

ADAVB RESPONSE TO DRAFT AUXILIARIES CODE

1. Introduction

The ADAVB thanks the Board for the opportunity to comment on its draft Code of Practice for Dental Auxiliaries, and for the opportunity to discuss this matter at the meeting held on Wednesday 27 March.

The Branch believes that any Code of Practice should fulfil the following criteria:

- be easily understood by its audience i.e. registered dental care providers and the public
- be clear, consistent and unambiguous
- be practical and workable
- provide minimum standards
- reflect the Act i.e. be a detailed interpretation of the legislation, as well as giving consideration to the objectives defined in the Act
 - To minimise the community's exposure to health risks in dental care.
 - To promote the community's access to care

The Branch suggests that the draft Code of Practice would need to be modified to fulfil these criteria, and offers the following comments and suggestions to help achieve this.

The ADAVB supports the broad direction of the Code and the description of duties described within it. However, we believe the Code could be improved with modifications, which we have grouped into three categories:

- Minor editorial changes
- Essential substantive changes
- Desirable substantive changes

2. Minor Editorial Changes (mainly for consistency with The Act)

Title

Practice of Dentistry by those registered in the division of dental auxiliaries i.e. dental hygienists and dental therapists.

Preamble

The Board has invited us to comment on the term “educationally prepared”, and we agree that it requires definition. During our discussions with the Board, the suggestion was made that it would be helpful for the Board to attach to the Code the current competencies achieved by auxiliaries through the Diploma of Oral Health Therapy. Arrangements by which to identify and confirm competencies achieved by graduates of interstate or international courses would also be usefully advised.

“registered practitioners” should be changed to “registered dental care providers”

“recency of practice” requires definition

“... extend their ~~range of~~ knowledge and skills ...”

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Part 1

“practising dentist” requires definition

“Dental hygienists and dental therapists to work in a consultative and delegation / referral relationship with ...”

The Code should recognise that the Act requires the dental auxiliaries division of the register to contain a subdivision of dental hygienists and a subdivision of dental therapists (refer s16(5)). The Act treats the two auxiliaries as separate entities and the Code should also reflect this. The Branch fully supports the DHAA wish that hygienists continue being recognised as a separate entity. Part 2 would therefore desirably be recast so that it contains all the tasks and other comments applicable to dental hygienists, under a heading “Sub-Division of Dental Hygienists”.

It then follows that Part 3 should contain all the tasks and other comments applicable to dental therapists, under the heading “Sub-Division of Dental Therapists”.

The use of separate lists of duties for each auxiliary may also help with the “Dental Examination” problem.

Part 2

“prescription” requires definition

Part 3

“Orthodontic procedures, on the prescription of a dentist, except for ...” as the treatment planning is being done by dentists.

“The restoration of coronal tooth structure damaged by caries or trauma, ~~including pulpotomies~~, but excluding indirect restorations and endodontics other than pulpotomies in deciduous teeth.”

Replace “Local anaesthesia” with “analgesia”.

“therapeutic solutions” requires definition. Does it include bleaching? The ADAVB view is that it should not.

3. Essential Substantive changes

Preamble – should include reference to S 3(h) of the Act, i.e. “providing dental care that the provider is not registered to provide” will constitute unprofessional conduct.

Part 1 of the Code does not seem to recognise the different environments of the School Dental Service and private practice. It could appear that the public sector model is to apply in all situations. The ADAVB and most members believe this is not appropriate, and that **in private practice dental auxiliaries should work under the prescription of the dentist**, who is responsible for the treatment. This position was overwhelmingly supported in the Branch’s survey of members reported in our earlier submission to the Board.

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The Code should also specify some level of supervision. Whether this would remain “direct” as presently applies in private practice, or “general”, as has been the case in the School Dental Service, the Branch and its members do not have as clear a majority view as for prescription. The Branch would not seek changes to the current arrangements in the School Dental Service, but in the interests of patient welfare, would lean towards direct supervision in private practice. A mixture of tasks that may or may not require prescription depending on the type of treatment, is likely to be confusing and impractical

It would seem that it is possible to accommodate all situations if the minimum standard becomes general supervision and prescription. General supervision does not require the physical presence of a dentist and prescription would have the flexibility to enable Dental Therapists to do “examinations” (see comments below under Part 3), as is presently the case. The dentist and auxiliary would then be able to work out a level of prescription that is appropriate. This would change with experience and would not require changing a formal agreement. It also supports, and is entirely consistent with, the Board’s view of professional responsibility.

If the above were included in the Code then there would be no need to insist that dentists and dental auxiliaries enter into written agreements. Such agreements would seem to be difficult if not impossible to implement, and place further unnecessary administrative burdens on practice owners.

The actual status of such agreements is not clear, and neither is the jurisdiction they may fall under, so that the ADAVB believes industrial problems could be created. Further, while Boards can restrict activities for public benefit, such is not the case for individual dentists. Any agreement that goes beyond the Code could potentially be interpreted as a restraint of trade.

Unless dental care providers are clearly identified by name and title (as per the Register), it will be harder for consumers to differentiate between the types of service providers and their qualifications. This requirement should be reinstated in the Code. It could also be the subject of a separate Code or Guideline, or even be included in the advertising guidelines, as it would apply to all registered dental care providers.

Part 2 – We would urge the Board not to extend duties without valid evidence and appropriate training. To suggest such extensions is at odds with the Preamble’s requirement that auxiliaries “**may perform only those tasks for which they have been educationally prepared.**” This section also repeats the encouragement of research already contained in the Preamble.

Part 3 – As discussed at our meeting with Board representatives, the concept of a comprehensive “dental examination” should be used with care, as this activity could really only be undertaken by a registered dentist. Auxiliary personnel might perform screening or monitoring activities, or undertake various diagnostic or charting duties, but not a comprehensive examination.

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“Local anaesthesia for dental procedures” also needs to be handled carefully given the diverse training backgrounds of registered auxiliaries.

4. Desirable substantive changes

Inclusion of a clearly specified list of duties would be preferred.
Please consider different supervision requirements for the public and private sectors.

5. General Comments

The Code seems to treat dental hygienists differently from dental therapists. This is particularly so in relation to variable requirements for working under the prescription of a dentist.

The draft Code seems to be based on a premise that dentists and dental auxiliaries are both professional and so should decide what to do. Other Codes adopted by the Board however take a different and more prescriptive approach. Requirements for professional indemnity insurance, infection control, use of rubber dam for endodontic procedures, and sedation for dental procedures are tightly defined. This approach appears to be inconsistent.

The Code needs to be assessed in the light of the rapidly changing nature of dental service delivery, especially given new treatment modalities (Invisalign) and commercial styles (Britesmile spas).

Glossary

Consistent with the Branch’s earlier submission, this response to the draft Code has used the same definitions of various key terms as were employed in our survey of member opinions in early 2001, namely:

“Direct Supervision” means supervision of dental procedures provided by auxiliaries based on instructions given by a registered dentist, who must be physically present in the treatment facility during the performance of those duties.

“General Supervision” means supervision of dental procedures based on instructions given by a registered dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures.

“Prescription” means the detailed, written instructions provided by the dentist, usually specifying the treatment to be performed.

We point out that the ADAVB no longer advocates use of terms such as “direction” and “control”. Also that “supervising dentist” would be replaced by “dentist responsible for the patient’s care”.

March 2002