly moves from provision of a regulated dental health service to provision of a non-regulated service, yet the patient has not been invited to consent to the non-dental treatment, and advised of the different code requirements and complaint arrangements that apply

- Records of dental health care and non-regulated health services are blended and shared with non-registered personnel who do not require access to the patient's sensitive health data, thus potentially breaching privacy and health records legislation

- A massage therapy service is provided in a dental practice by an unregistered massage therapist employed by a dentist, and the consumer alleges that the treatment for whiplash provided by the therapist has caused further injury

- A mixed dental and 'wellbeing' practice owned by a dentist receives a complaint when a skin peel service provided by a beauty therapist leaves the patient with dermatological problems requiring medical care.

Commercial models of care are far more likely to lead to patient complaints due to over-servicing or to unreasonably high expectations of treatment outcomes. It is unfair for young and economically vulnerable practitioners to be held solely accountable for service models which are actually controlled by practice owners. Non-registered practice owners, including corporations, should therefore also be bound to comply with the National Code of Conduct.

Key Issue 2 – Resolution and Support

Recently, the Health Services Commissioner changed complaint procedures so that all complaints are now treated as conciliation matters. While these changes are helpful in providing a consumer with more immediate attention to their concern, they have resulted in less flexibility from the perspective of the practitioner's professional indemnity insurer. Matters which might previously have been dealt with as commercial issues that could be settled by informal dispute resolution processes, now require review by the indemnifier's legal advisors, and more of these cases now involve the practitioner being represented by lawyers. This increases claims management costs and is at odds with the objective of using alternative dispute resolution processes to expedite negotiated outcomes.

Great care will be required in provision of any support to consumers to avoid the perception amongst practitioners that the complaint system is biased in favour of the complainant. The provision of such support would desirably be at arm's length, and the Commissioner would merely make its availability known to the complainant or their carer.

Key Issue 3 – Protecting the Public

'Own motion' powers are agreed as necessary for the Commissioner, especially where a practitioner has a pattern of persistent complaints.

Key Issue 4 – Quality Improvement

Given the complexity of the regulatory landscape affecting health practices,

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a diagnosis of MH or MH*. In both the study population and the treatment subset, 81% of first permanent molars were affected by hypomineralisation. Affected teeth showed no predilection for any particular arch or quadrant. Distribution of hypomineralisation characteristics in the first permanent molars is outlined in the table below:

Although a high number (68%) of children were diagnosed with MIH, when all permanent incisors were assessed only 26% showed hypomineralisation defects. This represented 451 of the 1718 permanent incisors assessed. Central incisors were the most commonly affected, with maxillary central incisors being the most frequent of these. Post-eruptive breakdown, sensitivity and restorations were all much less common in the incisors than in first permanent molars and most visual defects noted were white in colour.

Molar Characteristic	At Study Entry	Treatment Subset
Total number of molars	1124	604
Hypomineralised molars	**908 (81%)**	**491 (81%)**
Prior extraction	58 (6%)	45 (9%)
Prior Stainless Steel Crown	41 (4%)	29 (6%)
Prior atypical restoration	230 (25%)	109 (22%)
One prior restoration	275 (30%)	129 (26%)
Two or more prior restorations	47 (5%)	31 (6%)
Defects Visible	**805 (89%)**	**414 (84%)**
Brown defect colour	379 (47%)	153 (37%)
Yellow defect colour	291 (36%)	184 (44%)
White defect colour	135 (17%)	77 (19%)
Cuspal defect location	599 (74%)	318 (77%)
Occlusal defect location	99 (12%)	42 (10%)
Smooth surface defect location	107 (13%)	54 (13%)
Post eruptive breakdown	386 (48%)	188 (48%)
Presence of sensitivity	181 (22%)	84 (20%)

Treatment was performed in the dental chair for 51% of children with the remaining 49% receiving treatment under general anaesthesia. The 417 affected first permanent molars in the treatment subset received a total of 572 treatment interventions, which was five times more than that completed in molars unaffected by hypomineralisation (unaffected molars MHSI = 1). Treatment is summarized in the table (right) according to MHSI scores:

Summed MHSI scores were compiled for each dentition, ranging from scores of 5 to 52. Permanent incisors were not included in these summed scores. As MHSI dentition scores increased, the frequency of children with at least one extracted first molar increased and all first molars were extracted for patients with scores in the range of 45-52. Increasing MHSI dentition scores were associated with decreased fissure sealant use, with dentitions scoring a low score (5-12) receiving at least one fissure sealant in 93% of cases.

A logistic regression analysis was performed in order to assess the predictive value that hypomineralisation characteristics might have for treatment provided. The full model made use of six characteristics (colour, location, post-eruptive breakdown, sensitivity, prior restorations and atypical restorations) and was predictive for all treatments provided (remineralisation, fissure sealants, interim GIC, adhesive restoration and extraction). Treatment with SS crowns or amalgam showed insufficient frequencies to be included in the analysis.

DISCUSSION

This study was completed within several different specialist paediatric dentistry practices in Melbourne. Most children included were new patients who had been referred to the practices as a result of having teeth affected by hypomineralisation. Treatment of children with molar hypomineralisation (and the related molar incisor hypomineralisation) can be challenging for several reasons, including susceptibility to sensitivity, post-eruptive breakdown, caries and repeated loss of restorations. Assessing the severity of hypomineralised teeth can require a multi-faceted approach. The MHSI used in this study aims to create an objective way to assess the severity of affected teeth and hence to guide treatment planning decisions.

At both the baseline examination and in the treatment subset presenting for recall, 81% of first permanent molars were affected with hypomineralisation. This is a high number but is in a population of children who have already been diagnosed with MH (or MIH), which was a prerequisite for inclusion in this study. Hypomineralisation defects were most often brown or yellow in colour and were most often located in cuspal areas. Post-eruptive breakdown of enamel was noted in almost half (48%) of cases.

The restorative burden was significantly greater in hypomineralised first molars compared with unaffected molars. Not only was there a five-fold increase in the number of treatments provided for affected molars but such treatments were more commonly restorative in nature. Conversely, unaffected teeth or teeth with lower MHSI scores were more likely to receive preventive treatments such as fissure sealants. This is in line with previous studies showing that restorations are more commonly required for hypomineralised teeth and that such restorations may be more likely to fail and require replacement.

The MHSI was developed to address deficiencies in indices concerning hypomineralisation severity. Logistic regression showed that all six characteristics (colour, location, post-eruptive breakdown, sensitivity, prior restorations and atypical restorations) were predictive of treatment received by affected FPMs, thereby validating the use of these characteristics. Some levels within the characteristics were also predictive for treatment. Having an index with predictive value can be a useful tool in treatment planning for hypomineralised teeth. There may be distinct advantages to assessing the severity of affected teeth as early as possible and being able to make definitive treatment planning decisions early in life.

MHSI Score	1		3-4	5-6	7-8	9-10	11-13	Total affected	p
Number of teeth	113		44	108	150	96	19	417	
Remineralisation	11		12	14	22	28	5	81	0.006
Fissure sealant	76		34	59	53	24	3	173	0.0001
Interim GIC	6		3	9	42	30	6	90	0.0001
Adhesive restore	8		10	18	61	42	13	144	0.0001
SS crown	2		1	0	1	3	1	6	N/A
Amalgam	0		0	0	1	1	0	2	N/A
Extraction	4		0	8	34	31	3	76	0.0001
Total treatments	107		60	108	214	159	31	572	

The authors suggest that MHSI scores for a tooth and for a dentition as a whole may be able to guide treatment and make recommendations as such within the article. It is acknowledged that longer term follow-up of patients would be desirable and that further study is required in this area.

CONCLUSION

Children in this study showed a wide range of hypomineralisation defects in term of defect severity and number of teeth affected. Individual teeth and dentitions were scored with the MHSI, which was found to be predictive for treatment provided. This index may serve as a tool to guide clinical decision-making in cases of molar hypomineralisation.

ADAVB in Action - Continued from page 4

notice in the Victorian Government Gazette on 19 August 2015 - refer to page 21 - what to do leading up to the public holiday) and Easter Sunday being made a public holiday. In a submission to the Victorian Government, ADAVB says that the additional holidays would result in a significant economic cost to dental practices as well as impacting on public access to dental care. The Branch recommends that the current public holiday schedule be maintained with no further public holidays introduced.

ADAVB wrote to State Health Minister Ms Jill Hennessy urging the Victorian Government to press the Federal Government for more funding for public dental services. The National Partnership Agreement on Adult Public Dental Services that was supposed to provide Victoria $220 million over three years, was cut in the recent Federal Budget to just $38.5 million for one year only. During Dental Health Week, the State confirmed that it was investing $207 million in public dental services this financial year.

The Branch commented on a consultation paper which canvassed a number of key issues requiring attention in Victorian legislation. This included the definition of 'health service'. See the CEO's column on page 5.

As stated in the President's column, August was a particularly busy time with the Association promoting oral health. The media was very helpful embracing the key themes of Dental Health Week - sports drinks and mouthguard protection.

Clinical Update Review – SEPTEMBER 2015

Completion and return of this questionnaire with 9 correct answers will gain 1 scientific CPD hour towards satisfying Dental Board of Australia requirements. This is an ADAVB members only service. An administration fee of $11 (GST inclusive) applies. Circle the correct response on this form (or a photocopy) and return it with payment to: CPD Coordinator, ADAVB, PO Box 9015, South Yarra, Victoria 3141 - Submit by 30 September.

Or submit your answers online AT NO COST at www.adavb.net

1. A B C D 2. A B C D 3. A B C D 4. T / F 5. A B C D
6. A B C D 7. A B C D 8. A B C D 9. A B C D 10. T / F

Name: ..... Member No: .....

Address: .....

Cheque (made payable to ADAVB Inc) ☐

Credit Card ☐ AMEX ☐ MasterCard ☐ Visa

Card No _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Exp Date _ _ / _ _

Signature: .....

Answers to last issue's Clinical Update (AUGUST 2015)
1 A, 2 C, 3 B, 4 TRUE, 5 C, 6 A, 7 C, 8 FALSE, 9 D, 10 B

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Questions

1. ***Within the classification of this study, a child presenting with three hypomineralised first permanent molars and one hypomineralised permanent incisor would be diagnosed with:***
   a. Molar hypomineralisation (MH)
   b. Molar incisor hypomineralisation (MIH)
   c. Provisional molar hypomineralisation (MH*)
   d. Amelogenesis imperfecta

2. ***Molar hypomineralisation involves:***
   a. A reduction in the organic protein content in affected enamel
   b. An increase in translucency in affected enamel
   c. A reduction in mineral content in affected enamel
   d. The absence of enamel on affected teeth

3. ***Patients in this study were examined and treated in:***
   a. A university environment
   b. Private general dental practices
   c. Private specialist dental practices
   d. A combination of general and specialist practices

4. ***What MHSI score would an unrestored first permanent molar with a yellow hypomineralisation defect located on a cusp receive, assuming there is no post-eruptive breakdown or sensitivity?***
   a. 5
   b. 6
   c. 7
   d. 8

5. ***What MHSI score would an unrestored first permanent molar with a brown hypomineralisation defect located on the occlusal surface receive, assuming there is some post-eruptive breakdown but no sensitivity?***
   a. 5
   b. 7
   c. 9
   d. 11

6. ***TRUE or FALSE?***
   The clinicians in this study had treatments for each tooth dictated to them by the results of the initial MHSI score.

7. ***Which of the following statements is true?***
   a. At the baseline examination, 1124 hypomineralised molars were recorded
   b. At the baseline examination, 604 hypomineralised molars were recorded
   c. In the treatment subset, 604 hypomineralised molars were recorded
   d. In the treatment subset, 491 hypomineralised molars were recorded

8. ***Most children included in this study:***
   a. Had a diagnosis of molar incisor hypomineralisation (MIH)
   b. Had a diagnosis of molar hypomineralisation (MH)
   c. Had a diagnosis of provisional molar hypomineralisation (MH*)
   d. Had molars free from hypomineralisation

9. ***Which of the following was not a hypomineralisation characteristic considered in the logistic regression model?***
   a. Colour of hypomineralisation defect
   b. Presence of post eruptive breakdown
   c. Prior restorations
   d. Size of hypomineralisation defect

10. ***TRUE or FALSE?***
    The MHSI showed predictive value for treatment provided and may be used to guide treatment planning decisions.