



Australian Dental Association Inc.

**AUSTRALIAN DENTAL ASSOCIATION INC. RESPONSE  
TO DENTAL BOARD OF AUSTRALIA'S CONSULTATION  
PAPER ON REGISTRATION STANDARDS AND RELATED  
MATTERS**

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**Authorised by**

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## About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The primary objectives of the ADA are:

- to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry, and
- to support members of the Association in enhancing their ability to provide safe, high quality professional oral health care.

There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at [www.ada.org.au](http://www.ada.org.au)

## Response to Consultation Paper

This submission will deal with each of the Mandatory registration standards as listed in chapter 2 of the Consultation paper.

### **2. Mandatory Registration Standards**

It is noted that 2.1 Criminal History and 2.2 English Language Skills will be a common standards for all boards.

#### **2.1 Criminal History**

The Australian Dental Association Inc. (hereinafter referred to as the "ADA") is in general agreement with the sentiments expressed in the "Summary" section of the report but does have some concerns regarding the Board's consideration of the factors identified under the "Requirements" heading in the report.

Whilst the consultation paper identifies the factors that will be considered under this heading when determining fitness, the paper does not identify what weight will be given to the various factors in a Board's determination of the suitability of a person for registration. Some further consideration needs to be given to identifying the weight to be given to each of the factors identified.

The ADA will comment later in this submission that there appears to be some duplication of the impact of factors in any assessment of fitness. For example, to evaluate the nature and gravity of an offence as a factor, and to then similarly evaluate a sentence imposed for an offence seems duplication.

The ADA will deal with each of the ten factors identified and provide comment.

- i. *The nature and gravity of the offence or alleged offence and its relevance to health practice.*

The ADA supports this and the comments underpinning it in the paper.

- ii. *The period of time since the health practitioner committed or allegedly committed the offence.*

The ADA generally supports this factor but will make comment later in relation to alleged offences when dealing with the next factor.

- iii. *Whether a finding of guilt of a conviction was recorded for the offence or a charge for the offence is still pending.*

In so far the comments made in the paper relate to actual convictions and actual findings of guilt, the ADA agrees with the comments made.

The ADA would not agree with any weight being attached to a factor that involves either a pending charge or a non conviction charge. It is a fundamental premise of Australian justice that persons are considered innocent until proven guilty. To evaluate a practitioner's criminal history by evaluating and providing assessment of pending charges or non conviction charges is fundamentally contrary to this basic premise and should not be included in any evaluation as to the suitability of a person for practice. Only when an offence has been proven should it be considered in any determination of fitness for registration.

- iv. *The Sentence imposed for the offence.*

Whilst the ADA can see what is intended by this, it would seem that to include this as a factor in the evaluation of a practitioner's "fitness for practice" represents a duplication of factor (i) referred to above.

The nature of the sentence imposed for an offence would, in any sentencing policy, have regard to a number of factors and would certainly include the "nature and gravity of the offence"- as identified in factor (i). It should not be repeated. To do so would duplicate the weight given to the offence. Factor (iv) should therefore be removed.

- v. *The ages of the health practitioner, and of any victim, at the time that the health practitioner committed, or allegedly committed, the offence.*

The ADA would agree that the age of the health practitioner is a relevant factor to be evaluated. It agrees with the comments that a Board may place less weight on an offence committed when an applicant is younger especially before qualifying. This generalisation may be dangerous as it has to be recognised that some offences may be more likely committed by younger offenders than others. The ADA would expect that the Board would be heavily rely on expert testimony or evidence in determination of the impact of this factor.

What the ADA is not prepared to accept is that additional weight be given for the factor relating to the age of the victim of an offence. The ADA believes that it can see the sentiment behind the inclusion of this in the factor; however this issue would seem to be adequately covered by factor (viii). Again, there would seem to be a duplication of the factors to be assessed if the age of a victim is to be included in this factor (v).

The ADA repeats its comments relating to the need to not take any account of alleged crimes. Only crimes proven to have been committed should be included in any evaluation.

- vi. *Whether or not the conduct that constituted the offence, or to which the charge relates, has been decriminalised since the health practitioner committed, or allegedly committed, the offence.*

The ADA would agree with this factor.

- vii. *The health practitioner's behaviour since he or she committed, or allegedly committed the offence.*

The ADA would agree with the commentary provided pursuant to the identification of this factor. Rehabilitation from the offence is to be rewarded and if this can be demonstrated then minimal weight should be applied to the impact of the previous offence.

The ADA repeats its comments relating to the need to not take any account of alleged crimes. Only crimes proven to have been committed should be included in any evaluation.

- viii. *The likelihood of a future threat to a patient of the health practitioner.*

The ADA agrees with this and assumes that the Board would seek expert advice relating to the applicant to determine the likelihood of a future threat. If the earlier offence, or offences, were offences that demonstrated a propensity for a particularly crime and that crime clearly indicated an unfitness to practice then strong evidence must be produced to substantiate the applicant having been rehabilitated from that behaviour.

- ix. *Any information given by the health practitioner.*

Independent support for the information provided by the health practitioner should allow the board to provide more weight to this factor.

- x. *Any other matter that the Board considers relevant*

Whilst the ADA agrees with this "catch all" factor, some definition of the criteria to be identified as to the sorts of matter that would be considered relevant by the Board must be provided.

## **2.2 English Language Skills**

The ADA agrees that English language skills are imperative in the practice of dentistry. Communication between patient and practitioner is a crucial factor in the provision of treatment.

The ability to properly communicate with a patient is essential for any health practitioner and the registration standards must require a level in English that will ensure proper and full communication occurs to further ensure high quality and safe treatment is provided.

The ADA notes that the Board has identified alternative test procedures be recognised. The ADA would ask that whatever tests are adopted for registration equate with those utilised by the accrediting agency: The Australian Dental Council.

The ADA agrees with the necessity for recency of the test results. The ADA suggests the generalisation that test results be within two years be removed and that a strict timetable of two years for compliance be adopted. (There seems to be some inconsistency between the time limitations referred to under the "Requirements" heading, particularly at paragraph 3).

The ADA generally agrees with the specifics raised under "Requirements." Under the "Exemptions" the ADA would accept these save for one exception. This is in relation to the Exemption dealt with at paragraph 1 (b) – 3<sup>rd</sup> dot point. The ADA notes the requirement under the Exemption relating to patient safety but says this should be extended to include "quality" also. Whilst patient safety is very important, so must be the quality of treatment being provided by the practitioner.

The ADA understands that the Australian Dental Council has found the OET to be the most suitable test in assessing overseas qualified dentists and so the ADA supports the use of the OET as first choice.

### **2.3 Professional Indemnity Insurance**

The ADA agrees that professional indemnity insurance be obligatory for practitioners.

The ADA is assuming that professional indemnity insurers will be responding to the consultation paper on this issue and so will not cover in detail matters best left to their expertise. It is noted that in the ADA Victorian Branch submission that some beneficial comments have been made regarding this issue that should be noted.

An issue that the ADA anticipates will be raised by the insurers is the requirement that the insurance policy include "unlimited retroactivity of cover". As the Board would be aware, there was, earlier in this decade, a hiatus in professional indemnity cover for health practitioners that required federal legislative intervention. Prior to that hiatus, many health practitioners held policies that provide claims incurred discretionary cover. Such cover remains available under those arrangements.

To require a current insurance policy to provide "unlimited retro activity" would mean that cover for such events is being duplicated by the cover provided by the discretionary provider and that provided by the current insurer. The requirement of unlimited retro activity would require current insurers to alter their existing reinsurance arrangements and the like, to provide cover for claims incurred prior to that hiatus.

It is understood that the Medical Indemnity (Prudential Supervision and Products Standards) Act 2009 (NIPS&PS Act) requires insurers to make an offer of retroactive cover available for otherwise uncovered prior incidents. This means that practitioners already have the option of covering any gaps but are not required to insure for periods for which they already have claims incurred cover.

Costs for such cover would be duplicated. Problems of potential dual insurance would arise in litigation that would result in additional legal costs being incurred and confusion in respect of claims.

There needs to be refinement to this requirement to address this potential situation.

The Board may wish to consider some additional requirements in its standards in this area and they are:

- a) Practitioners be required to declare or undertake that their PII arrangements will be maintained for their period of their registration, and
- b) As an adjunct to Requirement 5, practitioners be required to produce to the Board on application for registration a "certificate of the currency" for the PII cover, identifying relevant terms and compliance with the standards.

## **2.4 Continuing Professional Development**

The ADA has always opposed the requirement that Continuing Professional Development (CPD) activities be mandatory. The ADA does not believe that there is any evidence, in existence, that suggests the requirement for making CPD mandatory in any way enhances a practitioner's ability to deliver safe and quality dental services.

Notwithstanding this, the ADA is in general agreement with the standards proposed regarding CPD but raises the following qualifications/comments:

- a) To impose an identical period of participation in CPD (60 hours per three year cycle) for all categories of dental practitioner registrant seems inappropriate. Whilst the imposition of this period of CPD might be appropriate for a dentist practitioner, the ADA questions the necessity for that same number of hours to be completed by the other categories of dental practitioners. These other practitioners have a more limited scope of practice and should therefore not require the same period of participation in CPD that a dentist would require. This distinction is recognised in Victorian and overseas schemes. If CPD is to have any value practitioners should enjoy participating and 60 hours for all practitioners may negate this.
- b) It is noted that registration is required to be completed annually yet the CPD cycle is one over 3 years. Requirement 1 (d) indicates that a declaration of compliance with CPD requirements is necessary at the time of annual renewal, yet there is in fact no specific requirement for CPD activities to be conducted annually, only per three year cycle - 60 hours over 3 years. A declaration of compliance could therefore be provided by a registrant who has not completed any CPD activities over the first two of the three year cycle.

Some clarification as to whether this is permissible should be provided or if there should be a minimum of say five hours undertaken each year.

- c) The ADA would like some clarification as to the criteria to be applied by the Board in approving CPD activities. The ADA would hope that the Board would impose stringent requirements upon providers to ensure appropriate CPD activity. However, such a system should be simple and not impose undue administrative burden on practitioners.
- d) Whilst the nature of CPD for "Infection Control" and "Cardiopulmonary Resuscitation" is clear, however it would be advantageous if some clarification could be given to the definition of "clinically or scientifically" based CPD. The ADA would support the definitions used by the Dental Practice Board of Victoria.
- e) Some concern has been expressed that requiring 3 hours of infection control CPD per cycle may be difficult to provide. It has been suggested that once infection control CPD has been undertaken within the first cycle then perhaps the standards could be revised to reduce the 3 hour requirement in subsequent cycles to a period of 2 hours per cycle thereafter.
- f) The system should be as simple to administer as possible for the practitioners. Some aspects of the Victorian scheme such as gaining credit for overseas activities are time consuming.

The ADA awaits with interest the publication of *"Guidelines for Registration Standards-Continuing Professional Development"* when published.

## **2.5 Recency of Practice**

The ADA is supportive of the concept of a "Recency of Practice Standard". The period of 5 years that is identified is also accepted. The ADA will reserve final comment until it can review the yet to be developed *"Guidelines for Registration Standards-Recency of Practice"*.

A matter that the ADA feels the Board should consider is the impact the Recency of Practice Standards will have upon practitioners that have family care commitments. The ADA would promote the development of a requirement that will provide some recognition of the need for some practitioners to provide family leave. For instance, females returning to practice after maternity leave ought to be given some flexibility to allow for the family leave/domestic circumstances of home care.

## **3. Proposal for Board Specific Standards**

### **3.1 Scope of practice Standard**

In all current jurisdictions dentists can practice all of dentistry and the other dental practitioners parts of dentistry. This situation must be carried through to the proposed scopes of practice standards. In most jurisdictions the scopes of practice for allied dental practitioners are defined. These standards do not do this.

The ADA supports in general the Requirements identified in paragraphs 1, 3 and 4. It is pleasing to see the Board's recognition that dentists remain the "clinical team leaders".

The requirement that dentists be the only dental practitioners supplying and fitting dental appliances for the treatment of sleep disorders is accepted and reflects current ADA policy. See attached ADA Policy 5.7 "Use of Dental Appliances to treat Sleep Disorders". However there is no statement that dentists can practice all of dentistry and this must be included.

The ADA believes that modification to Requirement 2 is essential and suggests that reference to "those dental procedures" be removed and replaced with the words "*those parts of dentistry*".

The ADA believes that with this amendment it will provide greater clarity as to the duties able to be performed by the various categories of dental practitioners. Once amended the standards must then define those parts of dentistry that can be performed by hygienists and therapists as is the case for dental prosthetists. See attached ADA Policy 2.2 and 2.3 "Dentists" and "Allied Dental Personnel".

In respect of paragraph 5, the ADA would seek some clarification as to the exact nature of the denture that is being referred to. For example, would it extend to a screw retained implant supported with a removable denture?

In respect of paragraph 6, the ADA believes the terminology used is ambiguous.

For example:

- i. The is reference made to dental hygienists, dental therapists and oral health therapists being able to exercise "autonomous" decision making" yet refers to those same practitioners as being "not independent practitioners".
- ii. It is difficult to be precise as to what is meant when the standard refers to dental therapists, oral health therapists and dental hygienists not being independent practitioners "in terms of training."
- iii. In the Guidelines it is unclear as to how the Board expects the various members of the dental team to interact. Paragraph 6, due to its ambiguity, will only cause confusion and possibly result in services rendered that compromise safety and quality.

Clarification on these issues is needed.

Further, the ADA is of the view that the Scope of Practice Standard would be enhanced if there defined duties of each practitioner provided within the scope. This will enable the public to know what these practitioners are registered to practice and define training and accreditation requirements. The ADA's policy in this area (which is attached) may provide some guidance to the Board on this issue, as may the General Dental Council's supplementary guidance on scope of practice for dental care providers. Hopefully these will be referred to in the yet to be developed "*Guidelines for Registration Standards-Scope of Practice Standard*".

Without clarification of these issues the ADA cannot endorse the existing Scope of Practice Standard.

#### **4. Proposals for Specialist Registration**

##### *4.1 Approval as a Health Profession for which Specialist Recognition Operates.*

The ADA is pleased to note that the National Law has specified dentistry as a profession for which Specialist recognition will operate.

##### *4.2 Proposed list of specialities.*

The ADA is in general agreement with the proposed list. Noting that the list is a "proposed" list, the ADA would suggest:

The definitions of the various specialties should more accurately reflect the definitions provided in the ADA Policy on this issue. See attached ADA Policy 2.4 "Specialisation in Dentistry". This suggestion is made as these definitions have been developed over a considerable time and the ADA believes accurately reflects the area of specialty being dealt with.

It is noted that the Board has identified a category of Specialist –"Forensic Odontology". The ADA would question the necessity for the creation of this speciality. As you can see from ADA's policy it does not believe this to be a necessary category for specialization in the practice of dentistry. While the ADA has no strong opposition to this category of specialist, the title chosen seems to be inconsistent with the other titles for specialities that are adopted.

The ADA would recommend that the title be "Forensic dentistry" and thus be in line with the terminology used elsewhere for example: "Paediatric dentistry" and "Public health dentistry".

At this stage Oral surgery and Forensic dentistry do not fulfil the requirement in section 4.4 and so their introduction should be delayed at the very least.

The ADA recommends that for clarity for the public there should be set out in the standards the specified title by which the various categories of specialists can be identified. For the ADA's suggestions as to the titles to be used please refer again to the ADA Policy.

##### *4.3 Specialist registration standard*

The ADA generally accepts the Board's standard here.

The ADA had submitted in response to calls for comment in relation to Bill B that registration as a specialist should only follow registration as a general dentist. This was not adopted into the Act however the ADA strongly suggests that at least some additional provision requiring Recency of practice regarding the period of general dental practice be incorporated in this standard.

#### 4.4 *Qualifications for specialist registration*

The ADA agrees with the requirement for an applicant to have “a minimum three year postgraduate specialist qualification” and it be accredited. It suggests that the standard actually reflect (not infer) a requirement that in some cases longer clinical training may be necessary for some specialities.

The ADA believes, any dental speciality should meet the following criteria. It should:

- Have a clear need and demand of a substantial portion of the population.
- Be important to the health of individual patients.
- Be an area of dentistry in which general practitioners may have need to refer patients for provision of expert services in a particular area of dentistry.
- Require special knowledge and skills, superior to undergraduate dental education and training, in order to perform procedures of an advanced, difficult, or unusual nature.
- Be definable in order to prescribe the scope of the speciality.
- Be one in which approved educational institutions conduct accredited formal courses to qualify practitioners appropriately.
- Have an established specialist organisation.

#### **5. Proposals for endorsements.**

##### 5.1 *Proposed endorsement for conscious sedation.*

The “Application” specifications are appropriate. See attached ADA Policy 2.5 “Areas of Practice Adjunctive to Dentistry”.

The “Requirements” are also considered acceptable noting that they require extra specific qualifications and knowledge befitting this category of dental practice.

The *Guidelines for Conscious Sedation* is awaited.

Thank you for the opportunity to respond to the Consultation Paper. Should you wish to discuss any of the matters raised in this response, please contact the Association.



Dr Neil D Hewson  
Federal President  
Australian Dental Association Inc.

24<sup>th</sup> November, 2009.

## USE OF DENTAL APPLIANCES TO TREAT SLEEP DISORDERS

### 1 Introduction

#### 1.1 **Definitions**

1.1.1 SNORING is a common sleep disorder and is a sign of upper airway obstruction. It affects people of all ages, but is most common in overweight, middle-aged and elderly male adults.

1.1.2 OBSTRUCTIVE SLEEP APNOEA (OSA) is caused by a more significant obstruction than simple snoring with consequent sleep fragmentation, hypoxaemia or both.

1.2 Sleep disordered breathing has seriously interfered with quality of life and has been associated with premature death. Symptoms of OSA include:

- excessive daytime sleepiness;
- pulmonary hypertension;
- ischaemic heart disease;
- cerebrovascular disease;
- impaired social relationships;
- psychiatric illness;
- impotence;
- decreased libido;
- a disturbing increase in vehicle-related accidents; and
- death related to driver drowsiness.

1.3 Anatomical airway collapse and altered respiratory-control mechanisms cause OSA and snoring. Contributing structural abnormalities can include nasal-septal deviation, hypertrophied turbinates, nasal polyps, mid-facial hypoplasia, lymphoidal hyperplasia, macroglossia, retrognathia, micrognathia, benign and malignant neoplasms and retroglossal narrowing.

1.4 An increased incidence of OSA and snoring is associated with obesity. Disordered airway-control mechanisms are also involved in sleep apnoea.

1.5 In recent years, there has been growing interest in the use of dental appliances to treat snoring and OSA. Treatment with dental appliances may lead to a reduction of snoring or the harmful effects of OSA by one or more of the following mechanisms:

- mandibular repositioning;
- tongue advancement; and
- alteration of palatal and mandibular position or dynamics.

### 2 Management

2.1 There is a growing body of literature to support efficacy of dental appliances for snoring and mild to moderate forms of sleep apnoea.

- 2.2 In cases of snoring or OSA, the initial diagnosis should be made by a specialist respiratory physician.
- 2.3 In severe sleep apnoea, dental appliances may not be consistently successful. For such patients, both initial prescription and monitoring efficacy require careful assessment, including study of their breathing during sleep.
- 2.4 Concern has been expressed regarding claims that severe sleep apnoea patients (who are stable on nasal continuous positive airway pressure (CPAP) therapy) can be treated by dental appliances only. Given the significant morbidity associated with sleep apnoea, extreme caution should be exercised before discontinuing CPAP.
- 2.5 Where there is long term use of dental appliances, then monitoring of the patient's temporomandibular joint and orthodontic movement of teeth is essential.
- 2.6 These matters have been considered by the executives of the Thoracic Society of Australia and New Zealand, the Australian Dental Association and the Australasian Sleep Association and each organisation wishes to ensure that appropriate standards of practice are maintained. Correct treatment strategies are succinctly expressed in a report published by the American Academy of Sleep Medicine (formerly the American Sleep Apnoea Association) entitled *Practice Parameters for the Treatment of Snoring and Obstructive Sleep Apnoea with Oral Appliances: an Update for 2005*. Dentists involved in the use of these therapies are advised to read the report and use it as a guide to their own practice.

### **3 Policy**

- 3.1 Medical and dental expertise are both required to manage patients who are candidates for dental appliance therapy for snoring and sleep apnoea. Medical expertise is needed to determine whether it is indicated and to ensure that, once prescribed, the therapy is and remains effective. Dental expertise is needed to assess suitability of the treatment from the dental viewpoint, to supervise its implementation, and to follow up to ensure that side effects or complications are promptly recognised and managed. A team approach is essential.
- 3.2 Dentists are the only dental care providers who are qualified to diagnose and manage dental appliance therapy for sleep disorders.

#### **Policy Statement 5.7**

Adopted by ADA Federal Council, November 11/12, 2004.  
Editorially amended by SPC Policy Review, February 23, 2006.  
Amended by ADA Federal Council, April 12/13, 2007.  
Amended by ADA Federal Council, April 10/11, 2008.

## APPENDIX TO ADA POLICY STATEMENT 5.7

# PRACTICE PARAMETERS

### Practice Parameters for the Treatment of Snoring and Obstructive Sleep Apnoea with Oral Appliances: An Update for 2005 (An American Academy of Sleep Medicine Report)

#### DEFINITIONS

**Standard:** This is generally accepted patient-care strategy, which reflects a high degree of clinical certainty. The term standard generally implies the use of Level I Evidence, which directly addresses the clinical issue, or overwhelming Level II Evidence.

**Guideline:** This is a patient-care strategy, which reflects a moderate degree of clinical certainty. The term guideline implies the use of level II Evidence or a consensus of Level III Evidence.

**Option:** This is a patient-care strategy, which reflects uncertain clinical use. The term option implies either inconclusive or conflicting evidence or conflicting expert opinion.

#### 3.0 RECOMMENDATIONS

The following are recommendations of the Standards of Practice committee and the Board of Directors of the American Academy of Sleep Medicine. Recommendations are given as standards, guidelines, and options.

##### 3.1 **Diagnosis**

3.1.1 The presence or absence of OSA must be determined before initiating treatment with oral appliances to identify those patients at risk due to complications of sleep apnoea and to provide a baseline to establish the effectiveness of subsequent treatment. Detailed diagnostic criteria for OSA are available and include clinical signs, symptoms and the findings identified by polysomnography. The severity of sleep-related respiratory problems must be established in order to make an appropriate treatment decision. (Standard)

##### 3.2 **Appliance Fitting**

3.2.1 Oral appliances should be fitted by qualified dental personnel who are trained and experienced in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures. Dental management of patients with OAs should be overseen by practitioners who have undertaken serious training in sleep medicine and/or sleep related breathing disorders with focused emphasis on the proper protocol for diagnosis, treatment, and follow up. (Option)

3.2.2 Although cephalometric evaluation is not always required for patients who will use an oral appliance, appropriately trained professionals should perform these examinations when they are deemed necessary. (Option)

##### 3.3 **Treatment**

###### 3.3.1 **Treatment Objectives**

3.3.1.1 For patients with primary snoring without features of OSA or upper-airway resistance syndrome, the treatment objective is to reduce the snoring to a subjectively acceptable level. (Standard)

3.3.1.2 For patients with OSA, the desired outcome of treatment includes the resolution of the clinical signs and symptoms of OSA and the normalization of the apnoea-hypopnea index and oxyhemoglobin saturation. (Standard)

3.3.2 Oral appliances are appropriate for use in patients with primary snoring who do not respond to or are not appropriate candidates for treatment with behavioural measures such as weight loss or sleep-position change. (Guideline)

3.3.3 Although not as efficacious as CPAP, oral appliances are indicated for use in patients with mild to moderate OSA who prefer OAs to CPAP, or who do not respond to CPAP, are not appropriate candidates for CPAP, or who fail treatment attempts with CPAP or treatment with behavioural measures such as weight loss or sleep-position change. (Guideline)

3.3.4 Patients with severe OSA should have an initial trial of nasal CPAP because greater effectiveness has been shown with this intervention than with the use of oral appliances. Upper airway surgery (including tonsillectomy and adenoidectomy, craniofacial operations and tracheostomy) may also supersede use of oral appliances in patients for whom these operations are predicted to be highly effective in treating sleep apnoea. (Guideline)

#### 3.4 **Follow-up**

3.4.1 Follow-up sleep testing is not indicated for patients with primary snoring. (Guideline)

3.4.2 To ensure satisfactory therapeutic benefit from OAs, patients with OSA should undergo polysomnography or an attended cardiorespiratory (Type 3) sleep study with the oral appliance in place after final adjustments of fit have been performed. (Guideline)

3.4.3 Patients with OSA who are treated with oral appliances should return for follow-up office visits with the dental specialist. Once optimal fit is obtained and efficacy shown, dental specialist follow-up at every 6 months is recommended for the first year, and at least annually thereafter. The purpose of follow up is to monitor patient adherence, evaluate device deterioration or maladjustment, evaluate the health of the oral structures and integrity of the occlusion, and assess the patient for signs and symptoms of worsening OSA. Intolerance and improper use of the device are potential problems for patients using oral appliances, which require patient effort to use properly. Oral appliances may aggravate temporomandibular joint disease and may cause dental misalignment and discomfort that are unique to each device. In addition, oral appliances can be rendered ineffective by patient alteration of the device. (Option)

# AASM CLASSIFICATION OF EVIDENCE

<b>Evidence Level</b>	<b>Study Design</b>
I	Randomized well-designed trials with low alpha and beta error*.
II	Randomized trials with high alpha and beta error*.
III	Non-randomized concurrently controlled studies.
IV	Non-randomized historically controlled studies.
V	Case studies.

\* Alpha (type I error) refers to the probability that the null hypothesis is rejected when in fact it is true (generally acceptable at 5% or less, or  $p < 0.05$ ).

\* Beta (Type II error) refers to the probability that the null hypothesis is mistakenly accepted when in fact it is false (generally trials accept a beta error of 0.20). The estimation of Type II error is generally the result of a power analysis. The power analysis takes into account the variability and the effect size to determine if sample size is adequate to find a difference in means when it is present (Power generally acceptable at 80-90%).

## DENTISTS<sup>1</sup>

### 1 Introduction

- 1.1 Dentists were one of the first formally trained health practitioners.
- 1.2 Dentists in Australia have a proud tradition of voluntarily supporting Australian Dental Schools and dental research.
- 1.3 Dentists in Australia have a strong culture of cooperation by sharing experiences and knowledge.
- 1.4 Dentists have a strong culture of philanthropy.
- 1.5 A dentist is the only oral health practitioner entitled to use the title "dentist" and may also be known as a dental surgeon, surgeon dentist or dental practitioner, or by a specialist dentist title.
- 1.6 Dentist training involves five to seven years training at university and so Boards and governments have recognised dentists as the principal dental care provider.
- 1.7 **Definitions**
  - 1.7.1 BOARD is a Federal, State or Territory dental registration board.
  - 1.7.2 A DENTIST is an appropriately qualified dental care provider, registered by Boards to practise all areas of dentistry.
  - 1.7.3 DENTAL CARE PROVIDER is a person registered by a Board to provide dental care.
  - 1.7.4 DENTISTRY is the science and art of preventing, diagnosing and treating diseases, injuries, developmental and acquired defects of the teeth, jaw joints, oral cavity and associated structures within the context of general health.

### 2 Principles

- 2.1 Dentists being the most completely and highly trained dental care provider should be central to the delivery of dental treatment.
- 2.2 All Australians should have access to modern, comprehensive oral health care.
- 2.3 Dental care providers should only perform those duties for which they are formally trained.
- 2.4 Dentists perform invasive and irreversible procedures and should be registered.

<sup>1</sup> This Policy Statement is linked to other Policy Statements: 2.1 *Dental Workforce*, 2.3 *Allied Dental Personnel*, 2.4 *Specialisation in Dentistry*, 2.8 *Overseas Trained Dentists*, 2.9 *Recency of Practice*, 2.10 *Clinical Practice Placements*, 2.12 *Benefits of Defined Health Professions*, 3.1 *Continuing Professional Development* & 4.7 *Regulatory Authorities*

### 3 **Policy**

- 3.1 Education and training of dentists must be to degree level in a programme conducted by a tertiary institution in the higher education sector and accredited by the Australian Dental Council (ADC).
- 3.2 Selection for entrance into such a programme should not be based solely on academic performance and may include:
- communication skills, including competence in the English language;
  - state of health, including being blood borne virus free;
  - good character; and
  - physiological suitability to be a health practitioner.
- 3.3 A one-year clinical placement year is supported.
- 3.4 Overseas trained dentists must satisfactorily fulfil ADC and Board requirements before practising in Australia.
- 3.5 The dentist must be responsible for diagnosis, treatment planning, delivery of dental procedures and continuing evaluation of the oral health of the patient. The dentist is also responsible for the support, direction and supervision of allied dental personnel working directly with them.
- 3.6 Dentists providing dental care within clinical practice must maintain an appropriate level of professional indemnity cover.
- 3.7 Dentists should conduct themselves in accordance with the Australian Dental Association's Principles of Ethical Dental Practice and their Branch Code of Ethics.
- 3.8 Dentists have an ethical obligation to engage in continuing professional development throughout their practising careers.

#### **Policy Statement 2.2**

Adopted by ADA Federal Council, November 21/22, 2002.  
Amended by ADA Federal Council, April 22/23, 2004.  
Amended by ADA Federal Council, November 13/14, 2008.



## ALLIED DENTAL PERSONNEL

### 1 Introduction

- 1.1 Over the years dental workers other than dentists have been introduced into the dental workforce. This varies greatly around the world depending on the particular country's existing dental workforce, resources, political climate but rarely on evidence-based analysis.
- 1.2 The Australian Health Ministers' Conference 2004 has determined a National Health Workforce Strategic Framework. The first guiding principle of this framework asserts that 'Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.'
- 1.3 **Definitions**
  - 1.3.1 ALLIED DENTAL PERSONNEL are those, other than dentists, working in the provision of dental services – namely dental assistants, dental therapists, dental hygienists, dental prosthetists, dental laboratory assistants, dental technicians and master dental technicians.
  - 1.3.2 REGISTRABLE allied dental personnel are those whose autonomous duties and tasks include invasive dental procedures.
  - 1.3.3 NON-REGISTRABLE allied dental personnel are those whose autonomous duties and tasks do not include any invasive dental procedures.
  - 1.3.4 PRESCRIPTION is detailed written instruction provided by a dentist to allied dental personnel, and usually specifies the treatment to be performed.
  - 1.3.5 INSTRUCTION is the oral elaboration of "prescription" and may include a teaching component.
  - 1.3.6 SUPERVISION is the direction and/or oversight by dentists of the performance of duties by allied dental personnel. Supervision can be direct (i.e., the dentist is physically present in the treatment facility at all times the patient is being treated by allied dental personnel) or indirect (i.e., the dentist need not be physically present in the treatment facility, but must be able to be contacted at all times the patient is being treated by allied dental personnel).
  - 1.3.7 INVASIVE PROCEDURES are those where entry to the tissue, body cavities or organs of a patient occurs, or where surgical repair of traumatic injury to a patient is undertaken.
  - 1.3.8 BOARD is a Federal, State or Territory dental registration board.

## **2** Principles

- 2.1 All Australians should have access to modern, comprehensive oral health care.
- 2.2 Australia must be largely self sufficient with regard to the training of the dental workforce.
- 2.3 Allied dental personnel should only perform those duties for which they are formally trained.
- 2.4 Only allied dental personnel who perform invasive and irreversible procedures should be registered.

### **Responsibilities of Dentists**

- 2.5 The dentist must be responsible for the diagnosis, treatment planning, and delivery of dental procedures and the continuing evaluation of the oral health of the patient. The dentist is also responsible for the support, direction and supervision of allied dental personnel in the conduct of prescribed duties for which they are legally accountable.
- 2.6 With respect to allied dental personnel other than dental prosthetists, it is the responsibility of the dentist to:
  - ensure that all members of the dental workforce at all times have appropriate competence and training for the tasks that are delegated to them;
  - have an understanding of the roles of all members of the dental workforce;
  - inform patients that a specified part of their treatment is to be undertaken by allied dental personnel;
  - monitor and supervise the performance of allied dental personnel;
  - consult with patients regarding the treatment plan and to instigate referral to specialists;
  - provide adequate prescription and instruction to ensure that the procedures and/or treatment to be performed are understood;
  - be available for consultation and management of any complications that may occur; and
  - ensure that all delegated procedures have been performed satisfactorily.

### **Responsibilities of Allied Dental Personnel**

- 2.8 It is the responsibility of allied dental personnel to:
  - have a complete understanding of the role of all members of the dental workforce;
  - carry out only those delegated tasks for which they are legally authorised where they practise and for which they are formally educated and trained and have appropriate competence;
  - refer to a dentist any condition or task which is outside their competence, education and training, including changes in a patient's health status or medication; and
  - if applicable hold appropriate professional indemnity cover.

## **3** Policy

- 3.1 The future dental workforce should provide services that:
  - are population based;
  - are patient focused;
  - lead to the coordinated, non-fragmented provision of oral health services;
  - are preventively oriented; and
  - should ensure an adequate dental workforce in rural and remote areas.

## Categories

3.2 The following categories of allied dental personnel in Australia are recognised:

### Non-registrable:

- dental assistant;
- dental laboratory assistant;
- dental technician; and
- master dental technician.

### Registrable:

- dental hygienist;
- dental therapist; and
- dental prosthetist.

## Regulation of Practice of Allied Dental Personnel

3.3 Dental hygienists, dental therapists and dental prosthetists must be registered and practise in accordance with all statutory requirements. Regulation of practice must be vested in the Boards enacted by legislation under the relevant Federal, State or Territory Acts which must provide that:

- the scope of practice is clearly defined;
- the course of training is prescribed;
- registration is required and a register regularly maintained; and
- penalties apply for contravention of any provisions of the relevant Act.

3.4 Dental technicians, and any other persons not registered with a Board, who own and/or control dental laboratories must be licensed to do so by Boards.

3.5 Provider numbers must only be issued to those members of the dental workforce who practice independently. Therefore amongst allied dental personnel only dental prosthetists shall be issued with provider numbers.

## Education and Scope of Practice of Allied Dental Personnel

3.6 Education and training for allied dental personnel must reflect their defined scope of practice, which should be nationally uniform.

## Dental Assistant

3.7 Basic education and training of dental assistants must be at Certificate III level in the vocational sector and in accordance with the National Competency Standards.

3.8 With additional education and training in clearly defined areas to Certificate IV level in the vocational sector, and in accordance with the National Competency Standards, the duties of dental assistants extend to:

- dental assisting – oral health promotion;
- dental assisting – dental radiography;
- dental assisting – technical procedures;
- dental assisting – general anaesthesia and conscious sedation; and
- dental assisting – dental practice administration.

3.9 Duties shall comprise established procedures associated with chair side assisting, infection control and practice administration

3.10 A dental assistant must work under the supervision of a dentist or suitable allied dental personnel as detailed in Appendix 2 to this Policy Statement.

## Dental Hygienist

- 3.11 Education and training of dental hygienists must be to Diploma level and of at least two years' duration. The education and training should be conducted in either the higher education sector in a tertiary institution associated with the training of dentists or in the vocational sector in a course dedicated to only dental hygiene training and accredited by the Australian Dental Council (ADC).
- 3.12 The duties of a dental hygienist should be directed towards oral health education and the prevention of dental diseases, including dental caries and periodontal disease.
- 3.13 Treatment services provided by a dental hygienist must be provided in accordance with a written treatment plan which has been signed and dated by a dentist who has personally examined the patient, and:
- such treatment plan shall be effective for not more than twelve months; and
  - the need for examination of the patient by the dentist after completion of the treatment plan by the dental hygienist will depend on the needs of the patient, the treatment provided and the experience and competency of the dental hygienist.
- 3.14 The role of the dental hygienist in the provision of dental treatment shall be subject to the following:
- 3.14.1 The dental treatment must be supervised by a dentist who is on the premises at the time of treatment, except in the case of dental treatment within categories referred to in paragraph 3.14.2 a. to h. provided on the premises of long term residential care, either government or licensed under local government legislation, for the elderly or persons with physical or intellectual disability, provided that a medical practitioner or registered nurse is at close call.
- 3.14.2 The dental treatment must fall within the following range of statutory duties:
- a. established procedures associated with chair side assisting and practice management;
  - b. oral health education;
  - c. instruction in monitoring and recording of plaque control routines and recording of periodontal disease;
  - d. prophylaxis;
  - e. polishing of restorations;
  - f. fluoride therapy, application of remineralising solutions and desensitising agents;
  - g. debridement to remove supragingival deposits from teeth;
  - h. debridement to remove subgingival deposits from teeth;
  - i. application and removal of rubber dam;
  - j. application of non-invasive fissure sealants;
  - k. taking of alginate impressions other than for the fabrication of prosthetic appliances;
  - l. removal of periodontal packs;
  - m. taking of dental radiographs;
  - n. orthodontic band sizing;
  - o. removal of orthodontic appliances including orthodontic cements and resins;
  - p. placement and removal of non-metallic separators and alastic modules;
  - q. administration of local anaesthesia by infiltration and mandibular nerve block.

## **Dental Therapist**

- 3.15 Education and training of dental therapists must be to Diploma level and of at least two years' duration. The education and training should be conducted either in the higher education sector in a tertiary institution associated with the training of dentists or in the vocational sector in a course dedicated to only dental therapy training and accredited by the ADC.
- 3.16 A dental therapist must work under the supervision of a dentist.
- 3.17 The duties of dental therapists shall be restricted to prevention of dental diseases and control of dental caries in school children.
- 3.18 The provision of treatment by a dental therapist must fall within the following range of statutory duties:
- a. established procedures associated with chair side assisting and practice management;
  - b. oral health education;
  - c. oral health examination;
  - d. taking of dental radiographs;
  - e. application and removal of rubber dam;
  - f. pre- and post-operative instruction;
  - g. irrigation of the mouth;
  - h. fluoride therapy, application of remineralising solutions and desensitising agents;
  - i. debridement to remove deposits from teeth;
  - j. taking of alginate impressions other than for the fabrication of prosthetic appliances;
  - k. application of fissure sealants;
  - l. direct coronal restoration of primary and permanent teeth;
  - m. pulpotomies in vital primary teeth;
  - n. administration of local anaesthesia only by infiltration and mandibular nerve block;
  - o. forceps extraction of primary teeth under local anaesthesia.
- 3.19 Education and training of dental therapists should be phased out in favour of dental hygienists.

## **Dental Laboratory Assistant**

- 3.20 Education and training of dental laboratory assistants must be to Certificate III level conducted in the vocational sector and in accordance with National Competency Standards.
- 3.21 A dental laboratory assistant must work under the supervision of a dental technician or dentist.
- 3.22 The duties of a dental laboratory assistant shall consist of the following established laboratory procedures:
- a. pouring impressions;
  - b. producing custom-made trays;
  - c. constructing occlusal registration rims;
  - d. constructing mouthguards;
  - e. articulating models; and
  - f. transferring records.

### **Dental Technician**

- 3.23 Dental technician education and training must be to Diploma level and can be two to three years' full time study with a period of structured learning of one to two years. The training should be conducted in the vocational sector and in accordance with National Competency Standards.
- 3.24 A dental technician may work independently of a dentist, but must adhere to the prescription of a dentist and is not permitted any direct dealings with members of the public except in the case of non-invasive shade taking at the direction of the dentist.
- 3.25 The duties of a dental technician shall consist of the following established laboratory procedures:
- a. fabrication, maintenance and repair of complete and partial dentures;
  - b. fabrication of inlays, onlays, veneers, crowns and bridges;
  - c. fabrication of mouthguards, occlusal splints, medicament trays and stents;
  - d. fabrication of appliances used in orthodontics, oral and maxillofacial surgery and other special areas of dentistry.

### **Master Dental Technician**

- 3.26 A master dental technician must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The education and training must be conducted in the vocational sector and in accordance with National Competency Standards.
- 3.27 The advanced training for a master dental technician shall include:
- a. attachments to implants in complete and partial dentures;
  - b. precision attachments associated with inlays, onlays, crowns and bridges;
  - c. greater depth understanding of materials and processes; and
  - d. ceramic systems, CAD/CAM.

### **Dental Prosthetist**

- 3.28 A dental prosthetist must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The education and training must be conducted in the vocational sector and in accordance with National Competency Standards.
- 3.29 Dental prosthetists may independently provide treatment to the public limited to the provision, in healthy mouths, of mouthguards and dentures not associated with implants.
- 3.30 All patients should be examined by a dentist prior to treatment by a dental prosthetist.
- 3.31 Education and training of dental prosthetists should be phased out in alignment with the decrease in demand for removable dental prostheses.

### **Career Path**

- 3.32 Education and training institutions should facilitate entry of allied dental personnel into dental workforce training courses that are at a higher level than their current qualification (e.g., dental assistants training to become dental hygienists). This provides a career path for allied dental personnel within the dental workforce based on appropriate training.

### **Policy Statement 2.3**

Adopted by ADA Federal Council, April 10/11, 2003.  
Amended by ADA Federal Council, November 11/12, 2004.  
Amended by ADA Federal Council, November 10/11, 2005.  
Amended by ADA Federal Council, November 2/3, 2006.  
Amended by ADA Federal Council, April 12/13, 2007.  
Amended by ADA Federal Council, November 15/16, 2007.  
Amended by ADA Federal Council, November 13/14, 2008.

APPENDIX 1 TO POLICY STATEMENT 2.3

ALLIED DENTAL PERSONNEL

AUSTRALIAN QUALIFICATIONS FRAMEWORK

SECONDARY SCHOOLS SECTOR	VOCATIONAL EDUCATION AND TRAINING SECTOR	HIGHER EDUCATION SECTOR
		Doctoral Degree
		Masters Degree
		Graduate Diploma
		Graduate Certificate
		Bachelor Degree
	Advanced Diploma	Associate Degree Advanced Diploma
	Diploma	Diploma
Senior Secondary Certificate of Education	Certificate IV	
	Certificate III	
	Certificate II	
	Certificate I	

## APPENDIX 2 TO POLICY STATEMENT 2.3

### ALLIED DENTAL PERSONNEL

#### MODEL STANDARDS STATEMENT FOR DENTAL ASSISTANTS

### EDUCATIONAL AND SUPERVISORY REQUIREMENTS FOR DENTAL ASSISTANTS

#### **Introduction**

Dentists, dental therapists and dental hygienists and their employers have a responsibility to know a dental assistant's clinical and educational experience, scope of duties in keeping with appropriate Federal, State or Territory legislation and regulations, and supervisory requirements during the provision of oral health care procedures. There is no necessity for dental assistants to be registered.

#### **Purpose**

This Standards Statement describes the supervisory responsibilities and the relationship between the scope of duties and educational experience associated with the employment of dental assistants.

#### **Scope of Duties**

A dental assistant is primarily employed as a clinical assistant to the dentist. Their duties include clinical chair side assisting, maintaining infection control standards and to assist in practice administration.

The usual duties of a dental assistant are in accordance with their educational and clinical experience and require the direct supervision of a dentist, dental therapist and dental hygienist depending on the tasks undertaken by the dental assistant.

#### **Educational and Clinical Experience**

All dental assistants should be encouraged and supported to gain entry qualifications in dental assisting or recognition of equivalence, which has been issued by an Australian registered training organisation. Qualifications in dental assisting are particularly suited to the Australian Apprenticeship/Trainee pathway, which involves on-the-job and off-the-job training.

There are several levels of dental assistant educational and clinical experience that are recognised.

1. A dental assistant undergoing on-the-job training for at least six months and has no prior work-related experience. During the period of training a qualified dental assistant may support the training of an unqualified and inexperienced dental assistant.
2. A dental assistant undergoing on the job training and off-the-job training for a period of at least 12 months. During the period of training a qualified dental assistant may support the training of an unqualified and inexperienced dental assistant.
3. A dental assistant qualified in a nationally based Certificate III in Dental Assisting<sup>1</sup> or its equivalent working under the supervision of a dentist, dental therapist or dental hygienist. Minimum units include<sup>2</sup>:
  - 3.1 Communicate and work effectively in health
  - 3.2 Comply with infection control policies and procedures in health work
  - 3.3 Process reusable instruments and equipment in health work

- 3.4 Participate in OHS processes
  - 3.5 Prepare for and assist with oral health care procedures
  - 3.6 Assist with dental radiography
  - 3.7 Assist with the administration in dental practice
  - 3.8 Apply first aid
4. A dental assistant qualified in a nationally based Certificate IV in Dental Assisting<sup>1</sup> or its equivalent working at an advanced level under the supervision of a dentist, including:
- 4.1 Dental Assisting – dental radiography
  - 4.2 Dental Assisting – oral health promotion
  - 4.3 Dental Assisting – technical procedures (also known as 'extended duties'<sup>2</sup>)
  - 4.4 Dental Assisting – general anaesthesia and conscious sedation
  - 4.5 Dental Assisting – dental practice administration

## **Supervision**

The legal and ethical responsibilities associated with the actions and omissions of a dental assistant are attributed primarily to the supervising dentist. Any allied dental personnel or employer involved in the supervision of the dental assistant may also be liable.

Compliance with Board and statutory regulatory bodies is essential. Consultation to clarify any matters related to a dental assistant's qualifications, experience and competence to perform advanced scopes of duties or undertake on the job training may be required to attain nationally based Certificate IV qualifications in Dental Radiography and Technical procedures such as taking an impression for study models.

The clinical responsibilities for the patient remain with the dentist, dental therapist and dental hygienist providing the treatment and/or providing supervision at all times.

All advanced duties undertaken by a dental assistant should be in accordance with a written treatment plan prepared by a dentist.

During the performance of an advanced duty by a dental assistant, a dentist should be on the premises to:

- Provide supervision
- Provide advice and consultation in relation to authorised dental assistant activities
- Be available for referral in relation to other matters falling outside the competence of an individual dental assistant

All the above supervisory responsibilities of dentists apply equally to dental prosthetists conducting independent practice.

## **Patient Consent**

Appropriate patient consent is to be obtained prior to the dental assistant undertaking any advanced duty involving direct patient contact.

The patient may decline to have the dental assistant undertake the advanced duty and elect to have a dentist, dental therapist or dental hygienist to complete the task. The choice of dentist, dental therapist or dental hygienist is dependent on the task and the dentist's supervisory obligations.

## **Records**

A dental assistant undertaking advanced duties must maintain a signed work record of each patient contact recording the date and procedure undertaken.

The name of the dental assistant performing an advanced duty should be entered into the patient record for that procedure according to the usual standards for record keeping.

<sup>1</sup> Health Training Package HLT07 found at [www.cshisc.com.au](http://www.cshisc.com.au)

<sup>2</sup> Terminology this section according to nationally based competency units, Health Training Package 07

## **Misrepresentation**

When undertaking advanced duties involving direct contact with the patient, a dental assistant, supervisory dentist and employer should not hold out or represent a dental assistant as a dental care provider to the patient or through advertising.

## APPENDIX 3 TO POLICY STATEMENT 2.3

### ALLIED DENTAL PERSONNEL GLOSSARY OF TERMS

PREFERRED TITLE	ALTERNATE TITLE	OCCUPATION APPROPRIATE FOR AUSTRALIA
Dental Assistant	Dental Nurse	Yes
Dental Hygienist		Yes
Dental Therapist		Yes - short term
Dental Laboratory Assistant		Yes
Dental Technician	Laboratory Dental Technician	Yes
Master Dental Technician		Yes
Denturist	Clinical Dental Technician, Advanced Dental Technician, Dental Prosthetist	Yes - short/medium term
Maxillofacial Prosthetist and Technologist		No
Orthodontic Chair Side Assistant		No
Orthodontic Technician		No
Orthodontic Therapist		No
Oral Health Therapist		No
Practice Manager		Yes (not Allied Dental Personnel)
Receptionist		Yes (not Allied Dental Personnel)

## SPECIALISATION IN DENTISTRY

### 1 Introduction

1.1 The recognition of specialities and specialist practitioners serves to identify to the public and to the dental and allied professions individual practitioners who have special competence in a specified area of dental practice.

#### 1.2 **Definitions**

1.2.1 **SPECIALISATION** is the exclusive practice of a recognised speciality of dentistry by an appropriately qualified practitioner.

Notwithstanding the delineation of a speciality, the area defined may be practised by registered dentists provided they possess the necessary skills, experience and expertise.

1.2.2 A **SPECIALIST PRACTITIONER** or **SPECIALIST** is one who practises a recognised speciality, possesses a higher qualification relevant to this area of dentistry, and has fulfilled any other statutory requirements within the State or Territory of practising and has been so registered.

In the absence of appropriate credentials, limitation of practice does not confer specialist status; nor does possession of a higher qualification and limitation of practice to an area of dentistry not formally recognised as a speciality.

1.2.3 **BOARD** is a Federal, State or Territory dental registration board.

### 2 Principles

2.1 Specialisation serves to stimulate organisation, education and research in a particular area of dentistry.

2.2 The establishment of a dental speciality must address a clear health need and public demand.

2.3 The acquisition of specialist status and the use of the designated title of the speciality should be strictly regulated.

2.4 Only fully qualified and registered dentists will be eligible for training as specialists.

2.5 A specialist's primary purpose must be to render a service to patients and the community which requires knowledge and skill beyond those which could normally be expected in the relevant area of dental practice.

2.6 Specialisation should not in any way curtail the right of the general dental practitioner to practise any discipline of the profession.

2.7 Only dental specialists, as recognised by Boards, may use specialist titles or refer to themselves as specialists. The public must not be misled about a practitioner's specialist status.

### **3 Policy**

#### **Recognition of Dental Specialties**

- 3.1 To be recognised as a dental speciality, any proposed speciality should meet the following criteria. It should:
- Have a clear need and demand of a substantial portion of the population.
  - Be important to the health of individual patients.
  - Be an area of dentistry in which general practitioners may have need to refer patients for provision of expert services in a particular area of dentistry.
  - Require special knowledge and skills, superior to undergraduate dental education and training, in order to perform procedures of an advanced, difficult, or unusual nature.
  - Be definable in order to prescribe the scope of the speciality.
  - Be one in which approved educational institutions conduct accredited formal courses to qualify practitioners appropriately.
  - Have an established specialist organisation.
  - Be recognised by the Australian Dental Association Inc. (ADA).

#### **Requirements for Specialisation**

- 3.2 A person seeking recognition as a specialist in a chosen area shall have:
- Successfully completed an acceptable undergraduate course in dentistry.
  - Attained the legal status to practise dentistry.
  - Completed a mandatory period in the general practice of dentistry in private practice, hospital or other institutional practice, a public health service or the Armed Services.
  - Completed a course of graduate education leading to an acceptable higher qualification relevant to the area of specialisation.

#### **Education Requirements**

- 3.3 The minimum period of postgraduate education, including training/experience for any speciality, should preferably be three years full time, but longer clinical training may be deemed to be appropriate for some specialities.
- 3.4 Only those courses of specialist education which have been accredited by the Australian Dental Council or courses deemed equivalent by Boards should be recognised as acceptable qualifications for specialisation.
- 3.5 Completion of research, no matter how advanced or valuable, should not be considered as sufficient grounds for registration in any speciality.

#### **Registration**

- 3.6 Specialist status shall be subject to registration conferred through statutory powers vested in State or Territory Dental Boards.
- 3.7 Dental Acts should prescribe:
- areas of dental specialisation;
  - requirements for registration as a dental specialist; and
  - that only recognised dental specialists may use specialist titles.

## Currently Recognised Specialties

3.8 The specialties recognised by the ADA shall be designated and defined as follows:

### 3.8.1 **Dento-maxillofacial Radiology**

That part of dental practice which deals with diagnostic imaging procedures applicable to the hard and soft tissues of the oral and maxillofacial region and to other structures which are relevant for the proper assessment of oral conditions.

A Specialist in dento-maxillofacial radiology shall have the title of Dento-maxillofacial Radiologist.

### 3.8.2 **Endodontics**

That part of dental practice which deals with the morphology, physiology, and pathology of the human tooth and, in particular, the dental pulp, root and peri-radicular tissues. It includes the biology of the normal pulp, crown, root and peri-radicular tissues and the aetiology, prevention, diagnosis and treatment of diseases and injuries that affect these tissues.

A Specialist in endodontics shall have the title of Endodontist.

### 3.8.3 **Oral and Maxillofacial Surgery**

That part of dental practice which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.

A Specialist in oral and maxillofacial surgery shall have the title of Oral and Maxillofacial Surgeon.

### 3.8.4 **Oral Surgery**

That part of dental practice which deals with the diagnosis, surgical and adjunctive treatment of diseases and injuries limited to the dento-alveolar complex.

A Specialist in oral surgery shall have the title of Oral Surgeon.

### 3.8.5 **Oral Medicine**

That part of dental practice which deals with the clinical diagnosis, assessment and principally non-surgical, pharmacological management of anatomical variants, pathological conditions, diseases and pain of the dental, oral and adjacent anatomical structures and the dental/oral manifestations and complications of systemic diseases, pathology and conditions and their treatment.

A Specialist in oral medicine shall have the title of Oral Physician.

### 3.8.6 **Oral Pathology**

That part of dental practice which deals with diseases of the teeth, jaws, oral soft tissues and associated structures, studies their causes, pathogenesis and effects, and by use of clinical, radiographic, microscopic and other laboratory procedures establishes differential diagnoses and provides forensic evaluations.

A Specialist in oral pathology shall have the title of Oral Pathologist.

### 3.8.7 **Orthodontics**

That part of dental practice which deals with the study and supervision of the growth and development of the dentition and its related anatomical structures, including preventive and corrective procedures of dentofacial irregularities requiring the re-positioning of teeth, jaws, and/or soft tissues by functional or mechanical means.

A Specialist in orthodontics shall have the title of Orthodontist.

### 3.8.8 Paediatric Dentistry (Paedodontics)

That part of dental practice which deals with the prevention and the treatment of dental diseases and abnormalities in children and their associated developmental and behavioural problems.

A Specialist in paediatric dentistry shall have the title of Paediatric Dentist or Paedodontist.

### 3.8.9 Periodontics

That part of dental practice which deals with the prevention, recognition, diagnosis and treatment of the diseases and disorders of the investing and supporting tissues of natural teeth or their substitutes.

A Specialist in Periodontics shall have the title of Periodontist.

### 3.8.10 Prosthodontics

That part of dental practice which deals with the restoration and maintenance of oral health, function and appearance by coronal alteration or reconstruction of natural teeth, or the replacement of missing teeth and contiguous oral and maxillofacial tissues with substitutes.

A specialist in prosthodontics shall have the title of Prosthodontist.

### 3.8.11 Public Health Dentistry

That part of dental practice which deals with the community as the patient rather than the individual, being concerned with oral health education of the public, applied dental research and administration of dental care programmes including prevention and control of oral diseases on a community basis.

A Specialist in Public Health Dentistry shall have the title of Public Health Dentist.

### 3.8.12 Special Needs Dentistry

That part of dental practice which deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans.

A Specialist in Special Needs Dentistry shall have the title of Special Needs Dentist.

## Obligations of Specialists

3.9 In treating a referred patient, a specialist shall:

- keep the referring practitioner informed of progress;
- attempt to seek consent of the referring practitioner before making a further referral;
- not perform services which are outside his/her specialty without the consent of the referring practitioner; and
- after completion of treatment, direct the patient back to the referring practitioner.

3.10 A specialist shall guide and educate dentists to higher levels of competence.

### **Policy Statement 2.4**

Adopted by ADA Federal Council, November 15/16, 2001.  
Amended by ADA Federal Council, November 11/12, 2004.  
Amended by ADA Federal Council, November 13/14, 2008.

## AREAS OF PRACTICE ADJUNCTIVE TO DENTISTRY

### 1 Introduction

- 1.1 Boards and other regulatory authorities in Australia have introduced specific requirements, including educational programmes, which dentists must fulfil if they are to include certain areas of practice adjunctive to dentistry. However, such requirements do not confer any special status.
- 1.2 The Australian Dental Council (ADC) offers a process for certification of programmes which are a requirement to gain endorsement to practise in areas adjunctive to dentistry.
- 1.3 **Definitions**
  - 1.3.1 BOARD is a State or Territory dental registration Board.
  - 1.3.2 AREAS OF PRACTICE ADJUNCTIVE TO DENTISTRY are parts of dental practice which are usually not unique to dentistry, nor part of undergraduate dental education and training. These could include acupuncture, conscious sedation for dental procedures, hypnosis, and external cosmetic procedures.
  - 1.3.3 CONSCIOUS SEDATION means a technique in which the use of a drug or drugs administered by the intravenous route produces a state of depression of the central nervous system enabling treatment to be carried out, and in which:
    - verbal contact with the patient can be maintained or the patient responds appropriately to stimulation; and
    - the drugs and techniques used have a margin of safety wide enough to render unintended loss of consciousness unlikely.

### 2 Principles

- 2.1 Dentists who practise in an area adjunctive to dentistry would be expected to complete a recognised programme of training and satisfy other specified criteria to ensure the safety of the public. Satisfying such criteria would not lead to specialist registration, but may be a requirement of a Board in order for a dentist to practise in such adjunctive areas.
- 2.2 Boards should endorse the registration of any dentist who has fulfilled the requirements to practise in an area adjunctive to dentistry.
- 2.3 Dentists must only include areas of practice adjunctive to dentistry if they have fulfilled the Board requirements.
- 2.4 Any educational requirements for areas of practice adjunctive to dentistry should be certified by the ADC.

### 3 **Policy**

- 3.1 Where a Board requires endorsement to practise in an area adjunctive to dentistry, a dentist must obtain such endorsement prior to commencing practice in that area.
- 3.2 To ensure uniformity, the ADC is the appropriate body to certify educational requirements for areas of practice adjunctive to dentistry.
- 3.3 Endorsement of areas of practice adjunctive to dentistry does not confer specialist status.
- 3.4 Areas of practice adjunctive to dentistry that should require Board endorsement include acupuncture, conscious sedation for dental procedures, and external cosmetic procedures.

#### **Policy Statement 2.5**

Adopted by ADA Federal Council, November 11/12, 2004.  
Amended by ADA Federal Council, November 13/14, 2008.