Submission
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INQUIRY INTO DENTAL SERVICES IN NSW

Organisation:

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Theme:

Summary

The Inquiry into Dental Services
The Standing Committee on Social Issues
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Titled: *"Time to Drag Dentistry from the Ninetieth into the Twenty-First Century"*

to the Inquiry into Dental Services in NSW

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Disclaimer
This submission represents the personal views of the author and is not representative of any of the organisations to which I am attached or associated.

Synopsis

I wish to convey to the Members of the Standing Committee on Social Issues, of the Legislative Council, Parliament House of NSW that fundamental, enlightened reform of the public oral health sector is urgently and critically required. This reform is a necessity to safeguard the provision of sufficient, high quality, general and specialist dental services, in both the public and private sector, for the citizens of NSW.

The key areas for reform are:

- Provision of an initially voluntary, (later to be both mandatory and of two years duration) dental intern programme (Dental Vocational Training Scheme - DVTS).
- Provision of fully-paid full-time specialist trainee (Registrar) positions in all of the dental specialties: Endoontics (root canal therapy), Oral Medicine/Oral Pathology, Orthodontics, Paediatric Dentistry, Periodontics, Prosthodontics (crown and bridge and implants), Public Health (Community) Dentistry, and Special Needs Dentistry.
- Full parity, or, preferably, outright inclusion of dental specialists with the award conditions of their medical counterparts.

Personal Background

I have worked in many areas within the dental profession, since graduating in 1987 (over 18 years ago) including private dental practice, hospital practice, specialist public practice and now specialist private practice. I have contributed to my profession in the form of research, scientific publications, contributions to the lay press, and an ongoing commitment to teaching at all levels, from undergraduate, to post-graduate and the provision of continuing professional education, not only to my fellow professionals, but fellow medical, nursing and pharmacy colleagues. I believe this background provides me with a unique insight into the provision of dental services, and in particular, its current failings.

The Problems and their Aetiology:

I. An Insufficiently Resourced (Financial and Personnel) Public Oral/Dental Health Service

The direct effect of an insufficiently resourced public oral health services is that of an enormous oral/dental disease burden, in the most economically and socially deprived segment of the population, that is those who receive some form of government benefit or financial support. This in itself should be sufficient justification for a dramatic increase in funding for public oral health. However, an indirect result, but one that that is of greater concern to wider general public, is, this will *imperil the quality of the training of future dentists, dental nurses and assistants, dental para-professionals and specialists.* The net result will be a decline in both the calibre and the number of future dentists. This unfortunately is coincident, at a time, when the patients seeking oral care are, older, are more medically-complex, and have greater dental needs than at any other time in NSW's history. The evidence in the decline in numbers of dentists is now well established, and easily demonstrated *by the lack of dentists in those areas with poorer remuneration and/or conditions. Namely, rural and regional areas*, public and/or institutional settings, such as the Faculty and the public sector (over 60 unfilled Dental Officer positions).

The decline in the calibre of recently graduating dentists is more difficult to ascertain, and the reasons are more complex than simply the issue of under-resourcing of the public sector. This has one direct effect in *that older, more experienced dentists, and specialists are presently not encouraged by either the current pay or conditions to remain to mentor their junior colleagues and students.*

II. An Insufficiently Resourced Faculty of Dentistry (University of Sydney)

Although superficial assessment of the personnel of the Faculty of Dentistry, would suggest that in absolute terms there has been no substantive decline in the numbers of academic staff, the current staff are younger, clinically in-experienced, largely non-specialists, or non-clinicians. Since the cessation of payment for clinical tutors, who for the most part, were more experienced, able dental practitioners, clinical supervision of the upcoming graduating dentists has largely been bourn by a handful of academics, and very junior staff, who themselves have just graduated and have at best, usually one to two years of experience.

II. i. Adoption of the first Two Years of the Graduate Medical Programme

The other issues confronting the Dental Faculty and specifically the training of future dental practitioners, has been the difficulties imposed by the substantive changes to the dental (under) graduate curriculum. Adoption and inclusion of the first two years of the Graduate Medical Programme (GMP) I believe represents a significant advance in the training of a dental workforce that needs to be equipped to handle a patient population that has a greater prevalence of complex medical problems. However, it has to be acknowledged that this commitment to the first two years of only a four year training programme will necessarily result in less time for graduates to develop their requisite technical skills and ability to become safe dental practitioners. This is compounded by an under-resourced public dental sector that cannot provide the time and infrastructure, allied to shortage of experienced clinical mentors for dental students to make-up this shortfall in time to develop technical expertise. Alienation of the dental graduate students from their medical counterparts and peers, plus little (if any) teaching material to demonstrate the clinical relevance of the educational material provided during the course of the GMP have led to a belief (among students, and I feel the wider dental profession) that the material offered by involvement in the GMP is irrelevant, and represents a unnecessary waste of time, possibly better used in obtaining the necessary "hands on" skills and technical expertise required of a dentist.

II. ii. Problems of a Problem-Based Learning (PBL) Curriculum

The other issue confronting the Faculty is the adoption of PBL. PBL is highly personnel-intensive if it is to be successfully undertaken. It entails teaching in small tutorial groups of up to eight students led by "Facilitator" to address a clinically-based problem, so as to lead to understanding of the underlying basic principles of the pre-clinical sciences, such as physiology, pathology, and biochemistry and their relevance to clinical practice. This is undoubtedly an advance in the delivery of complex information, but it requires the following conditions to be met, if its is to be successful: (1) large numbers of staff, (2) intensive technical support (computers, Internet access, etc), (3) students you have had some background information in the pre-clinical sciences and (4) and subsequently repeated and intense reinforcement of the learning objectives.

The Faculty at this time has insufficient personnel, and no opportunity to provide students with a basic grounding in the pre-clinical sciences so that they can make the most of the learning opportunities provided by PBL teaching sessions. These issues are not unique to Sydney, and overseas there has been an emphatic move to strike an appropriate balance between traditional, lecture based methods of teaching and PBL methods. Proper resourcing of the Faculty to undertake the necessary revision of its teaching programme and curriculum is essential.

II. iii. Insufficient time and resources to develop appropriate levels of clinical and technical competence prior to graduation

Dentistry and dental practice entails high levels of clinical competence and technical ability to perform the routine procedures expected of a qualified dentists, such as restorative procedures (drilling, with a ultra-high speed dental handpiece, or increasingly, a high-energy laser, and the placement of fillings), prosthodontics (crown and bridge), endodontics (root canal treatment), and surgery (extraction of teeth and the placement of implants). To develop such skills, dental students need time. Sufficient time, to constantly repeat and practice the necessary technical procedures needed to be a dentist, in a nurturing environment, without undue time pressures, with intensive clinical supervision, support and mentoring. Mistakes are then minimised, and a certain level of safe clinical competence before graduation can be achieved. Unlike most other professional groupings, there is no "internship" in which time is given to mature clinically and develop these skills to a minimal level of competence, expected by the general community. Two years only out of a four year training programme is insufficient time.

The solutions appear self-evident. The easy "fix", is to shorten the time taken by the first two years given over to the GMP. This is unacceptable, as the nature of the patient population, older, sicker, taking more medications that dentists are required to treat, requires that they have a high level of medical knowledge to treat their patients safely. The second, more appropriate, but harder "fix" is to provide a training programme, consistent with that of other professionals, and ***put in place an 'intern" year, more appropriately termed a "vocational training year".***

III. Dental "Internship" (Vocational Training Year)

The benefits of the provision of a one year (and I would strongly argue for a two year programme) Dental Vocational Training Scheme (DVTS) I believe are largely self-evident. The public hospitals and medical system is entirely dependent on the yearly intake of interns (first year medical officers) who then move, every year thereafter into higher ranks, with greater clinical experience and maturity, and in tum become Senior Residents and Registrars, and so oversee their junior colleagues (the interns) in turn. By this process, there is constant renewal of the medical personnel, and experience in providing clinical mentoring and support, invaluable for those who go on to become senior Consultant Medical Officers. This scheme is also central to the training of all doctors, include those who join the private health care system. A similar scheme is absolutely a necessity for the continuation of dentistry as viable profession.

This has been better expressed by Professor JR Anderson, Professor of Pathology, University of Glasgow, former Editor of Muir's Textbook of Pathology, who stated in his preface to the Eleventh Edition (1980): *"It has long been appreciated that the undergraduate course in medicine* (dentistry) *cannot do more than lay the basis for the further training, and that the newly-qualified doctor* (dentist) *must undergo a further period of training, followed by the appropriate specialist or vocational training before commencing independent practice."*

The model for the DVTS is in place and performing well in the United Kingdom, so that here in NSW we do not need to "reinvent the wheel".

Any such DVTS put in place in NSW must have the following elements to succeed:

- Initially, it would be voluntary until 2010 (hopefully earlier), then mandatory.
- Rotation of Interns between the two dental teaching hospitals (Westmead Centre for Oral Health and Sydney Dental Hospital) and rural and regional centres must be a central element to the scheme
- Ongoing mentoring and teaching has to be provided to the Interns
- Ongoing objective assessment of clinical performance and competency must be undertaken of the Interns (benchmarked to National Standards), and those deem unsatisfactory are required to undertake further remedial training as an Intern before being allowed to enter private practice.

III. i. Advantages of the DVTS

- Substantively increase the public dental work-force, with improve the provision of oral health services to rural and remote areas by the rotation of staff.
- Essentially, cost neutral. There are enough unfilled public Dental Officer positions to put in place the DVTS in 2006, with paid Interns (as in medicine) at essentially no additional cost. There would need to be some outlay in the upgrading and public dental infrastructure.
- Ensure protection of the oral health budget is spent on the payment of the Interns, and the associated costs – chairside assistant, reception and secretarial staff, and good and services and not "leached off".
- Allow for building of career pathway for public health dentists.
- The issues regarding the additional length of the training programme for dentists need to be addressed, but these are not an overwhelming concerns. Asking for a year of service by dentists to the wider community is fair. It is in accordance with what is asked of doctors, and appropriate given that in essence, the wider tax-paying community has effectively subsidised their training. The benefits that accrue for the dental interns is additional supervised clinical experience, for which they are paid, and thereby lowering their risk of subsequent medico-legal litigation. Interns would be exposed to wider career opportunities than merely inevitably going on to private practice.

IV Full-Time Paid Specialist Trainee Registrar Positions

Unlike in medicine, trainee specialists (termed Registrars) in the various clinical disciplines (Endoontics (root canal therapy [although no programme is offered in Sydney]), Oral Medicine/Oral Pathology, Orthodontics, Paediatric Dentistry, Periodontics, Prosthodontics (crown and bridge and implants), and Special Needs Dentistry) receive little or only a part time salary (equivalent to 0.5 FTE Dental Officer Grade 1 salary ~ $25 000 p.a). The cost of their Master of Dental Science (the specialty qualification) is $20 000 p.a for the three years of their programme (total $60 000) – payable to the University of Sydney.

The net result of this is that limited levels of clinical service are provided by the Registrars during the course of their training and serves as a further detriment to the public health system. The training of the Registrars is compromised because of this limited clinical exposure. Lastly, the high costs of specialty training bourn by the registrars acts to make if very unattractive for specialists to stay in the poorly remunerated public sector.

The solution is self-evident, and simple. Trainee specialists, as in medicine, should be paid a full salary to provide a comprehensive clinical services during their training, and be encouraged by attractive salaries to remain for a further two years in the public sector, gaining further valuable clinical experience for two years as Senior Registrars. This would provide to the public sector, in effect, specialists available to service remote, rural and regional centres, and more critically, mentoring and clinical teaching support for the dental interns. The cost would be small for an elegant imaginative solution for the poverty of specialist service provision throughout the public sector and rural and regional areas.

V Public Dental Specialists – Parity with Medical Specialists

Dental Specialists, undergo the same demanding, financially and in time, training pathways that their medical counterparts undertake, accept the same levels of administrative accountability and clinical responsibility, but because of antiquate awards are paid up a half to a third of their medical colleagues. This is patently discriminatory, but critically most adversely affects the public sector. Dental Specialists, as with medical specialists are the bedrock for speciality service provision, clinical training, undergraduate, postgraduate, and professional continuing education and research in the public oral health sector. Uniquely they are available only in the public sector to oversee and provide the training of future dental specialists. In select specialities, specialists in the public sector provided services completely unavailable in the private sector, such as care of the physically and mentally disabled (Special Needs Dentistry).

Fair and proper remuneration for dental specialists will make it far easier to maintain and build clinical and research expertise. In essential specialties, the public sector is unable to employ specialists because of the poor pay and conditions, namely in Endodontics, Orthodontics and Periodontics, leading to the non-provision of training programmes, as has occurred with Endodontics.

Conclusions

It is time that the dentistry was dragged from the nineteenth into the twenty-first century. From a time when dentistry was viewed as some form of "tooth carpentry", a trade best learned by an apprenticeship, to the present day – an esteemed encompassing profession, supported by a vocational training programme able to produce high calibre, competent oral health care professionals able to cater to the health needs of the citizens of NSW.