

REVIEW OF DPBV CODE OF PRACTICE C002 PRACTICE OF DENTISTRY BY DENTAL HYGIENISTS & DENTAL THERAPISTS



**Submission to Dental Practice Board of Victoria by
Australian Dental Association Victorian Branch Inc
September 2006**



22 September 2006

Mr Peter Gardner
Chief Executive Officer
Dental Practice Board of Victoria
Level 13, 114 Albert Rd
South Melbourne Vic 3205

Dear Mr Gardner

**SUBMISSION RE REVIEW OF CODE OF PRACTICE C002
PRACTICE OF DENTISTRY BY DENTAL HYGIENISTS
AND DENTAL THERAPISTS**

Please find enclosed the ADAVB submission in response to the Board's review of Code of Practice C002 Practice of Dentistry by Dental Hygienists and Dental Therapists.

Recognising that the Board has not proposed any specific changes to the current Code as yet, this submission anticipates arguments being presented from various other parties for expansion of duties or changes to supervision arrangements, and addresses these in general terms.

We acknowledge that if more specific proposals are presented at a future stage we will have opportunity to argue in a more scientific way about the impact of any such proposal on public health and safety.

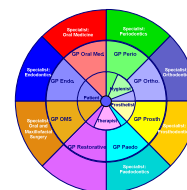
Branch representatives would be pleased to amplify any of the matters raised herein should this be of assistance to the Board.

Yours sincerely

A handwritten signature in blue ink that reads 'G Pearson'. The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Garry Pearson
Chief Executive Officer

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EXECUTIVE SUMMARY

1. ADAVB urges the retention of the general practitioner dentist as the 'coordinator' of dental care, ensuring that a patient's overall oral health is monitored and maintained, and that patients are referred to specialists or auxiliary personnel for aspects of their treatment as appropriate. We support the continued use of a Code as provided for in the Dental Practice Act to define restrictions on the duties of dental hygienists and dental therapists because they are only trained to deliver basic treatment within selected areas.
2. ADAVB supports the roles of both dental hygienists and dental therapists in providing treatment to certain categories of patients under a range of defined conditions. Without having completed a BDS, dental hygienists and dental therapists will not be equipped to provide the full range of care.
3. ADAVB supports hygienists being permitted to perform temporary restorations and treating residents in nursing homes providing there are controls whereby patients needing to see dentists do so before treatment by hygienists.
4. ADAVB does not support dental hygienists being responsible for diagnosis and management of periodontal disease, undertaking tooth whitening procedures, referring for OPGs, or providing relative analgesia.
5. ADAVB supports separation of the Code into distinct parts or alternatively, the establishment of separate Codes for each of dental hygienists and dental therapists. The new code needs to be more specific in setting parameters so it is not subject to mis-interpretation.
6. Workforce substitution is not an answer to shortages because of the complexity of public dental treatment needs.



1. Introduction

The Victorian Branch of the Australian Dental Association (ADAVB) is pleased to provide this submission in response to the Board's review of the Code of Practice on Dental Auxiliaries.

The ADAVB supports the important roles of both dental hygienists and dental therapists in providing treatment to certain categories of patients under a range of defined conditions.

The ADAVB is aware that some parties argue for the lifting of all restrictions on duties performed by dental hygienists and dental therapists, while some others advocate selective expansion of duties. Sometimes these arguments are expressed in terms of increasing access to care, as in the case with hygienists working unsupervised in nursing homes, whilst at other times the argument is more clearly industrial, and focused on 'graduates' being entitled to independence. Similarly, arguments have been mounted to suggest that the Dental Practice Act's use of the term 'auxiliary' is offensive and that these dental care providers should be recognised as professionals in their own right – not working under the supervision of a dentist.

The new hybrid training courses now offered at Melbourne and LaTrobe Universities will produce dual qualified and dual registerable personnel, with both restorative and preventive skills. While the ADAVB has no concern with these practitioners working within their skill and training, we remain of the view that they will not be equipped to provide the full range of care required in the community. To be equipped to provide that care would require them to complete a BDS degree. We also hold that these operatives should remain separately registered rather than being blended into a single classification.

ADAVB maintains that substituting these operatives for dentists for the treatment of adult public patients will result in more costly and inefficient double treatment, and would limit treatment to the simple and obvious problems while more complex needs are un-noticed. The majority of public patients need complex restorative care, and so they require treatment by dentists, supported by dental therapists and dental hygienists for selected aspects of patient care.

2. Scope of Practice - Dental Hygienists

The ADAVB is a member of the Victorian Oral Health Alliance (VOHA), an informal and non-aligned group of consumer, welfare and professional bodies committed to improving public dental health. VOHA has adopted a policy platform which it is advocating to the parties contesting the State election in November, and a key element of this package is the need for more teams of dental care providers being made available to treat residents of nursing homes, or others who are unable to attend public or private clinics.

A small pilot study has been conducted over recent months on the use of hygienists in nursing homes, without the supervision or presence of a dentist. ADAVB expects that some parties will seek modification to the scope of practice for dental hygienists to allow them to provide basic oral health maintenance for residents without having been seen first by a dentist.

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The ADAVB strongly supports the use of hygienists to treat these people and considers that many more such operatives should be employed in the public sector to address the needs of the elderly. We accept that where it is difficult for dentists to attend residential care facilities, dental hygienists should screen residents to determine which of them require appointments with dentists. We support them providing oral care within their current scope of practice, but would urge that if the screening determines that the resident should see a dentist, this should occur before the hygienist's treatment proceeds.

Hygienists providing treatment in residential care facilities should not do so as independent contractors, but should only do so by arrangement between the nursing home and their employer, who should own and operate a dental practice in which at least one dentist is available to supervise the patients' overall oral care.

The DHAABV recently briefed the ADAVB on a number of their proposals for extension of hygienists' duties. These include tooth whitening and placement of temporary restorations where a filling becomes dislodged during hygiene care and the patient needs a temporary measure while they await an appointment with a dentist. The former proposal is not supported, however the latter is, with some qualifications.

Our opposition to inclusion of tooth whitening duties is based on patient safety and the likelihood that it will further reduce access to care. Patient safety concerns relate to lack of knowledge regarding underlying issues with tooth anatomy. There are many varied reasons for tooth discolouration, and some would mean that bleaching is contraindicated. Such decisions should only be made by dentists who are qualified to distinguish between the various causes of variations in tooth colour. ADAVB considers that increasing provision of cosmetic treatment could only be done at the expense of diverting time away from the basic preventive care that is so urgently needed amongst large sections of the population. There is already more than enough cosmetic dentistry being done while public patients wait an unacceptably long time for treatment.

Provided the placement of a temporary restorative material does not require any preparation of the tooth, ADAVB supports hygienists performing this task as a holding measure while the patient waits to see a dentist.

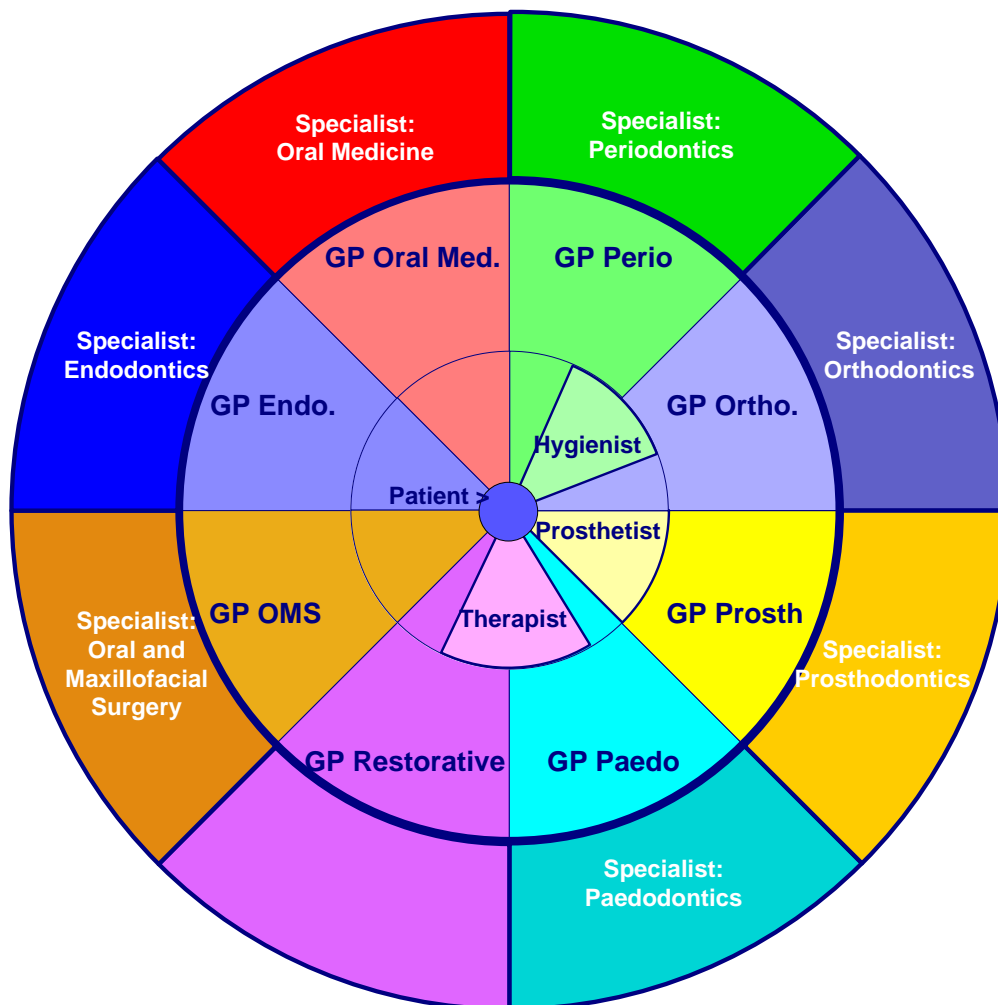
The ADAVB would be concerned if dental hygienists were permitted to refer for orthopantomograph (OPG) x-rays as this would imply that hygienists have the ability to read them. The OPG is a very complex film requiring a thorough knowledge of radiography and anatomy to fully appreciate its benefits and shortcomings.

As one member expressed it:

"I am very concerned about proposals regarding auxiliaries and radiographs. ... (W)hen a dentist is financially reimbursed for radiography, it is not the film that the patient is paying for, rather the opinion of the dentist regarding findings on the film and their clinical relevance. There is much discussion in the dental/medical literature that radiographs cannot be read in isolation, that attention must be given to the clinical findings. Radiographs are only a diagnostic aid."



The schematic chart below, presents a simplified view of the way in which treatments in the various fields of dentistry are delivered by the different types of dental care providers. The chart should be read to suggest that the simpler problems and treatments are near the centre of the wheel, while the conditions and diseases, and their interactions with other health conditions, become more complex the further towards the outer rim one travels. The patient perspective in the inner blue circle reflects their limited understanding of oral diseases and conditions, and their contribution to treatment through self-managed care.



General practitioner dentists are trained to provide treatment across all modalities and areas, while specialist dentists provide highly complex treatment in only one nominated field. Likewise, dental auxiliaries such as dental hygienists, dental therapists and dental prosthetists only deliver basic treatment within selected areas, to which their training and diagnostic skill are limited.

Patients attending for dental treatment will often have needs in multiple areas, and the general practitioner dentist is the coordinator for their overall dental health, referring to specialists and/or auxiliaries as appropriate for selected aspects of patient care. Arguments for workforce substitution fail to recognise the sound patient welfare basis of this model by naively suggesting that a lesser trained auxiliary should substitute for a general practitioner dentist.



The best training for a dental operative to be able to provide treatment across the full range of dental diseases and conditions is the Bachelor of Dental Science, not the Bachelor of Oral Health or its predecessor qualifications. In other words the ADAVB would be happy to support expansion of duties for dental therapists and dental hygienists so that they substituted for dentists if the qualification they completed was a BSc.

A member made the following observations:

“I can see massive use for hygienists in both public and private sectors.

Can see great need for therapists in the school dental context but, in contrast, only very limited need in private practice. I could never envisage use of therapists in my practice as I consider it vital that I establish a positive relationship with the children in my practice.

Why train at all for dual qualification? This seems to me to be a huge misdirection of limited resources.”

A general practitioner dentist who employs a hygienist commented:

“(The) current scope of practice is more than adequate, but under utilised by the profession. Dentists who have never used a hygienist need to be educated as to how much their practice can be improved with their use, both in the improved quality of care and increased profitability. In saying this, their numbers need drastic increasing, they are so hard to find.

How on earth do you draw a line as to what restorative care they can provide? For example, if a patient needs 2 fillings in one quadrant, one shallow, one with possible pulpal involvement, do they do the first then refer to a dentist for the second? Does the patient then have to go through 2 procedures and lots of local anaesthesia on 2 separate days? Does the dentist work under the direction or prescription of the hygienist, or does the patient pay for 2 examinations? How ridiculous!

Many carious lesions look like one thing radiographically and/or clinically, and turn out completely differently in actual fact. What does the hygienist do if they find themselves in over their heads, continue on and create a disaster, or hope the dentist down the road can bail them out while the patient is still anaesthetised? The Dental Board can’t possibly put people at risk like this.

In short, there is no doubt we need to increase public accessibility to dental care. This means increasing the number of dental professionals able to give care, but under existing guidelines. Separating hygienists will only create more problems, will not decrease the cost of dentistry in any way, because most adults will only need to see both dentist and hygienist anyway.”

Independent practice not supported

We do not support independent practice rights for dental hygienists, believing that they are very effective as auxiliary personnel providing preventive services, and that many patients require restorative and more complex care, of which preventive treatments are just one element.

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If there was a view that independent practice would somehow reduce fees for preventive care and that this would enhance accessibility of hygiene services, this does not appear to have been borne out in the US State of Colorado, where unsupervised hygiene practice has been permitted.

“Unsupervised private dental hygiene practice has not had a notable effect on access to care in Colorado. The impact of those practices is limited in two important ways: 1) there are very few practices; and 2) they are located in areas served also by dental offices with traditional dental hygienists. The economic viability of the unsupervised hygienist business model is questionable because their prophylaxis fees, on average, are not different from traditional dental practices, which have the advantage of providing a full range of practice services. This may explain why independent hygienist practices have not expanded substantially in a state where they are permitted.”

Source: Brown LJ, House DR, Nash KD. The economic aspects of unsupervised private hygiene practice and its impact on access to care. Dental Health Policy Analysis Series. Chicago: American Dental Association, Health Policy Resources Center; 2005.

Suggested Code modifications

Dental Hygienists

- For patients attending the dental practice, management of periodontal disease (excluding surgical management) within the context of an overall treatment plan undertaken by a dentist;
- For patients in residential care and unable to attend a dental practice, screening and referral to a dentist, and provision of oral hygiene care in accordance with a generic plan approved by a practicing dentist, without the presence of either that dentist or any other;
- Preventive dental procedures including, on the prescription of a practising dentist, fissure sealants.

An orthodontist suggested that some amendments might be helpful in relation to orthodontic duties mentioned in the Code:

“I would like to suggest that in relation to the wording of the orthodontic provisions page 2 of 3 of the code where it says:-

- *Orthodontic procedures under the supervision of a dentist, except for:*
- *Diagnosis and treatment planning for orthodontic treatment*
- *Initial fixation of bands and brackets*
- *Design of orthodontic appliances*
- *Activation and adjustment of orthodontic*

I suggested in 2002 that the wording should not have employed the word "fixation".

"fixation" means making the bands and brackets "fixed" to teeth.

These days, brackets and bands become "fixed" (to teeth) by shining a light at the adhesive. Shining a light at the adhesive is definitely a non-critical job that an auxiliary should and can



perform without any risk to the patient. It already exists in the Code in relation to other aspects of dentistry permitted for Dental Therapists. Examples include light curing fissure sealants, and composite and glass ionomer restorative procedures. I do not believe that the above code has been tested in court but it is a weak part of the code where problems could arise. Even if chemically cured adhesives are used, my point following below holds.

I propose that underlined phrase above should be replaced with the following words:-

- *determining the positioning of orthodontic attachments on teeth”*

3. Scope of Practice - Dental Therapists

ADAVB supports dental therapists working within their skill and training, but we firmly believe that without having completed a BDS, they will not be equipped to provide the full range of care required by the community.

The integration of the School Dental Service with the Community Dental Program is being used to facilitate dental therapists providing treatment to 18-25 year old patients, and while we recognise that the Board’s current Code permits this, dentists employed in the public sector have told the ADAVB that they do not appear to be working in the manner required by the Code. Dentists have reported to us that they have been asked to sign agreements with therapists in order for the appearance of Code compliance to be established, whereas there is no supervision of the kind envisaged by the Board.

We also consider that substituting these operatives for dentists for the treatment of adult public patients will result in both ‘supervised neglect’ and more costly and inefficient double treatment. When the majority of public patients require complex restorative care, this means they require treatment by dentists, supported by dental therapists and dental hygienists for selected aspects of patient care.

A public sector dentist commented:

“No procedure is performed in isolation in the human body; there are direct and indirect ramifications. What defines the scope of practice of an individual is not the ability to perform a technical task, rather it is the ability to deal with the outcomes of performing that task, be they positive or negative. Inherent in this comment is an understanding of the consequences associated with that task. In order to have a comprehensive understanding of all the consequences and how to deal with them, comprehensive knowledge is required. It is axiomatic that a fully trained dentist is the only person with that knowledge.

Implicit in the ability to perform a technical task is not only the ability to carry out that task but the ability to gather adequate diagnostic information that allows one to provide a diagnosis, provide treatment options and adequately inform a patient as to the risks associated with each option. Again, only a dentist has the adequate skill set to perform these duties.

A number of the duties mooted are irreversible, especially when moving to the adult dentition.”



Another public sector member with team leadership responsibility for dental therapists reported:

“The current scope of practice is very general and broad. If a dental therapist gains competencies in all the dental practices in Part 3, they would have performed nearly all the common dental procedures of the age group they treat. The procedures they refer to dentists are permanent extractions, periodontics, endodontics and orthodontics. Given that many dental therapists still have not gained competencies in all the areas covered in the current scope, instead of further extending the scope of practice, it is better to put the resources into a proper training program to train all those now in the workforce.”

A private sector member made the following observations:

“My concern about independent practice rights would be that they may be tempted to perform more complicated dental procedures with no back-up should they run into trouble. I know this sounds very high and mighty, but, again, I reiterate - if they want to continue to increase their scope of practice with no supervision and to become independent, why not just do the BDS course?”

...

Unfortunately, the therapists that I have had contact with when my children were in primary school often failed to identify themselves as therapists to the public, thereby misleading them - as a matter of fact, in the 17 years of preschool service with Frankston Council, I lost count of the number of parents who were under the impression they were dentists. I hope this has changed. Hence the reason for my skepticism.

I personally don't use either a therapist or hygienist as I find patients have questions regarding their other dental work which only the dentist would be able to answer.”

A Periodontist remarked:

*“-Auxiliaries are not "mini" dentists
-Their training is shallow and only suitable to carry out prescribed tasks under supervision.
-Independent practice is putting the public at risk.
-The cost to patients will increase once they have their own practice and the fee will be much the same as dentist - as demonstrated by dental Prosthetists. -Shortage of man power should be addressed by training more dentists and not trying a short cut by using auxiliaries as pretend dentists.
We have been aware of this shortage for nearly 30 years!”*

4. Limitations on age of patients

The number of dental therapists in the public sector is not even enough to meet the demand of the preschool to 18 age group, so any suggestion to extend the age group is premature. It may well further restrict access to these age groups whose oral health status has a significant impact on the future of public dental health needs.



5. Access to dental care

The Public Accounts and Estimates Committee Report on 2006-07 Budget Estimates stated:

“Current policy aimed at integrating community and school dental services will, according to the Minister, also help to reduce vacancy rates by maximising the potential of the dental health teams to allow dental therapists currently employed in the school dental service to treat clients up to the age of 25.”

Given a substantial difference in remuneration between public and private sector employment, ADAVB understands that around 30% of dental therapists have left the public sector, reducing their therapist workforce to around 80. This outcome was predicted by the ADAVB when the Dental Practice Bill was presented to the Parliament and we warned then that it would damage the School Dental Service. The recall period for the School Dental Service has apparently now stretched to almost three years, and this is a clear reduction in access for eligible children.

We acknowledge the efficiencies being sought by the integration of the School Dental Service and Community Dental Services, and the concerns that had been held about OHS issues in the older mobile vans that are now being retired. Our concerns now focus on the gradual erosion of the School Dental Service and a tendency for the Government to further ration their limited dental funding so that pressure is being applied to use therapists to reduce the adult waiting lists at the expense of the School Dental Service. This is simply bad public health policy, and if the Board agrees to a de facto shift in the use of these auxiliaries, then it will be responsible for a process of rationalising further reductions in access to care for children, with the consequent shift away for the sound preventive philosophy which had informed the School Dental Program. This will move Victorian public dental services more rapidly towards an emergency service mentality that uses whatever dental personnel can be thrown at the problem of unacceptably long waiting lists for restorative care.

Access to dental care by the disadvantaged has been reduced as a result of the introduction of the Code.

The ADAVB argues that if hygienists and therapists are permitted to do tooth whitening procedures, this would further reduce the emphasis on access to health care, whilst encouraging wider use of discretionary cosmetic treatments,

Some community sector advocates have suggested that more use should be made of dental therapists to treat adult public patients, but in our view, the majority of such patients have complex treatment needs. Substituting therapists for dentists will mean that only their simple problems will be addressed while their more complex needs will still need to be referred to a dentist, thus creating greater inefficiencies in the use of their time and public funds.

While waiting lists appear to have been reduced over the last two years, less than half of the eligible population is actually receiving care. The more people realise that treatment might be available, the more they will seek it and thus return waiting lists to politically unacceptable levels.

There are over 1 million Victorians who are eligible for public dental care and yet the 2005 Annual Report for DHSV shows that less than 30% of them receive treatment in any one year.

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“In 2004-05, more than 182,126 adults and 107,085 children from rural, regional and metropolitan areas of Victoria received general and specialist care from DHSV. Our adult services are available to all Victorians who hold a pensioner concession or health care card, and their dependents. Treatment for concession cardholders under the age of 18 is fully publicly funded, while treatment for those over 18 is subsidised.

All primary school children and concession card dependents in years seven to 12 are eligible to receive treatment through our School Dental Service and the Youth Dental Program, and co-payments apply for children whose parents are not concession cardholders.”

(Source: DHSV 2005 Annual Report)

ADAVB considers workforce substitution arguments to be based on simplistic notions of competency, usually derived from an industrial skills context, where a series of discrete skills is catalogued, and according to which modules of a skills-based course one has completed, additional roles are assigned and wage increments awarded.

For the Government to be more effectively committed to access to care, it needs to define the rights of public patients to minimum levels of service, and ensure that these targets are met. No targets have been set and pressure applied to the Board to adjust the scope of duties will not solve the problem.

6. The Professional Agreement

The ADAVB considers that the Professional Agreement is an untested element of the Code. As no copies of these agreements are publicly available, no one can really assess the extent to which they have been well understood and effectively implemented.

Given the attention to compliance required under other Codes, this is a surprising aspect of the Board’s approach to this Code. Have there been any audits of these Agreements of a similar nature to those proposed for CPD compliance? If so, publication of the findings would be of interest to the dental community.

If the agreements are of so little importance that none are ever considered worthy of checking, then we query why they are required under the Code.

The ADAVB has seen some examples of agreements used by members, and we have been concerned that none met the requirements of the Code as we understand them.

One public sector member remarked:

“Not sure how it has been enforced. I have been asked to be a team leader of a Dental Therapist who I never see or work with (we both work part time at the same location but different days). Concerns raised to management were ignored. I have also been asked to sign professional agreements for Dental Therapists who I don’t even know.



My experience is that dentists who have never worked with Dental Therapists before are not familiar with what they can and cannot do. Many are not familiar with the code of practice. If the practice manager of a dental clinic has no dental background, how can the professional agreement be relied on as a means of safeguarding the compliance of the Code?"

If these remarks are an accurate reflection of the prevailing approach within the public sector, then it seems the Code is effectively being breached on a systematic basis, and the agreements adopted are not achieving the Board's objective.

7. Forms of supervision

In commenting on the difference in relationships between dentists and auxiliaries in the public and private sectors, a public sector dentist noted:

"The comments I make are based on my experience working with dental therapists in the public sector where the employer and employee (dental auxiliary) relationship is different to those in the private practice environment. In the private practice environment, the interactions between the professional groups are a lot more direct than in a public institute. The relationship/dynamics between a dentist who is an employer and team leader is different to the one between a dentist and dental therapist when both are employees and the dentist was asked to be the team leader by an employer who may not be a dentist and may not have a dental background."

One member who uses both therapists and hygienists in her paediatric practice advised:

"I feel strongly that the dentist should be controlling the quality of care by examining all cases and prescribing what is required to be done by each person in the practice. The level of expertise in complex cases requires in depth knowledge of the patient, which is obtained after a dental degree. The majority of the cases are very well handed by Dental Therapists in public and lately in private practice help provide care for a significant number of children in Victoria. With a likely increase in caries rates in the near future due to an increase in sweetened snacks offered to children in the last few years, we are likely to see a high demand on services for children. I strongly support a team approach where every member of the team feels confident to deal with the challenges presented by each patient with the adequate knowledge at the individual level."

Another public sector dentist remarked:

"Under the current Code of Practice, the work relationship between the dentist and the dental therapist is one of 'consultation and referral'. DTs do not require a dentist's supervision to practice. It is up to the dental auxiliary to initiate the process. The risk is if you don't know what you don't know, you may not know when to consult. For example, DTs have mistaken grossly hypoplastic permanent teeth as grossly carious deciduous."

As many dentists are not familiar with what a DT can do or cannot do, sometimes they provide inappropriate advice to them. I am aware of one incident where a dentist advised a DT to use an endodontic file to clean the canals of a molar. The DT admitted she never used a file before, not entirely comfortable with it but thought it was ok to go ahead as she was operating under the instruction of a dentist."



The code stated that a DT can provide dental care to 19-25 years old on the prescription of the dentist. The work 'prescription' to me means the dentist examines and draws up the treatment plan, the DT carries out the specified procedures. To the DTs and some of my colleagues, it means DTs can examine and decide on treatment, the DTs just need to verbally inform the dentists what is to be done without the dentist examining the patient. The risk of an adverse outcome is further increased if a DT chooses to consult with a dentist who is not familiar with the limitations of a DT. The new code needs to be more specific in setting the parameters so it is not subject to interpretations."

Another private sector member made the following observations about supervision of hygienists:

"I have had considerable experience in working with hygienists while I was in the RAAF. My experiences were very positive. I truly believe that as long as a dentist is present, in the sense of being in the same practice, and a dentist is readily available in case of a mishap, and a dentist has a supervisory role acceptable to the dental practice board, the number of problems should be very few compared with the huge advantage of having so many extra pairs of hands to look after our patients' mouths."

8. Public safety

On the matter of public safety, a member said:

"A patient is put at risk when a clinician (regardless of which professional group they belong to) is not aware of their limitations. One example is that before the introduction of the code, Dental Therapists referred the patient to the dentist for treatment planning and to arrange prophylactic antibiotic cover if required. Under the new Code, they refer directly to the GP. There were instances where the prophylactic antibiotic cover regime prescribed by the GP was not appropriate and the Dental Therapist did not pick it up."

9. The nature of dental auxiliaries' training

One member with direct experience of working with therapists in a training environment noted:

"The training the therapists get is limited with older (>16) patients, and they are often demonstrated to by a more senior DT who has had no training in the treatment of adults. This is of great concern as it is the blind leading the blind. If there is direct supervision by a dentist then this may improve the situation, however I have great doubt on whether this would really occur in the public sector - from experience, supervision is nearly always indirect."

Another suggested that none of the undergraduates receive enough clinical training:

"They face the same issue as training of dental students - not enough practical clinical experience; they learn when they come out into the 'real world'. As for providing training to those already in the workforce, the training is ad hoc."

10. Successful and unsuccessful innovations introduced by the 2002 Code

See remarks regarding the lack of effective use of professional agreements above (see pp 10-11).



INFORMATION SUMMARY 2006/07

ABOUT THE ADAVB

The ADAVB is the peak professional association of Victorian dentists and its aims are to

- improve the dental health of all Victorians;
- promote the art and science of dentistry; and
- promote the highest standards of professional dental care
- enhance the professional lives of members

MEMBERSHIP

- About 2480 dentists in private and public practice, as well as 4th & 5th year students and overseas trained candidates
- 95% of registered private practitioners
- 10 suburban and 7 country groups

MEMBER SERVICES & FUNCTIONS

- Continuing Professional Development Program
- Dental health education programs (eg. Dental Health Week)
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent Graduate support
- Dental Assistant Training seminars
- Member Service Plans (eg Professional Insurances; preferred suppliers)
- Industrial relations advice and representation
- Defence and legal support
- Advice on Practice Management
- Quality Assurance (including Doctors Health Support Service)
- Benevolent Fund
- Library and resource collection
- Political representation
- Representation to Government bodies
- Superannuation (Professional Provident Fund)
- Sports and social functions
- Publications – Newsletter, Journal, Award details, Manuals etc.
- Home Page (find us at <http://www.adavb.com.au>)

DISPUTE RESOLUTION SERVICES

The Branch provides information to the public on dental matters, and offers a conciliation service to assist patients to resolve disputes with members. Information on treatments, facilities, dental issues and careers is available.



PRESIDENT

Dr Greg Morris
BDSc, LDS

Greg is a general practitioner in Hawthorn. He has served on numerous ADA committees including Dental Health Education, Graduate Education and Infection Control

CHIEF EXECUTIVE OFFICER

Mr Garry Pearson
MEdSt, HDT (SAC)
AFAIM, MAICD

Garry commenced with the ADAVB in 1991 after senior executive roles in the Victorian Education Ministry



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